



Rural Health Clinic CONNECTION 2017

www.msرها.org



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

UPDATED MEDICARE PART D OPIOID DRUG MAPPING TOOL UNVEILED

CMS.gov Centers for Medicare & Medicaid Services
November 29, 2017

The Centers for Medicare & Medicaid Services (CMS) released an updated version of the Medicare opioid prescribing mapping tool. This tool is an interactive, web-based resource that visually presents geographic comparisons of Medicare Part D opioid prescribing rates.

The tool includes the addition of extended-release opioid prescribing rates and county-level hot spots and outliers, which may identify areas that warrant attention. The mapping tool offers local communities greater transparency into opioid prescribing in the Medicare Part D program. Communities can use this resource to understand how this critical issue affects their area, examine regional variation, and make informed decisions about how to allocate resources.

The underlying data that feeds this tool is also used by CMS to monitor and manage high risk use of opioids in the Part D program. “Addressing the opioid epidemic and its impact on every state, county and municipality is a priority of the Trump Administration,” said CMS Administrator Seema Verma. “This updated mapping tool gives providers, local health

officials, and others data about their community’s Medicare opioid prescription rate and information to help target resources and develop solutions for this problem

plaguing our nation’s neighborhoods.”

Prescription opioids can be prescribed by doctors to treat moderate to severe pain. However, they also can have serious risks including addiction and overdose. The majority of drug overdose deaths involve opioids, and since 1999, the number of overdose deaths involving prescription opioids has quadrupled. In 2015, more than 15,000 people died from overdoses involving prescription opioids. The data used in this mapping tool are from Medicare Part D prescription drugs prescribed by healthcare providers. In 2015, Medicare Part D spending on drugs was \$137 billion, which reflects about 40% of U.S. retail prescription drug spending. In total, for Medicare Part D, there were approximately 80 million opioid claims for 111 distinct opioid products in 2015, accounting for \$3.5 billion in spending.

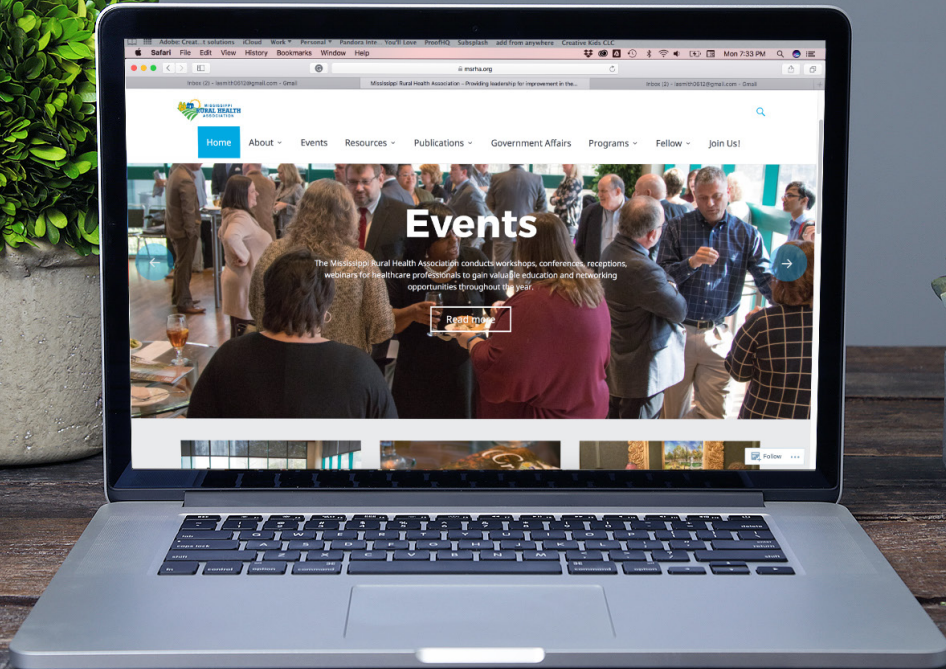
It is important to note that the information presented in the tool does not indicate the quality or appropriateness of opioid prescribing for an individual physician or in a given geographic region. The updated version of the mapping tool presents Medicare Part D opioid prescribing rates for 2015 as well as the change in opioid prescribing rates from 2013 to 2015.

