



Crossroads

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Crossroads is published quarterly by the Mississippi Rural Health Association

What is *Crossroads*?

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LAIRD HOSPITAL NAMED TO TOP 20 CRITICAL ACCESS HOSPITAL LIST

Laird Hospital in Union, Mississippi was recently named one of the Top 20 Critical Access Hospitals for Best Practices in Patient Satisfaction in the nation.

The Top 20 Critical Access Hospitals, including Laird Hospital, scored best among critical access hospitals as determined by The Chartis Center for Rural Health for patient satisfaction. The rankings were recently announced by the National Rural Health Association (NRHA).

“Rush Health Systems is proud of the efforts of Laird Hospital’s physicians and staff who have contributed to achieving this designation,” said Chuck Reece, Senior Vice President for Rush Health Systems.

The Top 20 Critical Access Hospital “winners” are those hospitals who have achieved success in the overall performance based on a composite rating from eight indices of strength: inpatient market share, outpatient market share, quality, outcomes, patient perspectives, cost, charge and financial stability. This group was selected from The Chartis Center for Rural Health’s 2018 Top 100 CAH list, which was released earlier this year.

Those hospitals that have been recognized as Top 20 Critical Access Hospital “best practice recipients” have achieved success in one of two key areas of performance:

Quality index: A rating of hospital performance based on the percentile rank across the five categories of Hospital Compare Process of Care measures.

Patient perspective index: A rating of hospital performance based on the percentile rank on two Hospital Compare HCAHPS measures (“Overall Rating” and “Highly Recommend”).

“Our health systems motto of being our brother’s keeper drives the work that we do for each patient,” said Tommy Bartlett, Administrator of Laird Hospital. “Our results as a Top Critical Access Hospital for Best Practices in Patient Satisfaction means our community can count on us to deliver the services they need now and in the future.”

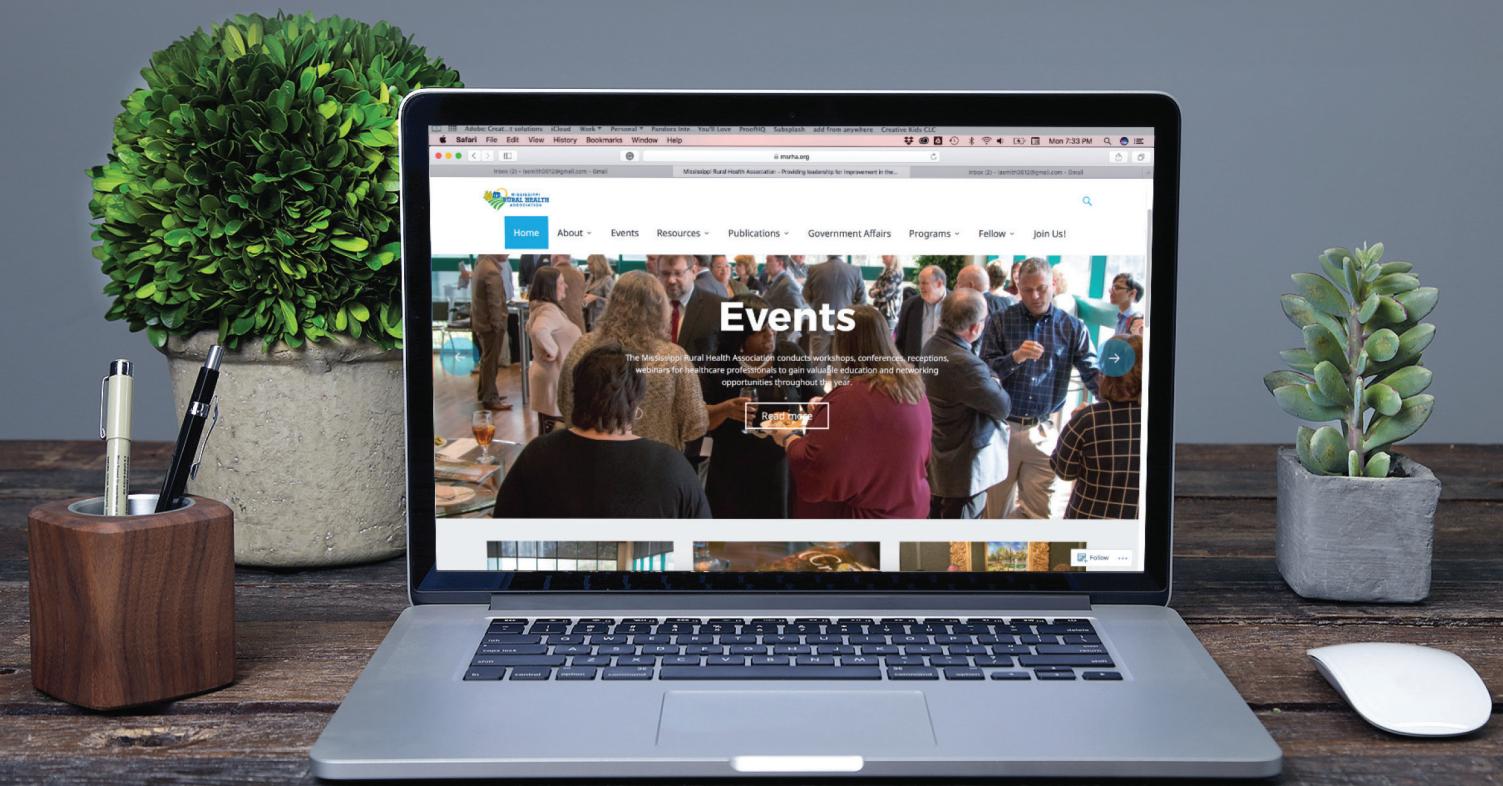
Fred Duggan, MD, Chief Medical Officer for Rush Health Systems said, “Quality healthcare is of high importance to Rush Health Systems, and we are proud of Laird Hospital’s commitment to excellence.

