



Crossroads

Summer 2017

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Production Team

Production Leader

Ryan Kelly

External Relations

Kate Cooley

Graphic Designer

Lorie Hanson

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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.

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MISSISSIPPI NOW HAS THREE MEDICAID MCOS

By Ryan Kelly

Most are aware that the Mississippi Division of Medicaid recently released an RFP for new and existing insurance companies to bid on management of Mississippi's Medicaid population. Previous to this release, UnitedHealthcare and Magnolia Health (Centene) filled two of the three spots originally created by the Mississippi legislature. The goal of the Medicaid Managed Care Organizations (MCOs) is to create efficiency and decrease the cost of the Medicaid program.

The Division of Medicaid recently announced the successful recipients of the RFP. Those recipients include the two incumbent insurers,

as well as the addition of Molina Health. The MRHA has been in frequent contact with Molina about their process for on boarding practices and providers into their system. They will join the Association's Quality Assurance Task Force and will be a partner of the Association's moving forward.

Although more information will be supplied soon, and the Association will host a webinar with Molina soon to answer questions, interested practices and providers may request enrollment information by contacting the network team at:

mhine@molinahealthcare.com.

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JOIN MRHAS NEW TASK FORCES AND USER GROUPS

In order to better serve Association members with key interest areas and opportunities, we are starting two new task forces and two new user groups. Please see the information below and contact us if you would like to join one of these groups.

EMR TASK FORCE

This group is designed to be a temporary meeting of any facilities or providers in Mississippi interested in switching to a new electronic medical record system and who would like to work with others also looking to switch. The goal of the group is to identify the top needs that they have with a new EMR and to identify bundled purchase options for reduced cost and maximum impact.

DELEGATED CREDENTIALING/ PROVIDER ENROLLMENT TASK FORCE

This group is designed to bring together clinic and hospital staff working to improve their credentialing and provider enrollment services. This is one of the most common issues that our members face, and improvement is needed. This task force will investigate several delegated credentialing and provider enrollment options to see if they will help to improve each facilities' processes.

ACCOUNTABLE CARE ORGANIZATION

The ACO User Group is designed to unite members of Mississippi's ACOs into a central location for monthly learning sessions. This user group will meet once per month to share updates and best practices on what has helped them to achieve reduced cost and increased quality in the nation's new population health model.

TELEHEALTH

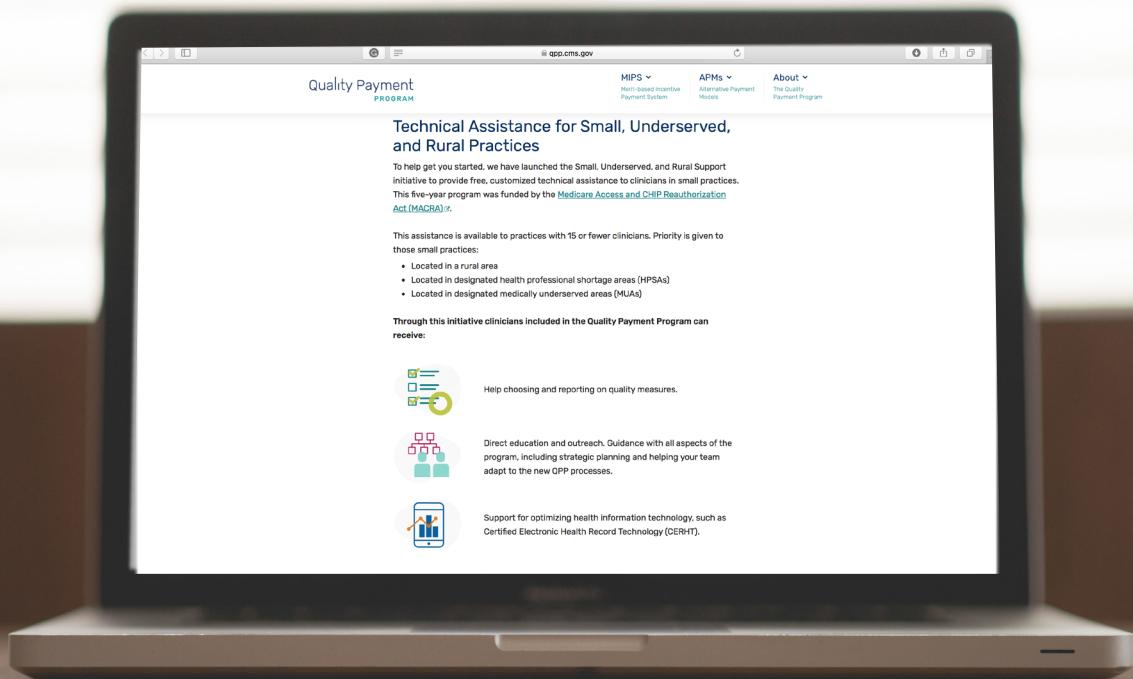
The Telehealth User Group will combine efforts with the Mississippi Telehealth Association and unite providers, users, and technology companies together to discover better ways to deliver telehealth and improve access to quality health-care and increased profitability of telehealth. In addition, the user group will work to complete a new manual for telehealth implementation in the state.

