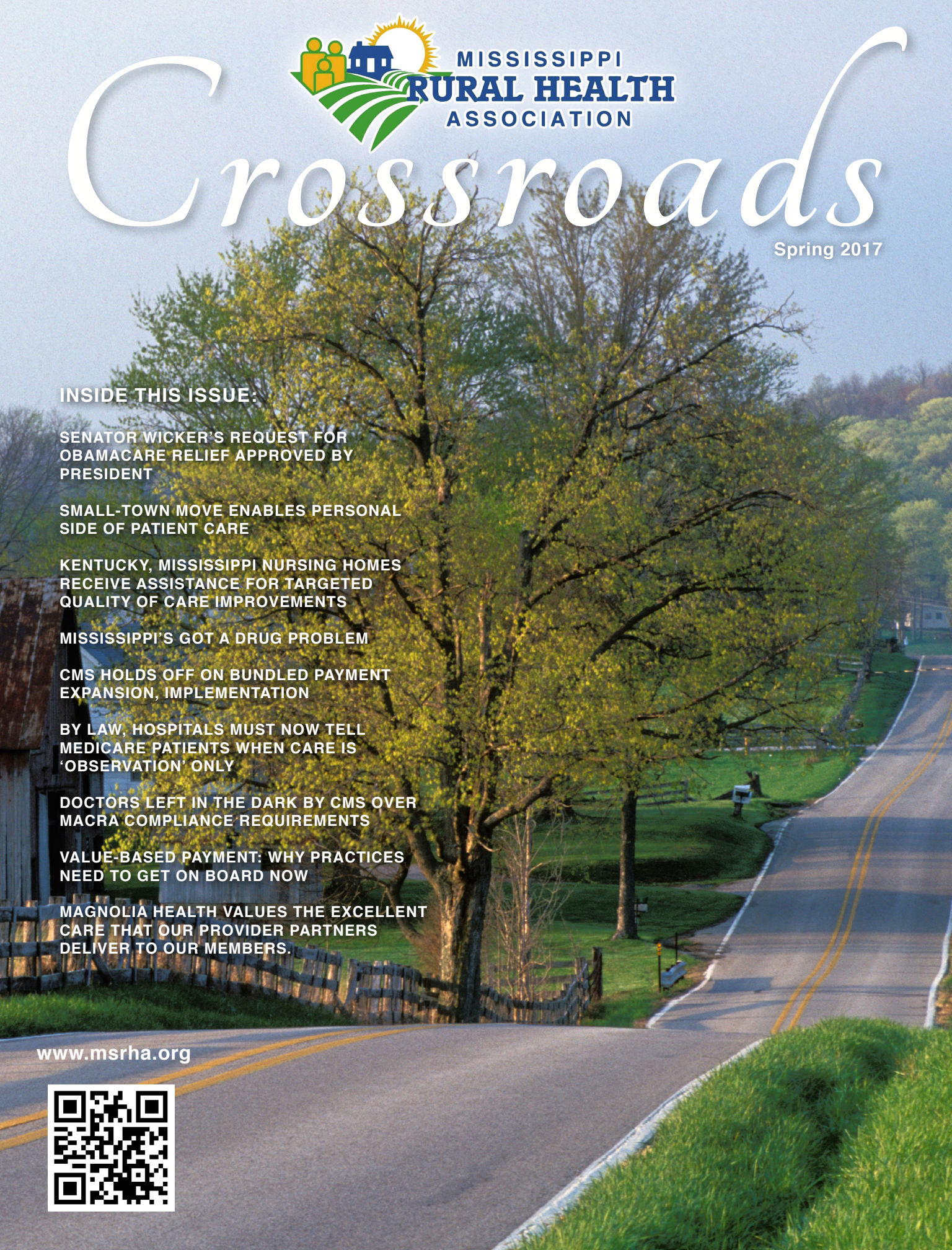
MISSISSIPPI RURAL HEALTH ASSOCIATION

Crossroads

Spring 2017



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Crossroads Magazine

MISSISSIPPI RURAL HEALTH ASSOCIATION

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Crossroads is published quarterly by the Mississippi Rural Health Association

What is *Crossroads*?

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

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A TRIP TO RURAL MISSISSIPPI

By: Ryan Kelly

I took a trip across rural Mississippi with my family – one of my favorite things to do!

We were driving through some country roads when I came across this metal barn in south central Lamar County. I grew curious when I saw this barn, "how far would it be to the nearest hospital?" With my one bar of cell service I searched the distance to the nearest facility. It was exactly 16 miles to either Merit Health Wesley or Marion General Hospital. Then I searched for the distance to the closest clinic...8.2 miles at Hattiesburg Clinic Bellevue location.

Driving back to Hattiesburg I timed the drive to that clinic. It took 16 minutes. So, if someone cut themselves on rusty barbed wire and needed a tetanus shot, or if they were bitten by a rattle snake, it would take them almost 30 minutes to reach a hospital or 16 minutes to reach a clinic. Such could be a dangerous proposition.

This is a very common example of the distance between medical providers in rural Mississippi. In many areas, the distance is much, much further.

This is why rural health is so important. Most Mississippians live in rural areas, and the distance to their nearest medical provider can be great. This is usually fine for normal procedures or visits, but for emergencies, it can be the difference in life and death.

So keep supporting rural health. For our providers, know that you are serving a population that needs you. For patients, trust in your providers that are here for you and use your local services. For insurers and lawmakers, know that your investment in rural health pays huge dividends in the lives of Mississippians. Together we will keep Mississippi's health strong.