Laird Hospital will be recognized at an awards ceremony during the NRHA’s Critical Access Hospital Conference in September in Kansas City, MO.

www.rushhealthsystems.org

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TRUMP ADMINISTRATION EASES ACA ESSENTIAL HEALTH BENEFIT REQUIREMENTS

Mike Stankiewicz, Fierce HealthCare

The Trump administration is moving forward with new rules to restructure the federal health exchanges, giving states more freedom to relax the regulations on what insurers must cover, which critics say will increase premiums and undermine patient protections.

Under the 522-page new rule released recently states will be able to choose from 50 essential benefit benchmark plans, instead of 10, beginning in 2020. Additionally, states will be able to pick and choose which benefits are included in their essential health benefit benchmark plan by drawing from plans used in other states.

The Centers for Medicare & Medicaid Services (CMS) also eliminated a requirement that each plan offered on the exchange have noticeable differences from one another, such as covered benefits or cost-sharing. Eliminating the requirement would “encourage plan design innovation,” CMS said.

The agency expanded coverage exemptions starting immediately, including for individuals whose only healthcare option is a plan that includes abortion services. Those that file for exemptions will have to submit in writing that they are morally averse to abortion, which can be prosecuted under perjury.

The rule also increased the out-of-pocket maximum to \$7,900 for individual coverage and \$15,800 for family coverage, a 7% increase, the highest since 2014. CMS also increased the threshold for reviewing rate increases from 10% to 15%.

Additionally, CMS will allow transitional plans that don’t follow ACA rules to remain in the individual and small group markets for another year. This, combined with recently announced expanded short-term plans will allow states and insurers more flexibility to get around ACA requirements.

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WHAT DOES YEAR TWO OF QUALITY PAYMENT PROGRAM MEAN FOR SMALL, UNDERSERVED, RURAL HEALTH FACILITIES?

Year two of the Quality Payment Program's (QPP) Merit-based Incentive Payment System (MIPS) brings expanded reporting requirements for many practices. Choosing overlapping and complementary MIPS measures and activities can help clinicians get additional credit for activities they are already doing and potentially increase their total MIPS score. This article highlights efficient ways to report with integrated MIPS measures: https://www.tmfqin.org/Portals/0/Resource%20Center/Quality%20Payment%20Program/MIPS%20Strategies%20article_TMF%20QPP-SURS.pdf



TOBACCO USE AMONG TEENAGERS IN MISSISSIPPI

2017 data indicate smoking and smokeless tobacco rates have decreased for Mississippi middle and high school students. E-cigarette use is up for high school students but down for middle school.