Learn more at
msrha.org/task-forces-and-collaboratives

NEW QUALITY PAYMENT PROGRAM (QPP) WEBSITE FOR RURAL CLINICIANS

CMS launched a new section on the QPP website dedicated to clinicians working in small or rural practices as well as those in underserved areas. This webpage serves as a single point of reference to get Technical Assistance about the

Merit-based Incentive Payment System (MIPS) and to review the flexibilities to help reduce the burden on small practices for participation and reporting. More features and information will be added over time.



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THE LATEST SCOOP ON THE FEDERAL HEALTHCARE BILL

By Ryan Kelly

This issue of Crossroads has largely been delayed due to the ever changing nature of the Senate healthcare bill. This article has been re-written five times in one week just to keep up with the advances to the changes in the bill! I decided that with all of the votes that have taken place over the past two weeks, there is no way to write a comprehensive article that would be accurate by the time this issue of Crossroads is printed. Therefore, this will give a higher look at the proposed Senate legislation to repeal elements of the Patient Protection and Affordable Care Act.

So what's the latest scoop on this legislation?

The US Senate's healthcare bill, called the Better Care Reconciliation Act of 2017, was designed to correspond to the American Health Care Act recently passed in the US House of Representatives. This bill, as well as several related bills, have all been considered but not approved by the Senate as of the time of the writing of this article. The Senate recently voted to open the floor for debate on legislation, but none have successfully received the needed 51 votes of approval through the process of reconciliation.

The originally proposed legislation would 1) repeal the individual and corporate mandates for health insurance, 2) keep popular aspects of the ACA such as preventing insurance plans from excluding patients based on preexisting conditions, and keep children on parent's insurance until the age of 26, 3) re-establish high risk pools and refund the Medicare and Medicaid Disproportionate Share Hospital Payments (DSH). 4) reform Medicaid

federal payments by moving from an open-ended matching program to a block grant or per capita program.

Our conversations with Sen. Thad Cochran's and Sen. Roger Wicker's offices have been very positive, and we have been in open dialogue with their offices supplying recommendations for amendments or inclusions for the healthcare bill. All of these efforts are to protect rural health in Mississippi and ensure that anything that is passed will allow for equivalent or increased access to care, reduced health care cost to the consumer, and level or increased funding to providers. In addition, to ensure that our safety net in Mississippi is maintained.

The devil is always in the details, as they say. We are watching closely and doing what we can to communicate with our legislators the needs that you communicate to us. Our Association at this time is not taking a positive or negative stance on the bill, but we are rather making attempts to ensure that the needs of rural Mississippi are being met as best as possible. We work for you, and we want to do the best that we can to fight for you on this...all the while knowing that the personal and professional opinions of all of our members vary. We believe in the team approach - the One Rural approach - and we want to continue to build partnership with our peers both locally and nationally to do the best that we can to serve our members.

If you have any questions, please contact Ryan Kelly at 601.898.3001 or ryan.kelly@mississippi-rural.org.



Showcase Yourself as a RURAL HEALTH PROFESSIONAL

The Mississippi Rural Health Association has established two new credentials designed to highlight the professionals that make up rural health in our state. The Mississippi Rural Health Fellow (MRHF) and Mississippi Rural Health Student Fellow (MRHSF) reward healthcare professionals and show others that you have attained the experience and knowledge befitting of one of Mississippi's best.

MISSISSIPPI RURAL HEALTH
FELLOW 

Mississippi's Medicaid Managed Care Organizations (MCOs)





RURAL ENTREPRENEURSHIP FORUM

The Catalyzing Entrepreneurship and Economic Development (CEED) Initiative works with UM students and faculty to build actionable partnerships with Mississippi communities.

These partnerships will increase entrepreneurship and promote economic development in rural Mississippi communities. The CEED Initiative is funded with generous support from the Robert M. Hearin Support Foundation. CEED includes several opportunities for University of Mississippi students, faculty, and community members: Each year ten undergraduate students will be named McLean Institute Innovation Scholars. These will be exemplary undergraduate students with an interest in entrepreneurship and economic development in Mississippi's rural communities. The two-year period for each project will be used to research a problem and to develop and pilot a sustainable and scalable solution. Solutions will take various forms: a business plan, a detailed framework for a non-profit organization, or a significant policy or academic research paper. Students will work with local communities to identify and refine compelling topics and to implement solutions. Projects will address social problems including poverty, education, asset building, and healthcare. Scholars are awarded an \$8,000 scholarship for two years, with additional stipends available for fieldwork and internships. The McLean Institute will sponsor four graduate student Innovation Fellows each year. Fellows are exemplary students with innovative ideas for addressing poverty-related problems in Mississippi as graduate assistants affiliated with the McLean Institute. The two-year period for each project will be used to assist undergraduate Innovation Scholars research a

problem identified by the local community and to develop and pilot, and evaluate a sustainable and scalable solution. Graduate fellows will work closely with faculty advisors and will meet regularly with undergraduate Innovation Scholars working on similar projects or communities. Fellows will receive \$20,000 each year to cover in-state tuition, health insurance, and a living stipend. Fellows receive additional stipends for research/planning within their project area. Two grants are provided each year to UM faculty members seeking to conduct research in Mississippi. Supported projects focus on economic development and entrepreneurship. The program will encourage research that can improve the economic position of our partner communities. Faculty chosen for these awards present their research to campus and the public at large. Applications for research grants will be made available in November. Starting in the fall of 2015, the McLean Institute will sponsor an annual Rural Entrepreneurship Forum. The forum will showcase the work of students and faculty around the country working to support economic development and entrepreneurship in rural communities, particularly in the communities in partnership with the CEED Initiative. Each cohort of Innovation Scholars and Fellows will work in four rural counties or communities in Mississippi. Students will work closely with community mentors in one of these regions. The 2014-2016 cohort engaged with partners in Calhoun, Coahoma, Lee, and Tallahatchie Counties.