#ONERURAL

SENATOR WICKER'S REQUEST FOR OBAMACARE RELIEF APPROVED BY PRESIDENT

By: Sarah Ulmer

U.S. Senator Roger Wicker applauded President Trump's agreement to extend transitional relief for Americans insured by Obamacare-exempt plans.
- WASHINGTON

Senator Wicker made the request through the Department of Health and Human Services (HHS) in order to help individuals insured through Obamacare during this time of transition. "No one should be penalized as Congress works to replace Obamacare with market-driven reforms,"

Wicker said. "This decision by the Trump administration will prevent millions of Americans, including more than 200,000 Mississippians, from losing their health insurance or facing premium hikes at the end of this year. I commend the Administration for recognizing that enough harm has been done. Our focus should be on putting workable health-care solutions in place, and I remain committed to working with my Senate colleagues, state leaders like Insurance Commissioner Mike Chaney, and the Trump Administration to do so."

Wicker led the letter with 22 other Republican Senators requesting the indefinite relief from Obamacare for individuals living in Mississippi and 34 other states.

SMALL-TOWN MOVE ENABLES PERSONAL SIDE OF PATIENT CARE

By: Lucy Schultze, Mississippi Medical News

As George County's only practicing ob/gyn, Jay Pinkerton, MD, is on call 24/7 and is responsible for delivering every patient he sees in clinic. He wouldn't have it any other way.


Dr. Jay Pinkerton

"It's very rewarding to know all the patients and all the families," said Pinkerton, who purposefully sought out a small, community-based practice after 10 years at a large academic center.

Pinkerton was previously division chief for general obstetrics and gynecology at Case Western Reserve University School of Medicine in Cleveland, Ohio.

His 2011 arrival at George Regional Hospital in Lucedale marked a new start for the hospital's labor and delivery unit, which had been defunct for four years. Before 2011, patients had to drive an hour away in one of three different directions to deliver their babies or have gynecologic surgery, Pinkerton said. Now, the convenience and quality of the George Regional program gives them good reason to stay close to home.

"When we opened labor and delivery here, we held the program to the same standards that applied at a large academic center," Pinkerton said. "When you look at our rates of complications, transfusions and c-sections, our quality measures are among the best in the area. There's nobody taking any shortcuts here."

George Regional, a 55-bed rural health facility, has marked nearly 1,000 deliveries since Pinkerton's arrival. It is now doubling the size of the labor and delivery unit, from four beds to eight.

Pinkerton is currently serving as chief of staff for the hospital. He is joined in his practice by his wife, Emily, a women's health nurse practitioner. While she is a native of the Cleveland, Ohio, area, her husband had a more rural upbringing which has helped him adapt easily to life in Lucedale, population 2,400.

"This are is not a whole lot different from where I grew up," he said. "It was a bigger transition for my wife, since she had never spent a significant amount of time outside larger cities.
"The fun part for us is the way everybody knows everybody. You walk into Tractor Supply, you'll see a half-dozen patients carrying around babies that you've delivered in the past few years. It's really a small town."

For Pinkerton, the scale helps make his schedule manageable, despite not having a partner with whom to share call. Whenever he has to leave town, he arranges to have an ob/gyn from nearby Keesler Air Force Base in Biloxi stay at the hospital and cover for him.

"Technically, I'm on call 24/7 — but we only live four minutes away," Pinkerton said. "My schedule is not difficult to manage, and it's really nice not to have any surprises: You're not putting out any fires in the morning that somebody else started last night."

The arrangement is a far cry from Pinkerton's previous situation at Case Western. There, he was among 16 physicians sharing call.

"There were a lot of rotations and handoffs," he said. "The hospital itself was pushing towards a system where you had one person tending labor and delivery, while everybody else was in the office. That took some of the fun out of it. You'd been with a patient for nine months or delivered her prior babies, but you were being told, 'We'd prefer you to continue seeing patients and let someone else do that delivery.'"

Pinkerton and his wife, who was working in the division of urogynecology at Case Western, decided to shift gears and seek out a small, community practice. They focused their search along the Gulf Coast, since they had relatives in the Southeast.

Ultimately, their aims provided to be in line with those of George Regional, which was seeking to reopen its labor and delivery unit. Still, he said, the community was somewhat skeptical initially.

"People were happy to have labor and delivery open, but a lot of people stood back and waited to see if it was going to work out," Pinkerton said. "Once we started delivering, people started talking about what a good experience they had, and our practice started growing fairly quickly. The hospital has really been great to work with. They've given us time to build and develop the practice."

Pinkerton started out with 150 deliveries in the first year; he has since more than doubled that number.

"We now have people who live closer to other hospitals but are traveling here to deliver," he said. "That's rewarding."
The office practice has also grown. He and his wife see patients along parallel three-room hallways, allowing her to step in and keep patients moving through whenever he has to dash between the office and the labor and delivery unit.

His wife is also trained as a first assist in the operating room.

"Emily is the one who's helping me out on c-sections, hysterectomies and complicated gynecologic surgery cases," Pinkerton said. "It's like having a chief resident beside me on every case. Working together works out great for us."

For Pinkerton, having the chance to deliver his own patients fulfills his primary reasons for choosing an ob/gyn practice. He was attracted to surgery during medical school, but was hooked on ob/gyn after a rotation at University Hospitals (UH) Case Medical Center.

"I had so much fun," he said. "We were up all night long delivering babies. I loved being part of this very happy moment for the families, and also the challenge of staying calm while solving any problem that came up."