New for this release is additional information on extended-release opioid prescribing rates. Extended-release opioids are formulated to release the active ingredient slower, over a longer period of time, and require less frequent administration. However, because extended-release drugs contain a large amount of the opioid, they have been associated with misuse, including both addiction and overdose deaths. In addition, this release includes county-level hot spots and outliers, which may identify areas that warrant attention.



RURAL HEALTH LISTSERV

This Mississippi Rural Health Association offers a rural health listserv available for all clinics to use to gain quick feedback on needed questions. Simply send an email to msrha_rhc@googlegroups.com with your question, and it will be answered by peers and/or a team of experts soon.





QUALITY PAYMENT PROGRAM HARDSHIP EXCEPTION APPLICATION DEADLINE: DECEMBER 31

CMS Network Bulletin

The deadline to submit a Quality Payment Program Hardship Exception Application for the 2017 transition year is December 31. Merit-based Incentive Payment System eligible clinicians and groups may submit a hardship exception application for one of the following reasons: insufficient internet connectivity, extreme and uncontrollable circumstances, or lack of control over the availability of Certified Electronic Health Record Technology.

For questions, contact the
Quality Payment Program Service Center
at QPP@cms.hhs.gov or 866-288- 8292
(TTY: 877-715- 6222)

**Pharmacy
Coupon**

Prescription

ID Number: 3327BE5D6E

RxBIN: 610709

RxGrp: MSRHAX4



MISSISSIPPI
RURAL HEALTH
ASSOCIATION

PATIENT INSTRUCTIONS: This card/coupon is pre-activated and can be used immediately. Present this card/coupon to any participating pharmacy to receive a discount on prescription medications.

PHARMACIST INSTRUCTIONS: Submit as a primary claim (cannot be processed as secondary) using the following pharmacy processing information. For processing questions and comments please call the Pharmacy Helpline below.

Customer Service: 877-321-6755 Pharmacy Helpline: 800-223-2146



MISSISSIPPI
DRUG CARD
www.MississippiDrugCard.com

This program is not insurance.
This is a point-of-sale discount plan.

This card can be cut out and
used at any participating
local pharmacy to receive
pre-negotiated discounts on
pharmaceuticals

MIPS SCORING 101 GUIDES

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), that provides for two participation tracks: Merit-based Incentive Payment System and Advanced Alternative Payment Models.

Clinicians practicing in RHCs or FQHCs who provide services that are billed exclusively under the RHC or FQHC payment methodologies are not required to participate in MIPS (they may voluntarily report on measures and activities under MIPS) and are not subject to a payment adjustment.

However, if these clinicians provide other services and bill for those services under the Physician Fee Schedule (PFS), they may be required to participate in MIPS and such other services would be subject to a payment adjustment. Check with the CMS MIPS Scoring tool to see if you are required to report with MIPS.

The Quality Payment Program takes a comprehensive approach to payment. Instead of basing payment only on a series of billing codes, the Quality Payment Program adds consideration of quality through a set of evidenced-based measures that were primarily developed by clinicians. The program recognizes and encourages improvements in clinical practice. All of these efforts are increasingly supported by advances in technology that allow for the easy exchange of needed information while protecting patient privacy.

The program provides special provisions for those participating in certain new models of care that provide an alternative to fee-for-service. MIPS is 1 of 2 tracks of the Quality Payment Program. MIPS combines 3 Medicare “legacy” programs – the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals – into

a single program. Calendar Years 2016 (for the PQRS and VM programs) and 2017 (for the Medicare EHR Incentive Program for Eligible Professionals) were the final reporting years for these programs, while 2018 is the last year clinicians may receive a payment adjustment under these legacy programs.