MISSISSIPPI'S ENTIRE CONGRESSIONAL DELEGATION HAS CO-SPONSORED THE "REMOVING BARRIERS TO COLORECTAL CANCER SCREENING ACT OF 2017"

In April 2017 Dr. Stephen T. Amann, the American College of Gastroenterology Governor of Mississippi, flew to Washington, DC. Dr. Amann, along with 50 other ACG Governors, held over 300 meetings with members of the United States House of Representatives and Senate to ask them to support the "Removing Barriers to Colorectal Cancer Screening Act of 2017 (S479, HR1017). This bill removes the cost sharing during a colonoscopy when a screening exam becomes a therapeutic one (i.e. a polyp is encountered and removed, for example). Dr. Amann met with health care liaisons of each member and met personally with Rep Gregg Harper. Representative Harper was a joy to meet with and Dr. Amann greatly appreciated his time and true interest in this issue. All were very encouraging and supportive of these efforts especially when this comes to the people of Mississippi. In each of his meetings, Dr. Amann discussed in detail the poor screening rates for colon cancer in the state and the implications this has on the GI health of Mississippians.

SOCIAL WORKERS HONORED BY GOVERNOR BRYANT

By David Kenny, WDAM

There was a standing ovation, as the first time ever award for Outstanding Service in Child Protection was given to two Mississippi social workers, by Governor Phil Bryant. Tausha Rawls and Melody Vaughn awarded for their work on a Canton child neglect case by the Mississippi Department of Child Protection Services. Late last year Vaughn and Rawls suspected a child was being abused in the Canton Villa apartments. Their investigation led to two arrests, and the removal of 8 children from an apartment, where one child was being seriously abused. Tausha Rawls said, "I was able to go in make an assessment, find out if the parents were lying and ultimately we were able to save a life." Melody Vaughn said, "This child had never been in school and couldn't even tell us his full name. This child looked like he was three, but he was in fact 11. I think he weighed 41 pounds." Police arrested and charged the child's parents Anthony Holiday and Latasha Leonard with child abuse. Their children were placed in foster care where they are now thriving. The social workers who saved them, say they will keep on fighting for kids in Mississippi. Melody Vaughn said, "I'm a social worker all day and I intend to keep on social working until God tell me my time in this field is up."



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MISSISSIPPI HEALTH SYSTEM FORMS A CLINICALLY INTEGRATED NETWORK THAT PARTNERS DOCTORS AND NURSE PRACTITIONERS

By Joanne Finnegan, Fierce Healthcare

North Mississippi Health Services' decision to form a clinically integrated network came with a dilemma. In its corner of Mississippi, nurse practitioners provide about 53% of patient's primary care. Most networks only include doctors, but that didn't make sense for NMHS. Given that the number of advanced practice clinicians is predicted to grow and the pool of physicians to shrink, North Mississippi rewrote the formula for forming successful partnerships to create a network for population health management. Along with doctors, the network includes advanced practice clinicians.

Erik Dukes, M.D., regional medical director for North Mississippi Health Services, says it may be the model for the future. "The primary care provider mix in Mississippi today is the U.S. provider mix of tomorrow," he told FierceHealthcare ahead of the Healthcare Financial Management Association conference in Orlando, Florida, this week, where he spoke at a session about the

network the health system has created. The Tupelo-based health system serves 24 mostly rural counties in the northeast corner of Mississippi and a few neighboring counties in Alabama. In 2016, it decided to form a clinically integrated network with the quadruple aim of providing quality, reducing costs, increasing patient satisfaction and increasing provider happiness. A clinically integrated network brings the advantages of being part of a group, where members typically share electronic health record systems to track and help determine the best methods of clinical care delivery that are most cost effective. The networks also allow for negotiating alternative, value-based contracts with payers. Breaking down barriers. Historically, like many hospitals, the North Mississippi health system had focused on physicians, leaving advanced practice clinicians—which in Mississippi is primarily nurse practitioners—off the radar screen, Dukes said. Yet, those nurse practitioners provide much of the area's primary care, making

one-third to one-half of specialist referrals. Mississippi ranks dead last on a list of states based on the number of active primary care physicians per 100,000 people.