Pinkerton completed his residency training at UH MacDonald Women's Hospital. He came to medical school after a career as a professional competitive ice skater and a stint in business.

He and his wife have one daughter, Olivia, 18 months, who was delivered by her father at George Regional Hospital.

KENTUCKY, MISSISSIPPI NURSING HOMES RECEIVE ASSISTANCE FOR TARGETED QUALITY OF CARE IMPROVEMENTS

By: Atom Alliance

Several nursing homes in Kentucky and Mississippi will soon receive a boost in their ongoing effort to provide quality care for residents. The atom Alliance, a partnership between Memphis-based Qsource in Tennessee, Kentucky and Indiana; Information & Quality Healthcare (IQH) in Mississippi; and AQAF in Alabama was recently named the recipient of a Special Innovation Project (SIP) award by the Centers for Medicare & Medicaid Services (CMS). The purpose of the study is to work collaboratively with nursing homes and long-term care facilities in Kentucky and Mississippi to improve quality-of-care concerns that represent the greatest potential for patient harm.

The atom Alliance, under CMS contract as a Quality Innovation Network-Quality Improvement Organization (QIN-QIO), works to improve overall healthcare quality throughout Alabama, Indiana, Kentucky, Mississippi and Tennessee.

The atom Alliance will work with state survey agencies and volunteer nursing home facilities in Kentucky and Mississippi to analyze outcomes and identify those measures of quality most frequently cited as posing potential risks to patients. Volunteer facilities will then work with the Alliance and state agencies to develop and support widespread adoption of effective interventions to address these concerns.

Michelle Jarboe, chair of the Kentucky Association of Health Care Facilities (KAHCF) Quality Initiative Committee, which works on a variety of quality improvement efforts, said, “It’s an important endeavor. Caring for older adults can be challenging and we know that many facilities will appreciate the added support and expertise atom Alliance will be providing through this project. It will be a benefit to the nursing facilities, their residents and families.”

Qsource’s Janet Pollock agrees. Pollock will lead the project for atom Alliance over the next two years and says her teams will work hand-in-hand with the nursing home facilities to develop and implement proven, data-driven interventions that are sustainable. “Given the scarcity of resources available to most nursing homes, we understand quality improvement programs must be systemically executable, consistent and sustainable,” Pollock said. “We’ll accomplish this by working closely with the facilities toward attainable quality improvement goals.”

Working in collaboration with the Kentucky and Mississippi state survey agencies and the participating nursing homes, atom Alliance will design tools, resources, a training curriculum and educational programs to help facilities ensure safe, effective and consistent delivery of services for residents in long-term care facilities.

The Division of Health Care in the Office of Inspector General (OIG) is responsible for licensure and certification of all health facilities in Kentucky and will partner with atom Alliance to help nursing homes address problems and improve care. “As the state survey agency, we see deficient practices and missed opportunities that may result in negative outcomes for facility residents, as well as for the facility itself. We are excited to work with atom Alliance by providing the data and support they need to assist facilities in addressing these problems,” said Sandra Houchen, director of the OIG Division of Health Care.

IQH’s Trannie Murphy is a state director for the atom Alliance in Mississippi. According to Murphy, atom Alliance expects to develop a thorough curriculum that includes at least eight general training modules for nursing home staff. “Six training programs will cover topics related to leadership, person-centered care, data reporting and other processes that ensure quality care is provided, documented and can be shared among other facilities. At least two training modules will be targeted toward more specific but frequently-cited quality of care issues, such as medication errors or infection control,” Murphy said.

LeadingAge Kentucky, formerly known as Kentucky Association of Homes and Services for the Ageing (KAHSA), represents not-for-profit community, church, proprietary and government sponsored healthcare facilities, retirement communities, assisted living, housing and service programs for the elderly and disabled.
LeadingAge Kentucky’s president, Timothy L. Veno, is a former Inspector General of the Kentucky Cabinet for Health and Family Services and director of the Kentucky state survey agency.“LeadingAge Kentucky has historically advocated for more technical support, training and dissemination of best practices when regulatory issues are identified. I can tell you that this approach, versus the highly punitive approach of leveling huge civil money penalties, will provide a more rapid improvement in care and longer lasting, positive results for residents,” he said.

Pollock noted that SIPs are two-year quality improvement projects aligning with goals of a broader, national CMS Quality Strategy that emphasizes the power of partnerships. “The atom Alliance is leveraging data-driven methods, state partnerships and stakeholder relationships, and our ability to ensure that the voices of patients and families are all represented. Already, additional partners like The Alzheimer’s Association, have agreed to assist in the effort,” Pollock said.

For information on SIP and other examples of how atom Alliance is assisting the region’s healthcare providers with quality improvement, practice transformation and other initiatives, please visit:
www.atomAlliance.org

MISSISSIPPI'S GOT A DRUG PROBLEM

By: Chad Dixon

According to the Mississippi Bureau of Narcotics, Mississippi is on the path to becoming "the most addicted state in the country." The problem? Opioid drugs.

Opioids are pain relievers that, when abused, can lead to physical dependence and withdrawal symptoms. Mainstream opioids include: Hydrocodone, Oxycodone, Codeine, Fentanyl and Heroin.

As of 2015, healthcare research firm IMS Health found Mississippi to be in the top six U.S. states prescribing opioids, per capita.

John Dowdy is the Director of the Mississippi Bureau of Narcotics. He says the majority of opioids are coming from prescribers.