Under MIPS, physicians and other clinicians submit measures and activities focused on quality – that assess evidence based and specialty-specific standards as well as practice-based improvement activities; cost of services; and the use of certified electronic health record technology (CEHRT) to support interoperability.

Visit msrha.org to find several tools and resources that can assist your practice with MIPS reporting.

RHC resources on msrha.org

The Mississippi Rural Health Association houses a number of beneficial resources in index format on our website.

Looking for more information on needed information specific to rural health clinics? Visit www.msrha.org and click on the resources tab to find an answer. If you can't find what you're looking for, call us at 601.898.3001 and we will help you find it!





MISSISSIPPI OVERHAULS OPIOID PRESCRIPTION RULES AMID EPIDEMIC

Anna Wolfe, Clarion Ledger

October 3, 2017

Pain management in Mississippi is seeing a significant overhaul amid a national opioid crisis. In conjunction with Gov. Phil Bryant's opioid task force recommendations, the Mississippi Board of Medical Licensure has passed a number of proposed changes to the guidelines that regulate how doctors prescribe painkillers. Common opioid prescriptions include: codeine, hydrocodone, methadone, morphine, and oxycodone.

The changes will require any medical licensee who has authority to write prescriptions to use the state's prescription monitoring program, which shows what medications a patient is receiving or has received in the past. The new regulations also require a patient to be drug tested before receiving schedule II medications for chronic non-cancer pain and limits opioid prescriptions to a seven-day supply for acute pain.

One seven-day refill is allowed under rare circumstances. "We want to still be able to manage pain if we can," said licensure board

president Dr. Charles Miles, but also decrease a person's supply of addictive painkillers and make sure doctors are meeting the prescription reporting requirements. "We're going to hold folks responsible if they do it incorrectly," Miles said. Another change: if more than 30 percent of a clinic's patients receive controlled substances to control chronic, non-cancerous pain, it will be considered a "pain management clinic."

The previous threshold was 50 percent. Pain management clinics have stricter regulations to operate. The changes will not affect patients managing pain following a cancer diagnosis. Mississippi is ranked fourth in the nation for per capita opioid prescriptions. Each year, doctors in the state prescribe enough hydrocodone combination pills, roughly 105 million, for each Mississippian to take a pill each day for 36 days.

"We have to do something to stem the tide," said Dr. Randy Easterling, a member of the medical licensure board and vice chairman of the governor's opioid task force.



Two months ago, Easterling prescribed one of his patients suboxone, a medication used to treat opioid addiction. Since then, she's received opioid prescriptions from five doctors. "This is the essence of the problem we have right now," Easterling said. If those doctors had checked the monitoring program, they would see the patient is on suboxone, indicating an addiction problem. They would then know not to prescribe her opioids, which Easterling said is the equivalent of giving an alcoholic a fifth of Jack Daniels.

The licensure board passed the proposed rule changes in its September meeting and filed a notice with the secretary of state's office. Now, physicians and stakeholders will have a chance to comment on the proposal and offer any concerns before the board takes it up for a final vote in November.

"Health care providers are part of the problem. They're certainly not the whole problem," Easterling said. "I know the physicians are going to step up to the plate and do what they've always done, which is to act in the best interest of their patients."

Backlash has already begun with at least one doctor expressing concern that the board is not adequately notifying physicians of the changes.

"Nobody I've talked to, even pain management doctors, has heard anything," said Merit Health Orthopedic Surgeon Donald Baker. "That's a drastic change from the way things are now. It seems like if you're going to change things like that, especially if you're going to have public comment, you'd let people know."

Easterling said when the licensure board makes rule changes, it sends out an email with a link to the proposed changes on its website to certain medical groups, which should send it to their members. Baker received information about the opioid rule changes from Merit Health.

After The Clarion-Ledger brought it to the board's attention that not everyone received notification, Easterling acknowledged that the board should not rely on other groups to get the word out and said the information would be emailed to each licensee this week.