Physician assistants, another type of advanced practice clinician, are very underutilized in the area, with only three in the entire health system, Dukes said. So when it formed Connected Care Partners, its clinically integrated network, the vision was to build a high-value system of care working towards that quadruple aim. That required a new strategy for providing cost-effective care in value-based contracts: a partnership that brought in those nurse practitioners. "It sounds kind of cliché and cheesy, but it was the right thing to do," Dukes says. "As we looked at a clinically integrated network, we had to reach out to them." Many of the nurse practitioners work in solo or small group practices. The big challenge was how to bring them into the network. North Mississippi Health Services had to set up its network differently than most, said David Fairchild, M.D., director of BDC Advisors, a company that worked with the health system for a year to set up the network, who also spoke at the HFMA session on Tuesday. One lesson learned in Mississippi was to acknowledge the historical divide between physician practices and nurse practitioner practices. Many doctors see the nurse practitioner practices as competition. Advanced practice clinicians have traditionally been looked at as physician "extenders" and mid-level providers. But they are taking on a new role as part of team-based care. In Mississippi, nurse practitioners in solo practice still require a supervising physician. For some people, there's also the question of the quality of care they provide since they have less training than doctors. The first question the health system faced when developing the network was whether the steering committee should include nurse practitioners. There was also the question of what the nurse practitioners would think about the network. The nurse practitioners felt they were not well connected to the health system and that it favored physicians, Dukes said. They felt they had no voice and no connection to the electronic medical record system. Supervising physicians were often looked at as a "hired pen" to review and sign a subset of charts

each month as required by state regulations for independent nurse practitioner practices.

A second lesson was to actively seek to understand the needs of all providers. The network development process set the stage. Instead of forming a physician steering committee, they formed a provider steering committee that was inclusive of nurse practitioners and the network included a nurse practitioner on its board. The network wanted to become the preferred partner for nurse practitioners in the region. How to engage and recruit the nurse practitioners? It was crucial to develop credibility and establish communication. The goal was to have one high standard of primary care and to begin to measure quality. By improving quality across the network, they focused on an "all boats rise together" philosophy. The primary care collaborative helped clarify clinical protocol needs to account for different levels of training and a newsletter was created to meet educational needs of the nurse practitioners and doctors. The steering committee went on a tour of nurse practitioner practices to hear their ideas and issues. There were dinners and brainstorming sessions and the group developed a set of initiatives to provide value to the nurse practitioners. Those included the newsletters to highlight care guidelines, assistance with monitoring and improving quality metrics, economies of scale and preferred pricing for network-selected solutions, access to provider information including continuing education opportunities and access to a physician preceptor program with network physicians to allow providers to network and share best practices, and read-only access to the network EMR.

One nurse practitioner, who runs a group of clinics, was moved to tears that the network would reach out to them, Dukes said. But both Dukes and Fairchild said the partnership is a work in progress. Fairchild said he thinks there will be more clinically integrated networks in the future that partner with advanced practice clinicians. "I think it's definitely headed in that direction, reading the tea leaves," he said.

To view this article, visit fiercehealthcare.com



POLICY UPDATES

340B BILLING POLICY IMPLEMENTATION DELAYED

The Mississippi Division of Medicaid (DOM) is further delaying 340B billing policy implementation pending Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 17-0002. DOM will notify providers of the implementation date following CMS approval. Providers should continue preparing for implementation. DOM plans to host an informational stakeholder call in the coming weeks. As a reminder, 340B Covered Entities are required to complete a 340B Attestation Form for each unique HRSA-issued 340B identification number that has chosen to opt-in (bill Medicaid for 340B purchased drugs).

EMERGENCY PREPAREDNESS RULES TAKE EFFECT NOVEMBER 2017

RHCs must comply with new Emergency Preparedness rules as a condition of participation (CoP) in the RHC program by November 15, 2017. These new rules can be found at 42 CFR §491.12. Earlier this week, CMS released their “advanced copy” of the emergency preparedness interpretive guidelines (IGs) which further

details specifically what RHCs need to do to pass their survey. This document (also known as Appendix Z to the State Operation Manual) represents the most granular and specific instructions we will receive from the government on the new emergency preparedness rules.

SETTING TRANSITION PLAN

The Centers for Medicare and Medicaid Services (CMS) granted the Division of Medicaid initial approval of its Statewide Transition Plan (STP) on May 25, 2017, to bring settings into compliance with the federal home and community based services (HCBS) regulations found at 42 C.F.R. §§441.301(c)(4)(5) and Section 441.710(a)(1)(2). Initial approval was granted because DOM has completed its systemic assessment; included the outcomes of this assessment in the STP; clearly outlined remediation strategies to rectify issues that the systemic assessment uncovered, such as legislative/regulatory changes and changes to vendor agreements and provider applications; and is actively working on those remediation strategies. To learn more about the Statewide Transition Plan initial approval, visit the 1915(c) and 1915(i) Home and Community-Based (HCB) Setting Transition Plan page.