"In 2016, there were 3,574,662 prescriptions written for opioids. The 3.5 million-plus prescriptions resulted in 201,224,298 dosage units being dispensed," said Dowdy.

That's enough opioids prescriptions to hand out 60-plus pills to every living man, woman and child in Mississippi.

A report by the Associated Press highlighted opioid theft in certain VA hospitals around the country. It begs the question: could a small part of Mississippi's opioid problem be coming from the states VA hospitals?

Shannon Arledge is with the Veterans Integrated Service Network 16, which oversees eight VA facilities throughout Mississippi, Arkansas, Texas, and Louisiana. He says while other states may have problems, Mississippi isn't one of them.

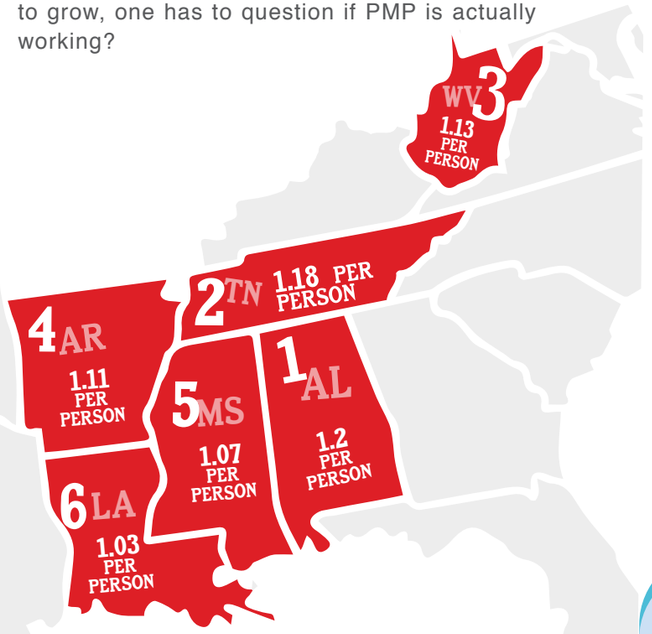
"All of our facilities monitor and track opioids through a controlled substance inspection program. Each area within our facilities that contain controlled substances is randomly inspected on a monthly basis by our VA health care professionals who are not involved with dispensing controlled substances. To further ensure accountability, a 100 percent count of all controlled substances in our facilities is completed quarterly."

In December 2016, Governor Phil Bryant signed an executive order that created a task force to address the growing opioid and heroin abuse across the state.

According to Executive Order 1388, "the Opioid and Heroin Study Task Force shall meet as often as necessary and from time-to-time make recommendations to the Governor of how to best fight opioid and heroin abuse and how to prevent it in the future."

Assisting Gov. Bryant's new task force is the state Prescription Drug Monitoring Program. The database, created in 2005, is used to recognize drug seekers who go from doctor-to-doctor for opioid prescriptions. It is also used to pinpoint unscrupulous prescribers.

With the program being around since 2005 and the number of opioid abusers continuing to grow, one has to question if PMP is actually working?



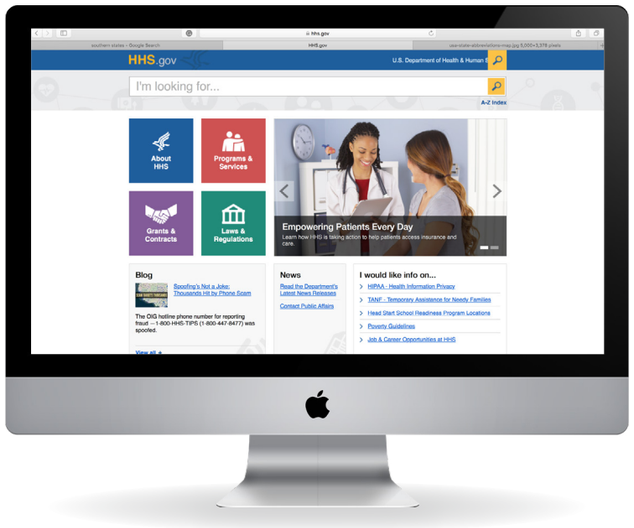
HHS LAUNCHES WEBPAGE HIGHLIGHTING ADMINISTRATIVE ACTIONS TO EMPOWER PATIENTS

The Health and Human Services Department launched a new page on HHS.gov highlighting the regulatory and administrative actions the Department is taking to relieve the burden of the current healthcare law and support a patient-centered healthcare system.

"We're taking action to improve choices for patients, stabilize the individual and small-group insurance markets, and expand access to more affordable coverage," said Secretary Tom Price, M.D. "This page will be the place to go for updates on our ongoing efforts."

The actions are part of a broader plan to repeal and replace the Affordable Care Act.

You can go the following link to see the newly launched webpage explaining the Department's actions: www.hhs.gov/healthcare/empowering-patients/providing-relief-right-now-for-patients/index.html



NEW MEASURES WILL BE ANNOUNCED AS SOON AS IS ALLOWABLE BY LAW. IN PARTICULAR, FUTURE ACTIONS WILL:

- Lower costs and increase choices by providing relief from the burdensome regulations and fostering competition in insurance markets;
- Work to ensure a stable transition period;
- Offer states greater flexibility of their Medicaid programs to meet the needs of their most vulnerable populations; and
- Increase the opportunities for patients to get the care they need when they need it.