High Schools in Mississippi

- Current smoking is down to 7.2% (9.4% last year), US 2016 rate 8%
- Current smokeless tobacco (SLT) is down to 6.6% (7.1% last year), US 2016 rate 5.8%
- Current e-cigarette use is up to 11.5% (10.3% last year), US 2016 rate 11.3%

Middle Schools in Mississippi

- Current smoking is down to 1.5% (3.8% last year), US 2016 rate 2.2%
- Current SLT is down to 3.0% (4.0% last year), US 2016 rate 2.2%
- MS current e-cigarette use is down to 4.8% (5.9% last year), US 2016 rate is 4.3%

The decrease in middle school current cigarette smoking from 2016 to 2017 is the only data that is statistically significant. Although the other reductions are not significant from 2016, the downward trend continues.

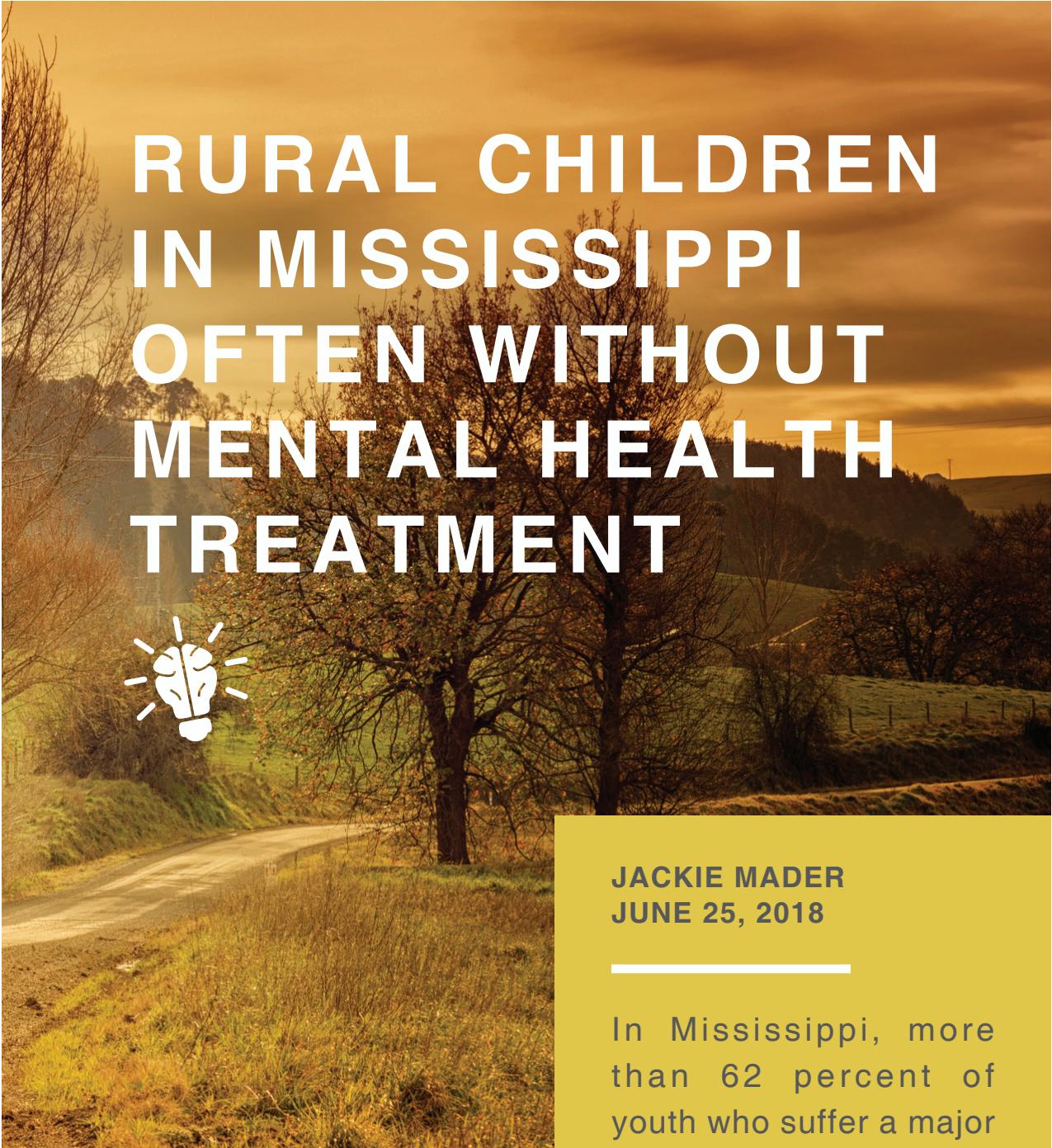


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RURAL CHILDREN IN MISSISSIPPI OFTEN WITHOUT MENTAL HEALTH TREATMENT



JACKIE MADER
JUNE 25, 2018

In Mississippi, more than 62 percent of youth who suffer a major depressive episode — 13,000 kids — don't get any professional help,

Jennifer Townsend was shocked when she found a note written by her oldest child, a 14-year-old: The teen was planning to commit suicide.

Townsend, a mother of four who lives in this rural Mississippi Delta town, wanted to get help for her daughter immediately. She called a nearby state-funded community mental health clinic to ask for counseling. The clinic told her

they had a wait list of at least six months. And even if the teen got in, they would only be able to see the girl once a month.

"I didn't think one time a month was good enough," Townsend said. "She was suicidal."

In Mississippi, many children with severe mental health needs have few local options for care. They must go to psychiatric institutions, often far from their homes, to receive mental health support and services.

Townsend — and her daughter — were lucky. Townsend was enrolled in a nonprofit parenting program she could turn to for help. The group connected her with a therapist who could counsel her daughter in personal home visits. Now, Townsend said, her daughter turns to the therapist for help and anticipates her visits.