MACRA PROPOSAL WOULD EASE EHR BURDEN FOR DOCS, BUT NOT HOSPITALS

By Rachel Arnut, Modern Healthcare

Although the CMS today proposed giving physicians a yearlong reprieve before having to upgrade their certified electronic health record system, hospitals may still be on the hook. The agency today proposed easing some requirements for physicians under the Medicare Access and CHIP Reauthorization Act, including allowing them to continue using the 2014 certified version of their EHR. The proposal only applies to physicians. Under meaningful use requirements, hospitals must have a 2015 certified product in place by the end of this year in order to have reporting data for the first three quarters of 2018. Failure to do so would result in Medicare penalties. But there's a catch: Vendors aren't ready, which means hospitals will be under a time crunch to deploy a system once it comes to market and is certified by the Office of the National Coordinator for Health Information Technology. As of June 20, there are 74 products—including some from Epic Systems Corp. and Cerner Corp.—that are certified under the 2015 Edition Health IT Certification Criteria, according to the ONC's Certified Health IT Product List. But, said Steve Posnack, director of the ONC's Office of Standards and Technology, some of the products certified are among the most popular and are therefore used by many providers. "The shift in moving things from meaningful use to MIPS added a little bit of time to the development cycle for the EHR developers," he added. So might have some of the new requirements, said Mari Savickis, vice president of federal affairs at the College of Healthcare Information Management Executives. She pointed specifically to the API requirements as a challenge. "That's a fairly big jump," she said. "It's a lot of work, and it's complicated. They need more time." Though many providers have their products certified, "that's not the end of the story," said Pamela McNutt, chief infor-

mation officer of Methodist Health System, Dallas. "You still have to install it, and these upgrades are huge." Methodist recently switched to Epic, and the version installed was already certified. That's fortuitous, McNutt said, because implementing a new EHR can take up to eight months or so for a hospital system. Even physicians face months long implementation times. "Even once you've got the software installed, you have to exercise it," she said. Providers that use software-as-a-service EHRs, such as Athenahealth, may fare better, McNutt said, since upgrades to those systems are more easily pushed out. (Athenahealth has yet to release 2015 edition-certified products, though it will by year-end.) "Vendors are very aware of the deadlines," said Justin Seger, vice president of product management for Athenahealth. Providers that don't use a product on the list could rush to get certified EHRs in place in time, but "do you really want to see a situation where providers are jamming in the new technology?" Savickis said. "It's not enough time." For some of these providers, there may be an option that allows them to avoid penalties: filing for hardship, which providers can do if they cannot meet the criteria "for a reason beyond their control," which can include the availability of a certified EHR. There's hope that the CMS will give hospitals more time, as it is proposing to do for physicians. "We think it behooves HHS to take a reasonable step to push the deadline out to allow the provider community an additional year using the 2014 edition," Savickis said, a sentiment echoed in a letter to CMS Administrator Seema Verma from CHIME, in which the organization wrote that its members are "very apprehensive about the looming requirement."

To view this article, visit Modernhealthcare.com



COMING IN APRIL 2018: NEW MEDICARE CARD NEW NUMBER

Medicare is taking steps to remove Social Security numbers from Medicare cards. In April 2018, people with Medicare will begin receiving new Medicare cards, replacing all cards by April 2019. These cards will have a Medicare Beneficiary Identifier (MBI) number that is randomly generated with “non-intelligent” characters that do not have any hidden or special meaning. If you currently send Railroad Retirement Board (RRB) Medicare claims to the RRB Specialty Medicare Administrative Contractor, Palmetto GBA, you will notice a change with the new

cards: You will no longer be able to distinguish people with Railroad Medicare by the number on the card. The RRB will continue to send cards with the RRB logo to people with Railroad Medicare. We will return a message on the eligibility transaction response for a Railroad Medicare patient. The message will say, “Railroad Retirement Medicare Beneficiary” in 271 Loop 2110C, Segment MSG. If you use eligibility service vendors to check patient Medicare eligibility, contact them to find out how to get this and other information.



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CMS HOSPITAL QUALITY STAR RATING: FOR 762 RURAL HOSPITALS, NO STARS IS THE PROBLEM

By Kristie Thompson, et al, MS Rural Health Research Program

In April 2017, the Centers for Medicare & Medicaid Services (CMS) released their fourth Hospital Quality Star Rating list. Since the first release, stakeholders have been publicly debating the star rating scale's usefulness in comparing hospital quality, but little focus has been given to the large number of rural hospitals with no rating. The brief looks more closely at the characteristics of rural hospitals with and without quality star ratings to help inform ongoing discussions about the usefulness of the quality star rating for comparing hospital quality and possible ways to improve the star rating initiative. The data in this brief highlight a limitation in using the Hospital Quality Star Rating to compare quality either among rural hospitals or between rural and urban hospitals. More than one third of rural hospitals did not receive a star rating, compared with 12% of urban hospitals. Among rural hospitals, CAHs and very small hospitals (lowest net patient revenue) were least likely to receive a star rating. Rural hospitals without a star rating were clustered across the West, Midwest, and South Census Regions. It is important for consumers, policy makers, and other stakeholders to know that the disproportionate amount of missing data limits the conclusions that can be drawn from comparisons of the rural hospital quality star ratings. Regardless of

the reason, it is important for consumers, policy makers, and other stakeholders to know that the disproportionate amount of missing data limits the conclusions that can be drawn from comparisons of the rural hospital quality star ratings. It is also important for consumers to avoid automatically interpreting no stars as zero stars (low quality) or a signal that a hospital is "hiding something." The challenges in healthcare performance measurement for rural providers were addressed by the National Quality Forum Rural Health Committee in 2015. The Committee's overarching recommendation was to "make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers but allow a phased approach for full participation across program types and address low case volume explicitly." More specifically, the committee recommended funding development of rural relevant measures to develop and/or modify measures to address low case volume explicitly, consider rural-relevant sociodemographic factors in risk adjustment, and to create composite measures that are appropriate for rural (particularly low-volume) providers.⁵ It might be prudent for CMS to reconsider the recommendations in the Committee's report as a solution to the missing star problem of rural hospitals.