HHS TO DELAY 340B FINAL RULE UNTIL MAY

By: Paige Minemyer

The federal government will delay for the second time the date the final rule on the 340B drug discount program takes effect. The rule would penalize pharmaceutical companies that knowingly overcharge hospitals for drugs purchased under the program.

In an interim rule posted Monday to the Federal Register, the agency pushes the effective date of the rule to May 22, and follows a similar move at the beginning of the month to delay its effective date to March 21. The Health Resources and Services Administration (HRSA) under the Department of Health and Human Services will also accept further comment between now and April 19 to determine if another delay to October is worth pursuing. The rule was originally supposed to take effect on March 6.

The rule's implementation was also delayed by a regulatory freeze issued by the Trump administration at the end of January. That freeze also had an impact on several other HHS rules so that President Donald Trump's new appointees could review the regulations.

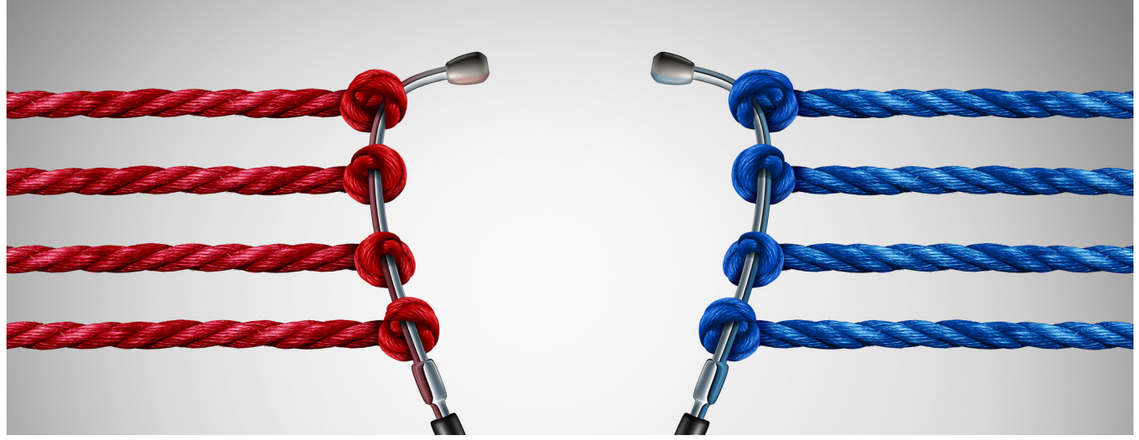
Initially, HHS intended to begin enforcing the 340B final rule on April 1 after it took effect, but the delay raised new questions about the provisions in the rule.

"After further consideration and to provide affected parties sufficient time to make needed changes to facilitate compliance, and because there are substantive questions raised, we intend to engage in longer rulemaking," according to the rule. "In addition, HHS believes that it is important to ensure that this rulemaking—as well as the implementation of this rule—is coordinated with and takes into consideration overall 340B Program implementation."

The final rule would allow HHS to issue fines of up to $5,000 to drug makers that overcharge hospitals for medications under the 340B program. The rule also included methodology for drug companies to follow when estimating the ceiling cost of a new covered outpatient drug.

Ted Slafsky, CEO of 34OB Health, a membership organization made up more than 1,200 public and private nonprofit hospitals and health systems that are enrolled in the 340B drug pricing program, said in a statement the group was "disappointed" by the delay.

"This much-needed regulation has been many years in the making and included two opportunities for the public to submit comments," Slafsky said. "Correct 340B pricing and enforcement of manufacturers' 340B obligations are vital for hospitals to be able to meet their missions to care for the underserved."



CMS HOLDS OFF ON BUNDLED PAYMENT EXPANSION, IMPLEMENTATION

By Ilene MacDonald

A new interim rule delays the expansion and implementation of major bundled payment initiatives and calls into question whether the new White House administration is committed to the programs.

In the interim rule (PDF) the Centers for Medicare & Medicaid Services:

- Delays the implementation of the mandatory cardiac bundle program and cardiac rehabilitation program from July 1 to Oct. 1.
- Postpones the expansion of the mandatory joint replacement bundle program to include other treatments for hip and femur fractures in addition to hip replacement from July 1 to Oct 1.
- Further delays the effective date of a final rule to implement the joint replacement bundle initiative, the cardiac rehabilitation incentive payment model and the initiative to advance care coordination through episode payment models from March 21 to May 20.
- Seeks comment on a potential further delay of the programs to Jan. 1, 2018.

These programs were part of a final rule issued in December, but CMS says the additional three-month delay allows the agency more time to review comments and modify the policy if necessary.

The December rule held acute care hospitals accountable for the quality and cost of care Medicare patients receive during inpatient stays and 90 days after discharge for treatment of a heart attack, bypass surgery or a hip or femur procedure.

The cardiac models apply to hospitals located in 98 metro areas. The surgical hip fracture treatment model applies to hospitals in 67 metro areas, which are the same metro areas currently included in the Comprehensive Care for Joint Replacement Model.

The latest delay came as welcome news to the Federation of American Hospitals and the American Hospital Association, which expressed concern last year that the accelerated pace of the program.

But the postponement also calls into question the future of the program. Newly appointed Health and Human Services Secretary Tom Price is not a fan of mandatory bundled payment initiatives. The former congressman has opposed mandates for bundled payments and last year wrote a letter to CMS, claiming the agency overstepped its bounds by requiring bundled payments because they took the decision away from patients and physicians.

NEXT GENERATION ACO MODEL

Building upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program (Shared Savings Program), the Next Generation ACO Model offers a new opportunity in accountable care—one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.