Nearly a decade after Mississippi was sued by the Southern Poverty Law Center for its treatment of children with mental health needs, the state still remains near the bottom of national rankings for getting help to youth with mental or emotional issues. Despite state attempts to increase funding and expand some programs, many children, especially those in Mississippi's most rural areas, still lack access to desperately needed mental health services.

In Mississippi, more than 62 percent of youth who suffer a major depressive episode — 13,000 kids — don't get any professional help, according to national statistics from a 2017 report.

The state has tried to address the problem by expanding some mental health services for children with more severe mental or emotional problems and has made an effort to divert some funds away from psychiatric institutions and into community-based services, but the efforts are

often stymied by a lack of funding. The state's Department of Mental Health has cut hundreds of staff members, reduced some services, and closed programs, including one that provided community-based mental health services to at-risk youth.

Mississippi's effort to reach more children is hampered by more than scarce resources: Another major hurdle to providing mental health care is the fact that 44 percent of the state's children live in rural communities. Experts agree that the state's dispersed population makes it harder to connect kids to mental health services.

The state's efforts to increase its mental health services could get some help from the federal government: The omnibus budget signed by President Donald Trump earlier this year allocated increases in funding to support mental health programs, including a \$700 million increase for a grant program that provides mental health services in schools and \$5 million for early childhood mental health programs.