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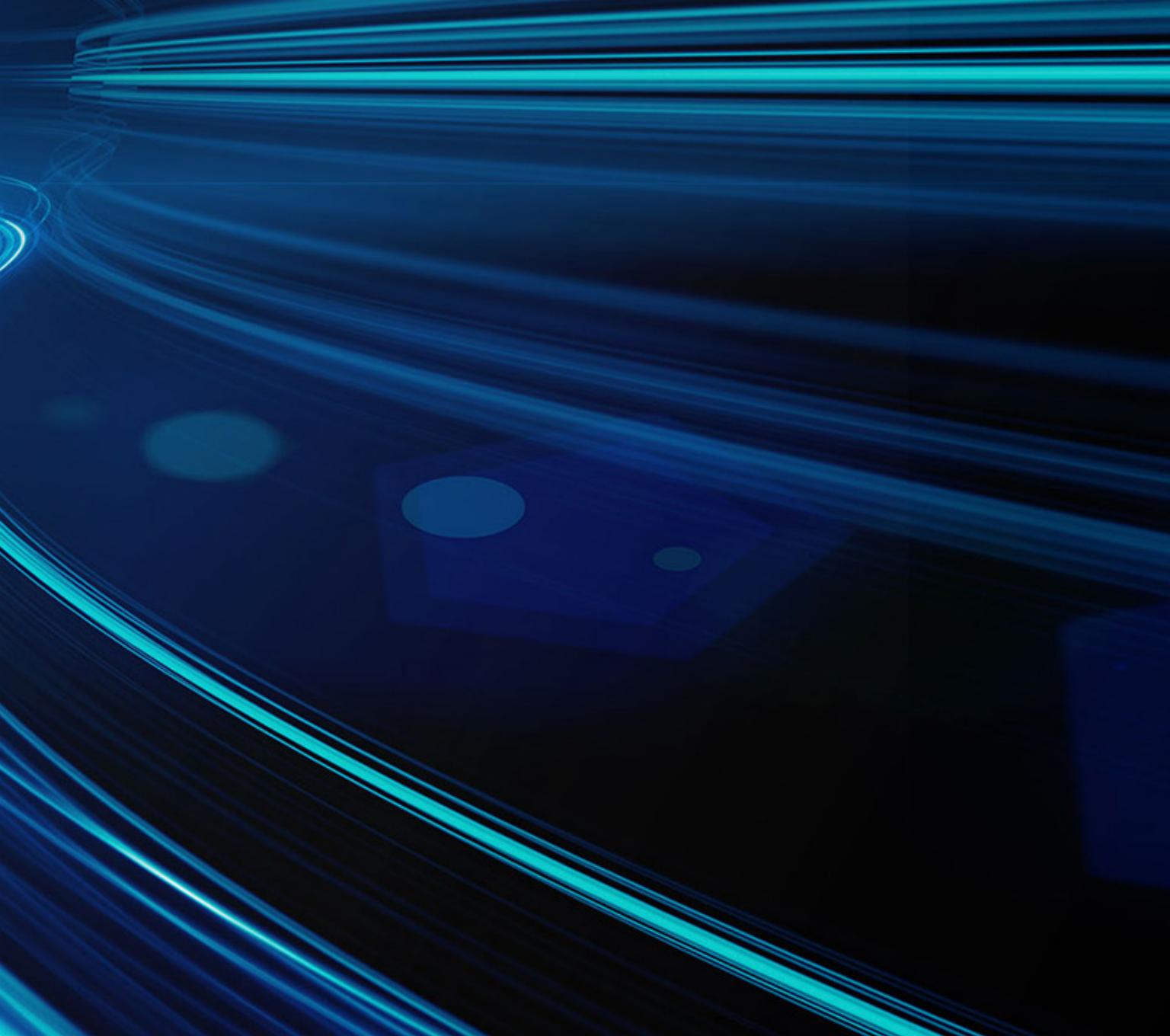
By Eric Wickland, M Health Intelligence

Telehealth advocates say better broadband connectivity is the key to pushing telemedicine out to rural parts of the country, where healthcare access is limited and residents face a slew of health concerns.