"In the future, it will be done that way," he said. Though the medical field cannot address the use of illegal opioids, like heroin, officials believe monitoring prescriptions is one aspect of solving the epidemic, which kills 91 Americans each day. "If we make pills more difficult to get, sooner or later you'll have fewer people going to the street to get heroin," Easterling said.



PROVIDER REIMBURSEMENT MANUAL. SECTION 1100 REVISION

Transmittal 9 updates the Provider Reimbursement Manual. Section 1100 is being revised to identify providers that must continue to complete Form CMS-339 – including Rural Health Clinics(RHCs). “Its purpose is to assist you in preparing an acceptable cost report and to minimize the need for direct contact between you and your MAC. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost reports and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.”



NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM IS STILL RECRUITING PRACTICES TO ENROLL IN THE TRANSFORMING CLINICAL PRACTICE INITIATIVE(TCPI)

CMS increased their enrollment goal from 5000 to 7000 clinicians after they exceeded their year 1 goal of 5000 in 2016. NRACC is devoted to preparing clinics and providers for new alternate payment models. TCPI is available to you at no cost, offers support to get you started with a billable chronic care management program, bolster your quality scores and provides support for MIPS reporting. We have enrolled 5,300 providers to date nationwide and can enroll 1700 more providers. Enrollment is voluntary and simple.



REPORTING CHANGES IN OWNERSHIP

Centers for Medicare & Medicaid Services

May 18,2017

A 2016 Office of the Inspector General (OIG) report noted that providers may not be informing CMS of ownership changes. Providers must update their enrollment information to reflect changes in ownership within 30 days. Owners are individuals or corporations with a 5 percent or more ownership or controlling interest. Failure to comply could result in revocation of your Medicare billing privileges.

REPORTED AUDITS FOR EMERGENCY PREPAREDNESS DOCUMENTATION

The Mississippi Rural Health Association has already received reports that audits are being conducted on rural health clinics in Mississippi respective to ensuring that emergency preparedness documentation is in place. Please be sure that you comply with all regulations and have it available upon inspection as needed.

Visit www.msرها.org to learn more about emergency preparedness guidelines.



AUDIT

The illustration shows two hands in orange skin tones holding a magnifying glass over a white document. The document has several horizontal lines representing text. The word 'AUDIT' is written in bold, black, uppercase letters and is centered within the magnifying glass's lens. The hands are wearing dark teal sleeves with white cuffs. The background is a solid dark blue.

IS YOUR RHC BILLING MEDICAID FOR ADMINISTRATION OF VACCINES?

It has been discovered that a large number of rural health clinics are billing Mississippi Medicaid for administration of a vaccine.

Please review the following section code to ensure that you are complying with regulations regarding billing for vaccines.

The Division of Medicaid does not reimburse:

1. An RHC, FQHC or MSDH clinic an encounter rate solely for the administration of vaccines, or
2. For the cost of vaccines provided through the VFC program.

The Division of Medicaid reimburses:

1. A physician's office for:
 - a) Each vaccine and its administration fee if the office visit is only for the administration of the vaccine(s), or b) Each vaccine, its administration fee and an Evaluation and Management (E&M) visit only when a separately identifiable service is provided at the time of the vaccine administration.
2. A Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), and the Mississippi State Department of Health (MSDH) clinic providers an encounter rate for a core service which includes the vaccine(s) and its administration.

The Division of Medicaid does not reimburse:

1. For the administration of the intranasal influenza vaccine, or
2. If an outside VFC provider administers the vaccine(s) the Division of Medicaid reimburses the outside provider an administration fee and the long-term care facility cannot claim the cost on the Medicaid cost report.