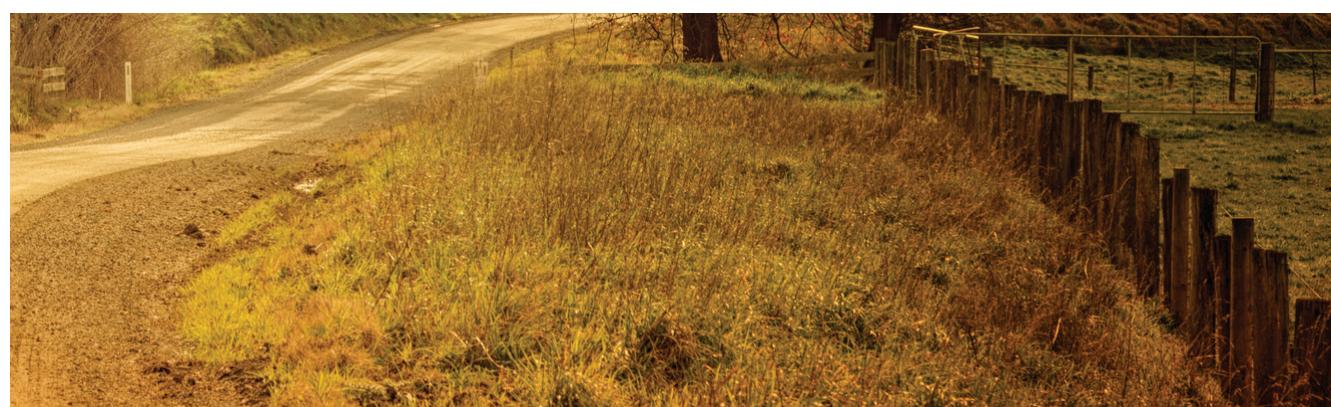
Experts say this is a good place to start: More access to early mental health care is critical for mitigating the long-term impact of mental illness.

"The earlier you intervene and support them and support their caregiver, the better they're going to do," said Hogge from Families as Allies.

mississippitoday.org

This story about mental health care for rural children was produced by The Hechinger Report, a nonprofit, independent news organization focused on inequality and innovation in education.

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DIABETES-RELATED HOSPITAL MORTALITY IN RURAL AMERICA: A SIGNIFICANT CAUSE FOR CONCERN

It has been reported that diabetes prevalence is higher in rural areas than in urban areas. Other studies have shown that rural persons with diabetes have higher morbidity from diabetes-related complications than urban persons with diabetes. This study used data from the Healthcare Cost and Utilization Project Nationwide Inpatient Sample (2009-2014) to examine hospital-based diabetes-related mortality and whether there were urban-rural differences across census regions. On average 2.63% of all diabetes-related urban hospital admissions resulted in death, while 2.73% of all diabetes-related rural hospital admissions resulted in death ($p<0.001$). Mortality rates were highest within rural areas of the South and Midwest (21.0 and 15.1 deaths per 100,000 population, respectively) compared

to other areas in both regions. The noncore, micropolitan, and small metropolitan areas of the South had the highest average diabetes-related hospital mortality rates (21.0, 20.3, and 14.0 deaths per 100,000 population, respectively) compared to corresponding areas in the Northeast, Midwest, and West regions. Results suggest that substantial differences exist between rural and urban diabetes-related hospital mortality. Furthermore, the burden is especially pronounced for rural residents in the South and Midwest census regions.

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CRITICAL ACCESS HOSPITAL SWING-BED QUALITY MEASURES

FINDINGS FROM KEY INFORMANT INTERVIEWS

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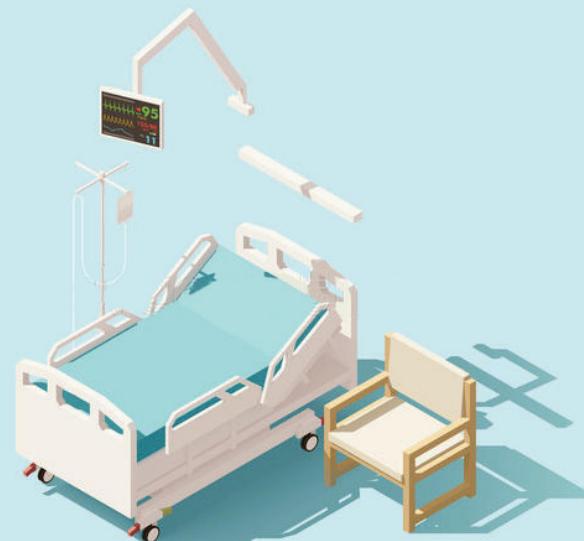
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Swing-beds are an important source of post-acute care for many patients residing in rural communities. Approximately 1,182 Critical Access Hospitals (CAHs) (88%) nationally provide swing-bed services. Medicare requires rural hospitals that receive reimbursement through the Prospective Payment System (PPS) to report data on their swing-bed patients through the Minimum Data Set (MDS), but does not require CAHs to collect similar information.