A new bill on Capitol Hill seeks to help urban healthcare providers expand telemedicine programs to rural areas by giving them access to federal funds for broadband connectivity. The bill is part of a full-court press by rural healthcare providers, state legislators, healthcare organizations and telemedicine experts to pressure the federal government to

improve broadband connectivity to underserved parts of the country. The “Reaching Underserved Rural Areas to Lead on Telehealth (RURAL) Act” was introduced this month by Sens. Brian Schatz, D-Hawaii, and Roger Wicker, R-Miss., two well-known supporters of telemedicine initiatives. S.1377 seeks to allow non-rurally classified health systems

to qualify for discounts in the Federal Communications Commission’s Healthcare Connect Fund as long as the money goes toward broadband services that would help people in rural areas. “Our bill will give telehealth service providers better incentives to serve more rural areas,” said Schatz, a key sponsor of the Expanding Capacity for Health Outcomes



(ECHO) Act, which became law earlier this year, and the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act, now under consideration, in a prepared statement. “Ultimately, that is good news for anyone who cares about expanding access to health care in Hawai‘i and other rural areas across the country.” “Telehealth services are critical to increasing rural

Americans’ access to quality care,” added Wicker, also a sponsor of the CONNECT Act. “Mississippi is leading the nation in developing telehealth technology. Our health-care providers have demonstrated that targeted investments in telehealth can increase access to life-saving services and drive down costs.” The bill, originally introduced in 2016, would update existing law to allow non-rural members of

telehealth consortia to qualify for the HCF’s 65 percent healthcare provider broadband connectivity discount. The HCF was established by Congress in 2013 as part of the Universal Service Fund (USF) to support advanced telecommunication and information services for eligible healthcare providers. Broadband connectivity is one of the chief impediments to the expansion of telemedicine services to rural areas. And it’s a

popular topic these days in Washington. Schatz and Wicker re-introduced their bill during a hearing this month on rural broadband support before the Senate Committee on Commerce Science and Transportation's Subcommittee on Communications, Technology, Innovation and the Internet, one of at least three hearings that week that touched on better connectivity for rural regions of the country.

That hearing also heard testimony from one of the nation's leading telehealth experts. Karen S. Rheuban, MD, director of the University of Virginia Center for Telehealth, lobbied for increased funding to expand broadband services into rural areas. "Affordable broadband connectivity is without question, the requisite underpinning of our telemedicine program, and as such, these efforts have changed the standard of care in rural Virginia," Rheuban, a former president of the American Telemedicine Association, told the subcommittee. Rheuban argued that rural areas need access to telemedicine – and, therefore, better broadband connectivity – because rural residents lack access to healthcare services and have a higher percentage of unhealthy habits and chronic diseases. She noted a database created by the FCC's Connect2Health Taskforce in which roughly half of the nation's counties were identified as "double burden" counties, with high levels of chronic disease and a need for better broadband. "More than 36 million Americans live in these double burden counties, according to the FCC report, where the fixed broadband access rate is 55 percent," she said. "The FCC also found that in these counties, as an example, the prevalence of obesity is 19 percent above the national average, while the prevalence of diabetes is 25 percent above the national average. A lack of Internet access is also connected with challenges in seeing health professional. 'Most of the counties with the worst access to primary care physicians are also the least connected,' according to the FCC report." In 2015, a coalition of telehealth and health IT organizations, including the Healthcare Information and Management Systems Society (HIMSS) and the Personal Connected Health Alliance (PCHA), petitioned the FCC to improve wireless and broadband access to rural healthcare providers through resources like the HCF. "The need amongst many rural

healthcare providers for access to high quality broadband access is profound," Thomas Leary, HIMSS' vice president of government relations, and PCHA Vice President Robert Havasy wrote in a two-page letter of support. "This need for wireless and wireline broadband access represents a critical component to furthering a nationwide network optimized for tomorrow's high-quality healthcare delivery systems. Benefits of expanded broadband access include the ability to conduct secure high quality eVisits such as telemedicine and expanded remote patient monitoring within the home."

Issues with broadband access have also prompted state legislatures to speak out. This past April, Alaska legislators issued a joint resolution urging the FCC to increase the budget for the Rural Health Care Universal Support Fund, which hasn't budged from its \$400 million limit since the fund was launched in 1997. That fund exceeded its limit this year for the first time. In making their pitch for federal support for broadband, Alaska's legislators pointed out that the Rural Health Care Universal Service Support Fund budget has never been adjusted for inflation, advances in technology or increases in demand; if it were adjusted for inflation alone, they said, the fund would total \$600 million. "The long-distance delivery of quality healthcare via telemedicine has made great strides in rural Alaska in recent years," Rep. Bryce Edgmon (D-Dillingham), the resolution's sponsor, said in a news release. "However, we're about to hit a roadblock. Increasing the FCC support budget will allow healthcare providers in isolated communities to continue expanding local treatment options in ways we never could have dreamed of just a few years ago." "Telehealth allows patients in rural parts of Alaska access to state-of-the-art diagnostic tools and treatments that can help the sick and afflicted," added Rep. Zach Fansler (D-Bethel). "This resolution puts the House on record supporting a proactive solution to a looming problem potentially jeopardizing healthcare for hundreds of thousands."

Also this year, Montana legislators rejected a bill to set telemedicine practice standards because they worried residents in one of the nation's most rural states wouldn't have access to the technol-

ogy. State senators reportedly soured on the bill because it focuses on audio-visual telemedicine and bans phone-based consults as a means of establishing a doctor-patient relationship. More than half of the state's residents reportedly don't have access to sufficient broadband to support video consults, so a telephone might be their best link to telehealth.