There are 44 ACOs participating in the Next Generation ACO Model. To view an interactive map of this Model, visit: https://innovation.cms.gov/initiatives/map/index.html#model=next-generation-aco-model

Background:
Medicare ACOs are comprised of groups of doctors, hospitals, and other health care providers and suppliers who come together voluntarily to provide coordinated, high-quality care at lower costs to their Original Medicare patients. ACOs are patient-centered organizations where the patient and providers are true partners in care decisions. Medicare beneficiaries will have better control over their health care, and providers will have better information about their patients' medical history and better relationships with patients' other providers. Provider participation in ACOs is purely voluntary, and participating patients will see no change in their Original Medicare benefits and will keep their freedom to see any Medicare provider. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Model Details:
The Next Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients. It will allow these provider groups to assume higher levels of financial risk and reward than are available under the current Pioneer Model and Shared Savings Program (MSSP). The goal of the Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare fee-for-service (FFS) beneficiaries.

Included in the Next Generation ACO Model are strong patient protections to ensure that patients have access to and receive high-quality care. Like other Medicare ACO initiatives, this Model will be evaluated on its ability to deliver better care for individuals, better health for populations, and lower growth in expenditures. This is in accordance with the Department of Health and Human Services' "Better, Smarter, Healthier" approach to improving our nation's health care and setting clear, measurable goals and a timeline to move the Medicare program -- and the health care system at large -- toward paying providers based on the quality rather than the quantity of care they provide to patients. In addition, CMS will publicly report the performance of the Next Generation Pioneer ACOs on quality metrics, including patient experience ratings, on its website.

The Model will consist of three initial performance years and two optional one-year extensions. Specific eligibility criteria are outlined in the Request for Applications (PDF).

How To Apply:
On December 15, 2016, CMS announced a new opportunity to apply for the Next Generation ACO Model. A Request for Applications (RFA) soliciting 2018 Next Generation ACO Model applications is posted below, along with a link to complete the Letter of Intent (LOI). The LOI is non-binding, but only those organizations that submit an LOI may submit an application. LOIs are due by Friday, May 4, 2017. The Next Generation ACO Model's application portal is now open; and applications will be due in May 2017. For application go to: https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model

CMS.gov
Centers for Medicare & Medicaid Services

BY LAW, HOSPITALS MUST NOW TELL MEDICARE PATIENTS WHEN CARE IS 'OBSERVATION' ONLY

By: Susan Jaffe, Kaiser Health News

The notice may cushion the shock but probably not settle the issue.

Under a new federal law, hospitals across the country must now alert Medicare patients when they are getting observation care and why they were not admitted—even if they stay in the hospital a few nights. For years, seniors often found out only when they got surprise bills for the services Medicare doesn't cover for observation patients, including some drugs and expensive nursing home care.

When patients are too sick to go home but not sick enough to be admitted, observation care gives doctors time to figure out what's wrong. It is considered an outpatient service, like a doctor's visit. Unless their care falls under a new Medicare bundled-payment category, observation patients pay a share of the cost of each test, treatment or other services.

And if they need nursing home care to recover their strength, Medicare won't pay for it because that coverage requires a prior hospital admission of at least three consecutive days. Observation time doesn't count.

"Letting you know would help, that's for sure," said Suzanne Mitchell of Walnut Creek, California. When her 94-year-old husband fell and was taken to a hospital last September, she was told he would be admitted. It was only after seven days of hospitalization that she learned he had been an observation patient. He was due to leave the next day and enter a nursing home, which Medicare would not cover. She still doesn't know why.

"If I had known [he was in observation care], I would have been on it like a tiger because I knew the consequences by then, and I would have done everything I could to insist that they change that outpatient/inpatient," said Mitchell, a retired respiratory therapist. "I have never, to this day, been able to have anybody give me the written policy the hospital goes by to decide." Her husband was hospitalized two more times and died in December. His nursing home sent a bill for nearly $7,000 that she has not yet paid.

The notice is—as of last Wednesday—one of the conditions hospitals must meet in order to get paid for treating Medicare beneficiaries, who typically account for about 42% of hospital patients. But the most controversial aspect of observation care hasn't changed.

"The observation care notice is a step in the right direction, but it doesn't fix the conundrum some people find themselves in when they need nursing home care following an observation stay," said Stacy Sanders, federal policy director at the Medicare Rights Center, a consumer advocacy group.

Medicare officials have wrestled for years with complaints about observation care from patients, members of Congress, doctors and hospitals. In 2013, officials issued the "two-midnight" rule. With some exceptions, when doctors

expect patients to stay in the hospital for more than two midnights, they should be admitted, although doctors can still opt for observation.

But the rule has not reduced observation visits, the Health and Human Services inspector general reported in December. “An increased number of beneficiaries in outpatient stays pay more and have limited access to [nursing home] services than they would as inpatients,” the IG found.

The new notice drafted by Medicare officials must be provided after the patient has received observation care for 24 hours and no later than 36 hours. Although there’s a space for patients or their representatives to sign it “to show you received and understand this notice,” the instructions for providers say signing is optional.

Some hospitals already notify observation patients, either voluntarily or in more than half a dozen states that require it, including California and New York.

Doctors and hospital representatives still have questions about how to fill out the new observation care form, including why the patient has not been admitted. During a conference call Feb. 28, they repeatedly asked Medicare officials if the reason must be a clinical one specific for each patient or a generic explanation, such as the individual did not meet admission criteria. The officials said it must be a specific clinical reason, according to hospital representatives who were on the call.