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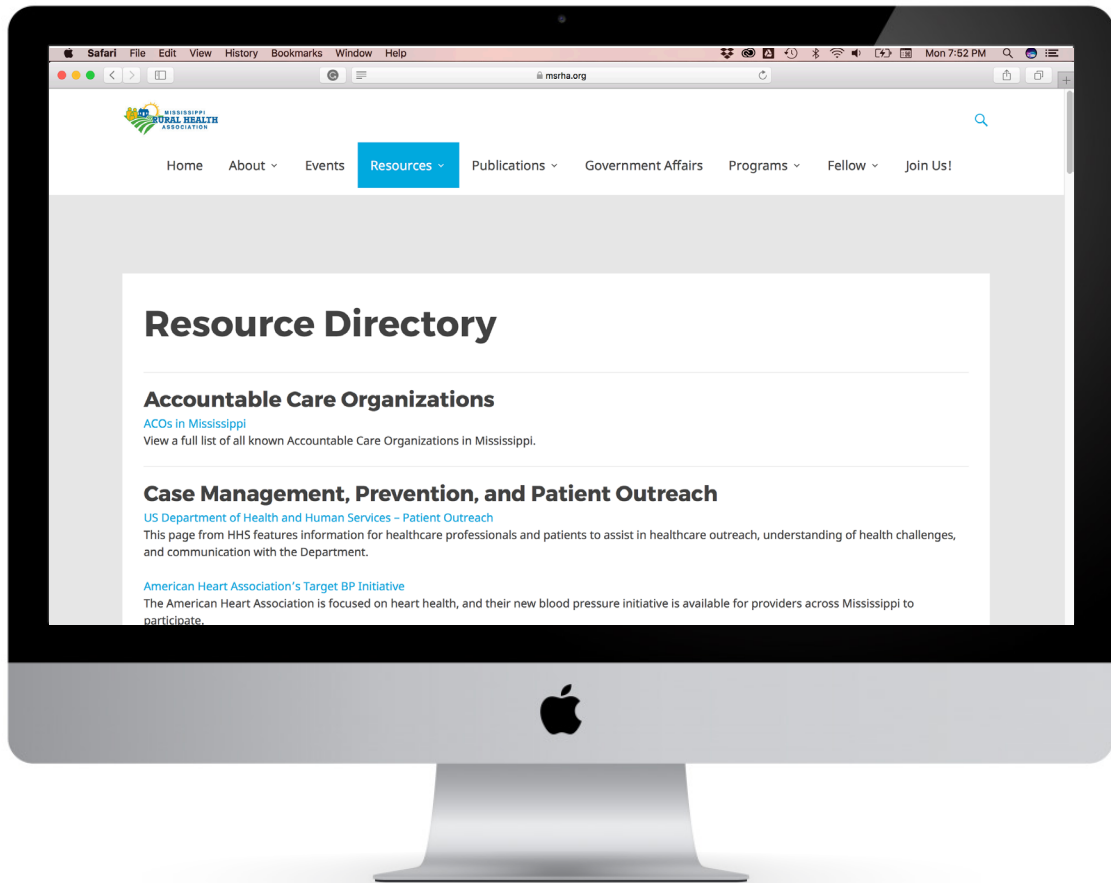
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VERIFY YOUR RHC INFORMATION



Please take a moment and verify the information that we have for your clinic in our rural health clinic directory. This directory has been translated into an interactive map that allows patients and other providers to locate your clinic. This map also helps to identify critical areas of healthcare shortage in Mississippi.

Visit the Rural Health Clinic directory in our resource directory at msrha.org/resource-directory and click on “Rural Health Clinic Directory.” Or, call us at 601.898.3001.

VACCINES ARE NOT JUST FOR KIDS

Centers for Medicare & Medicaid Services
August 28, 2017

National Immunization Awareness Month (NIAM) is an annual observance to highlight the importance of vaccinations. All adults should get vaccines to protect their health. Even healthy adults can become seriously ill and can pass certain illnesses on to others. Talk to your Medicare patients about vaccines they may need, including influenza, pneumococcal, and hepatitis B.



RURAL HEALTH CLINIC CONFERENCE

APRIL 6, 2018
HILTON JACKSON

The MRHA's rural health clinic conference is the perfect opportunity for RHC professionals to gather and learn more about topics applicable to our rural clinics in the state. Learn more and register online at

www.msrrha.org/events.