Earlier this year, Wicker joined 40 other senators in a letter to newly appointed Health and Human Services Secretary Tom Price asking him to advocate for better patient care access in rural areas. "We recognize that providers need to adapt to changes in the delivery of healthcare," the letter stated. "We are encouraged by innovations we have seen in our states as providers test new care models and technologies like telehealth and remote patient monitoring." "We know you will find bipartisan interest in supporting these types of innovations, and we look forward to working with you to improve our healthcare system," the senators added. "We recognize the importance of tackling this issue in a fiscally responsible way but believe investments in rural America yield substantial returns on investment." A new bill on Capitol Hill seeks to help urban healthcare providers expand telemedicine programs to rural areas by giving them access to federal funds for broadband connectivity. The bill is part of a full-court press by rural healthcare providers, state legislators, healthcare organizations and telemedicine experts to pressure the federal government to improve broadband connectivity to underserved parts of the country. The "Reaching Underserved Rural Areas to Lead on Telehealth (RURAL) Act" was introduced this month by Sens. Brian Schatz, D-Hawaii, and Roger Wicker, R-Miss., two well-known supporters of telemedicine initiatives. S.1377 seeks to allow non-rurally classified health systems to qualify for discounts in the Federal Communications Commission's Healthcare Connect Fund as long as the money goes toward broadband services that would help people in rural areas. "Our bill will give telehealth service providers better incentives to serve more rural areas," said Schatz, a key sponsor of the Expanding Capacity for Health Outcomes (ECHO) Act, which became law earlier this year, and the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for

Health Act, now under consideration, in a prepared statement. "Ultimately, that is good news for anyone who cares about expanding access to health care in Hawai'i and other rural areas across the country." [READ MORE: Broadband Offers a Telehealth Lifeline to Rural Hospitals](#) "Telehealth services are critical to increasing rural Americans' access to quality care," added Wicker, also a sponsor of the CONNECT Act. "Mississippi is leading the nation in developing telehealth technology. Our health-care providers have demonstrated that targeted investments in telehealth can increase access to life-saving services and drive down costs." The bill, originally introduced in 2016, would update existing law to allow non-rural members of telehealth consortia to qualify for the HCF's 65 percent healthcare provider broadband connectivity discount. The HCF was established by Congress in 2013 as part of the Universal Service Fund (USF) to support advanced telecommunication and information services for eligible healthcare providers. Broadband connectivity is one of the chief impediments to the expansion of telemedicine services to rural areas. And it's a popular topic these days in Washington. Schatz and Wicker re-introduced their bill during a hearing this month on rural broadband support before the Senate Committee on Commerce Science and Transportation's Subcommittee on Communications, Technology, Innovation and the Internet, one of at least three hearings that week that touched on better connectivity for rural regions of the country. That hearing also heard testimony from one of the nation's leading telehealth experts. [READ MORE: Broadband: The Missing Link to Rural Telehealth Success](#) Karen S. Rheuban, MD, director of the University of Virginia Center for Telehealth, lobbied for increased funding to expand broadband services into rural areas. "Affordable broadband connectivity is without question, the requisite underpinning of our telemedicine program, and as such, these efforts have changed the standard of care in rural Virginia," Rheuban, a former president of the American Telemedicine Association, told the subcommittee. Rheuban argued that rural areas need access to telemedicine – and, therefore, better broadband connectivity – because rural residents lack access to healthcare services and have a higher percentage of unhealthy habits and chronic diseases. She noted a

database created by the FCC's Connect2Health Taskforce in which roughly half of the nation's counties were identified as "double burden" counties, with high levels of chronic disease and a need for better broadband. "More than 36 million Americans live in these double burden counties, according to the FCC report, where the fixed broadband access rate is 55 percent," she said. "The FCC also found that in these counties, as an example, the prevalence of obesity is 19 percent above the national average, while the prevalence of diabetes is 25 percent above the national average. A lack of Internet access is also connected with challenges in seeing health professional. 'Most of the counties with the worst access to primary care physicians are also the least connected,' according to the FCC report." **READ MORE:** Taking Telehealth to Rural America In 2015, a coalition of telehealth and health IT organizations, including the Healthcare Information and Management Systems Society (HIMSS) and the Personal Connected Health Alliance (PCHA), petitioned the FCC to improve wireless and broadband access to rural healthcare providers through resources like the HCF. "The need amongst many rural healthcare providers for access to high quality broadband access is profound," Thomas Leary, HIMSS' vice president of government relations, and PCHA Vice President Robert Havasy wrote in a two-page letter of support. "This need for wireless and wireline broadband access represents a critical component to furthering a nationwide network optimized for tomorrow's high-quality healthcare delivery systems. Benefits of expanded broadband access include the ability to conduct secure high quality eVisits such as telemedicine and expanded remote patient monitoring within the home." Issues with broadband access have also prompted state legislatures to speak out. This past April, Alaska legislators issued a joint resolution urging the FCC to increase the budget for the Rural Health Care Universal Support Fund, which hasn't budged from its \$400 million limit since the fund was launched in 1997. That fund exceeded its limit this year for the first time. In making their pitch for federal support for broadband, Alaska's legislators pointed out that the Rural Health Care Universal Service Support Fund budget has never been adjusted for inflation, advances in tech-

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