Atlanta’s Emory University hospital system added a list of reasons to the form that its doctors can check off, “to minimize confusion and improve clarity,” said Michael Ross, medical director of observation medicine and a professor of emergency medicine at Emory. Emory also set up a special help line for patients and their families who want more information, he said.

The form also explains that observation care is covered under Medicare’s Part B benefit, and patients “generally pay a copayment for each outpatient hospital service” and the amounts can vary. But Ross said “this wording may be antiquated.” Medicare revised some billing codes last year to combine several observation services into one category. That means beneficiaries are responsible for one copayment if the observation stay meets certain criteria.

The new payment package also includes coverage for some prescription drugs to treat the emergency condition that brought the observation patient to the hospital, said Debby Rogers, the California Hospital Association’s vice president of clinical performance and transformation. Other drugs for that condition will be billed under Part B with separate copayments, she said.

But patients will have to pay out-of-pocket for any medications the hospital provides for preexisting chronic conditions such as high cholesterol, and then seek some reimbursement from their Medicare Part D drug plans for any covered drugs.

Yet, Ross said, most observation visits are less expensive for beneficiaries than a hospital admission if they stay a short time, which the IG’s report also concluded. Doctors should “front load” tests and treatment so that the decision to admit or send the patient home can be made quickly. “If you get them out within a day, they are more likely to go back to independent living as opposed to needing nursing home care,” he said.

Last summer, Judy Ehnert’s 88-year-old mother had a bad fall and broke her wrist. Following surgery, and additional complications, hospital officials told the family she would be kept for observation but she would need to go to a nursing home to recover. When the family learned what observation care meant, said Ehnert, a retired bookkeeper who lives in West Fargo, North Dakota, “that’s when we blew a cork.”

Then, after a few days in observation, Enhert’s mother contracted an infection and she was admitted to the hospital. “Her care was totally the same, in the same room, with the same doctor, the same nurse.” And Medicare covered her nursing home care.

“That’s what I expected at her age,” Enhert said. “I always thought that’s what Medicare was for.”

DOCTORS LEFT IN THE DARK BY CMS OVER MACRA COMPLIANCE REQUIREMENTS

By: Virgil Dickson

Doctors are potentially facing a loss of millions in Medicare reimbursement dollars due to lack of MACRA-related guidance from the CMS, according to a letter to the CMS from the Medical Group Management Association.

In a final rule announced last year, the CMS said it would exempt physician practices with less than $30,000 in Medicare charges or fewer than 100 unique Medicare patients per year from complying with the Merit-based Incentive Payment System outlined under MACRA.

The agency was supposed to formally notify these doctors in December of their exemptions. The threshold in the final rule would exclude 30% of physicians from complying with MIPS, according to an American Medical Association analysis.

But three months into the first year of MACRA implementation, doctors have not received the notifications. That leaves them vulnerable if they do nothing; the CMS can later tell them they're on the hook for complying with the law.

"This is generating considerable frustration and confusion," the MGMA said in a March 15 letter to CMS leadership.

Under MIPS, physician pay will be based on success in four performance categories: quality, resource use, clinical practice improvement, and "advancing care information" through use of health information technology. The latter is based on the meaningful-use program the government has used to decide whether doctors should be rewarded for using electronic health records.

Medicare reimbursement for providers in 2019 will be based on how well doctors perform on these metrics this year. Under MIPS, physicians can earn plus or minus 4% of reimbursement in 2019.

A CMS spokesperson said the agency plans to send out the notifications this spring. She did not comment on why the agency missed the December deadline.

The MGMA said the answer is unacceptable as doctors need answers now.

"Physicians need certainty to make timely business decisions about investments in technology, clinical systems and the staff necessary to comply," said Anders Gilberg, senior vice president of government affairs at the MGMA.

VALUE-BASED PAYMENT: WHY PRACTICES NEED TO GET ON BOARD NOW

By: Joanne Finnegan

The smartest move physician practices can make right now is to move ahead with value-based payment arrangements, experts say.

The transition from fee-for-service to value-based care is inevitable and practices that embrace new payment methods will be ahead of the curve, according to Physicians Practice. If doctors are still unsure, here are a few of the reasons it makes sense for practices to move ahead with value-based care:

You'll be better prepared for MACRA. The new payment systems implemented under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) are here to stay, and getting in on a payer's value-based system will get you ahead on changes you need to make, such as tracking quality patient data, says Mott Blair, M.D., a family physician, whose practice has added a health coach and can identify high-risk patients and be pro-active to keep them healthy.

You won't get left out in the cold. As local hospitals start setting up a system of providers, you want to be included in order to get referrals, particularly for specialty practices, Elizabeth Woodcock, president of the consulting firm Woodcock and Associates, told the publication.

You'll get paid for more patient care. Under fee-for-service arrangements, practices don't get reimbursed for some of the time they spend on patient care, such as returning patient calls or following up on missed appointments. With a value-based arrangement, you will be rewarded for these activities that lead to better patient care.

While there's lots of questions about the future of healthcare, experts say the push to value-based care will likely continue under President Donald Trump's administration. Dozens of leading healthcare organizations have called on Trump to continue the federal government's push to value-based, patient-centered payment models that reward providers for improved quality and cost-effective care.