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CHANGES TO PREFERRED DRUG LIST (PDL) TO TAKE EFFECT JAN. 1, 2018

Provider Notice of PDL changes, effective Jan. 1, 2018

The Mississippi Division of Medicaid's (DOM) Universal Preferred Drug List (PDL) underwent an annual review on Nov. 2, 2017. The revisions brought about by this annual review will become effective on Jan. 1, 2018. The Universal PDL is effective for Medicaid fee-for-service, MississippiCAN and Children's Health Insurance Program (CHIP) beneficiaries.

The Provider Notice of PDL Changes can be found at <https://medicaid.ms.gov/wp-content/uploads/2017/10/MSPDLProviderNotice010118.pdf>.

The Universal PDL can be found at <https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/>.

PDL change in the Inhaled Glucocorticoid class

The manufacturer (Teva) of QVAR Oral Inhaler has announced that it will discontinue sales of the currently available formula upon the launch of QVAR RediHaler in the first quarter of 2018, and as a result both formulations will move to non-preferred status, as recommended by the P&T Committee, effective Jan. 1, 2018.

These two formulations of QVAR are not generic equivalents, are not interchangeable and therefore, patients who have a prescription for the old QVAR Oral Inhaler will require a new prescription for the new formulation.

Current QVAR Oral Inhaler users, as of Dec. 31, 2017, will be grandfathered. Grandfathering

means that patients currently using QVAR (have had a prescription filled in the last 90 days) will be allowed to continue their regimen until the QVAR Oral Inhaler (HFA) stock is depleted. A written prior authorization (PA) request will not be required for this, and an electronic PA will be approved at the pharmacy point of sale. A manual prior authorization for QVAR Redihaler is, and will continue to be, required for all patients, as are all non-preferred agents in this PDL category.

Pulmicort Flexhaler (budesonide) is moving to preferred status and is currently the only hand-held agent preferred in this class. Pulmicort Flexhaler is a first line treatment for patients six years and older for the maintenance treatment of asthma. Budesonide nebulization solution is also preferred. Budesonide nebulization is a first-line treatment for patients 0-12 years of age for the maintenance treatment of asthma. The PA criteria for this class for non-preferred agents is a trial and failure of one preferred agent in the past six months. This class also allows for a stable therapy electronic PA which means that a patient who has received 90 days of therapy in the previous 105 days, regardless of preferred or non-preferred status, will not require a written PA request. The current 2017 NIH Asthma Care Quick Reference can be found at https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf.

Flovent HFA is moving to non-preferred status. However, so as to allow an HFA treatment option, it will be available for children from age 0 through six without a manual PA.

GLUCOCORTICOIDS (INHALED)_{SMARTPA}

budesonide 0.25mg and 0.5mg
PULMICORT (budesonide)
Flexhaler

AEROSPAN (flunisolide)
ALVESCO (ciclesonide)
ARMONAIR RESPICLICK
(fluticasone) ARNUITY ELLIPTA
(fluticasone) ASMANEX
TWISTHALER (mometasone)
ASMANEX HFA (mometasone)
budesonide 1mg
FLOVENT Diskus (fluticasone)
FLOVENT HFA (fluticasone)
PULMICORT (budesonide)
Respules QVAR Oral Inhaler
(HFA) (beclomethasone
dipropionate)*
QVAR REDIHALER
(beclomethasone dipropionate)





Baton Rouge Radiology Group (BRRG) has been a provider of radiology services in the Greater Baton Rouge area since 1951. We were the region's first outpatient radiology clinic, the first to perform then-new procedures like angioplasty, percutaneous nephrostomy and percutaneous cardiac intervention. Thanks to accomplishments like these, we've built a reputation for excellence. This, in turn, enables us to attract the best and brightest doctors – those with subspecialty expertise that keep us on the leading edge of radiology. For you, this translates into higher quality care through collaborative specialty consulting, greater insight and the most progressive diagnostic testing and treatment available.

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www.brrg.com