MAGNOLIA HEALTH VALUES THE EXCELLENT CARE THAT OUR PROVIDER PARTNERS DELIVER TO OUR MEMBERS

As you know, a critical component of quality care is understanding where to find the right provider. That is why Magnolia partnered with LexisNexis® last year to validate the accuracy of our provider demographic data. In order to ensure that our provider demographic data stays current for their members, they are partnering with LexisNexis® again to validate the data on a quarterly basis. The first of the 2017 quarterly validation efforts will begin in March. Providers will receive a joint email from LexisNexis® and the American Medical Association ("AMA") requesting an attestation that the patient's data is current.

CHANGE REQUEST (CR) 9911 MODIFIES THE MEDICARE CLAIMS PROCESSING SYSTEMS

This will help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers' ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare's claims processing systems. This system enhancement will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through the Medicare Summary Notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure billing staffs are aware of these changes: Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System.

CHANGE REQUEST (CR) 9933

This will instruct the Medicare contractors (MACs) to apply certain coding edits to the new Current Procedural Terminology (CPT) codes that are used to report physical therapy (PT) and occupational therapy (OT) evaluations and reevaluations, effective January 1, 2017. Make sure billing staffs are aware of these coding changes. Updated Editing of Professional Therapy Services

CLAIMS AND CODING

Inpatient Skilled Nursing Facility Denials
According to the 2015 Comprehensive Error Rate Testing (CERT) Report, the denial rate for Skilled Nursing Facilities (SNFs) increased from 6.9% in 2014 to 11% in 2015 due to missing or incomplete certification/recertification: statement must contain need for skilled services that can only be provided in SNF/swing-bed on a daily basis for a condition patient was treated for in prior hospital stay and must include physician's dated signature (printed name if signature is illegible). In addition, recertifications should include: expected length of stay, explanation if continued need for services is for a condition that arose after SNF admission, and any plans for home care.

CHRONIC CARE MANAGEMENT PAYMENT CORRECTION FOR RHCS AND FQHCS

Effective January 1, 2016, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) received payment for Chronic Care Management (CCM) services based on the Medicare Physician Fee Schedule national average non-facility payment rate. However, for claims with dates of service on or after January 1, 2017, RHCs and FQHCs have been receiving a locality adjusted payment rate for these services. Your Medicare Administrative Contractor will adjust any claim processed incorrectly. No provider action is required.

CMS ADDS A NINTH CONDITION OF PARTICIPATION - EMERGENCY PREPAREDNESS

Mark R. Lynn, Healthcare Business Specialists, LLC

In a new final regulation issued on September 16, 2016, effective November 16, 2016 and scheduled to be enforced starting on or after November 15, 2017 (possibly move that back 60 days due to President Trump's Executive Order) the government has enlisted 17 provider groups that participate in Medicare Part A to be defacto first responders in community disasters and emergencies by adding a condition of participation requiring providers to participate in community wide training drills annually and conducting tabletop exercises as well. There are four essential elements to the regulations which require RHCs to develop an emergency plan, emergency policy and procedures, a communication plan, and training and testing of the system.

The regulations add a ninth condition of participation which could result in termination from the RHC program if the Condition Level is not achieved to the satisfaction of the RHC inspector or deeming authority.

The regulations are somewhat daunting and appear to be beyond the scope of something that any individual RHC could comply without some outside resources. RHCs should reach out to the local hospital, the local Emergency Planning Committee In your county, or any of the over 500 coalitions that have formed throughout the country.

Currently 20% of all RHCs participate in a healthcare coalition and 83% of
all hospitals are in one. Hospitals can develop an integrated approach to complying with the regulation; however, each individual subunit or in this case rural health clinic must have a plan that will comply on its own.

There is also an organization that has been established to assist with emergency preparedness by the U.S. Department of Health and Human Services (HHS) called the Office of the Assistant Secretary for Preparedness and Response (ASPR) which sponsors the ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE).

One of the best ways to understand the regulation is spend 50 minutes watching the
Emergency Preparedness Requirements MLN Connects® webinar on October 5, 2016.

Interpretative guidelines are due out any day to provide additional insight on what is expected from rural health clinics.

§ 491.12 Emergency preparedness. The Rural Health Clinic (RHC) must comply with all applicable Federal, State, and local emergency preparedness requirements.

The RHC must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:
(a) Emergency plan. The RHC must develop and maintain an emergency preparedness plan that must be reviewed and
updated at least annually. ….
(b) Policies and procedures. The RHC must develop and implement emergency preparedness policies and procedures,
based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this
section, and the communication plan at paragraph **(c)** of this section. The policies and procedures must be reviewed
and updated at least annually….
(c) Communication plan. The RHC must develop and maintain an emergency preparedness communication plan that
complies with Federal, State, and local laws and must be reviewed and updated at least annually….
(d) Training & testing. The RHC must develop and maintain an emergency preparedness training and testing program

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2017

Register for all events online at **www.msrha.org/events**

Lunch and Learn Webinar: National Health Service Corps Program
May 11, 2017 | Noon- 1:00 CST | Webinar

Rural Hospital and Rural Health Clinic Workshop
MACRA and Revenue Cycle Improvement
May 19, 2017 | 9 a.m. – 3 p.m. CST | Vicksburg, MS

Lunch and Learn Webinar: Managing Workplace Stress: How to Create a Less Stressful and More Productive Work Environment
July 25, 2017 | Noon- 1:00 CST | Webinar

Rural Health Clinic Workshop | Complete / Improve Your Annual Program Evaluation
November 15, 2017 | 9 a.m. – 3 p.m. CST | Jackson Marriott, Jackson, MS

22nd Annual Conference
November 16-17, 2017 | Jackson Marriott, Jackson, MS