CAH swing-beds also have not been included in recent national quality measurement initiatives. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) requires post-acute providers—including Long-Term Care Hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies, and Inpatient

Rehabilitation Facilities—to submit standardized and interoperable patient assessment data that will facilitate coordinated care, improved outcomes, and overall quality comparisons, but does not include CAH swing-beds.

We identified CAH networks and hospitals and conducted 20 key informant interviews to discuss efforts to assess CAH swing-bed quality of care, including measures being used or considered by CAHs, data collection strategies, and usefulness of measures. The key informant interview data were summarized and analyzed to identify common themes, including CAHs' motivations to assess swing-bed quality and challenges measuring CAH swing-bed outcomes.

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DATACONNEX RECEIVES \$18.7M FINE FOR VIOLATION OF THE RURAL HEALTH CARE PROGRAM

The Federal Communications Commission (FCC) recently issued \$18.7M fine against health care telecommunications service provider DataConnex. A reseller of telecommunications services, DataConnex is alleged to have taken in millions of dollars from the Rural Health Care program. The FCC alleges that DataConnex "willfully and repeatedly" provided inaccurate, forged, misleading, or unsubstantiated documents to support that it had made payments to the Universal Service Fund. Furthermore, the FCC says that DataConnex violated the RHC's competitive bidding rules.

DataConnex's fine is three times the amount it wrongfully received from the RHC and the FCC has warned it may revoke the company's authorization to sell telecommunications services altogether. In addition, the FCC is considering a measure to waive the competitive bidding rules on account that DataConnex undermined the bidding process for other telecommunications services in the RHC.

Several Mississippi facilities have used

DataConnex for telecommunication services through utilization of the University Service Fund. Any facility using DataConnex for their telecommunication services should call their point of contact and determine next steps. All facilities should note that this was limited only and specifically to DataConnex and not any other telecommunications provider or user of the Universal Service Fund.

The Mississippi Rural Health Association has conducted many trainings on the proper utilization of USAC funding, and part of the training was to ensure that any provider fully met the laws that apply to this fund. This fine against DataConnex should not cause facilities to shy away from the use of the fund, rather it should allow facilities to instill confidence in their providers that are obeying all laws and are being forthright with information.

For more information, contact
Ryan Kelly at 601.898.3001
ryan.kelly@mississippirural.org.



RURAL HEALTH BLOG

Check out our recent post regarding the Mississippi Board of Medical Licensure's prescribing regulations and its impact on providers in Mississippi. The latest post includes a summary of the regulations, updates recently voted on by the board, and a white paper discussing the impact.

Visit the blog at
www.msrha.org/blog

DEBUNKING THE HILL-BURTON MYTH

By Carmen Oguz, North Sunflower Medical Center

The Hill-Burton Free or Reduced-Cost Care Program was passed by Congress in 1946 to provide hospitals and communities with funds to build healthcare facilities or to improve existing facilities. In exchange for this federal aid, the new facilities or newly renovated facilities were required to provide a percentage of free or reduced care to people who could not afford to pay and were required to provide these services to all people living in the hospital's service area. Many of the Critical Access Hospitals (CAH) which exist today were converted from Hill-Burton facilities following the Balanced Budget Act of 1997. (As an aside, it is unfortunate that these CAHs still look like the original Hill-Burton models built in the 1940s and 1950s, but that's another story.)

MYTH: ALL former Hill-Burton hospitals continue to be encumbered by the Hill-Burton Free or Reduced-Cost Care Program.

TRUTH: Many CAH leadership teams don't realize that, in 1997, the Hill-Burton Free and Reduced-Cost Healthcare Program stopped providing funds to Hill-Burton hospitals in 1997. So, approximately 140 health care facilities nationwide must still provide free or reduced-cost care based on the Hill-Burton program. Go to www.hrsa.gov/get-health-care/affordable/

[hill-burton/index.html](http://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html) to see if your hospital continues to be obligated.

A CAH's fundamental strategy should be to reasonably divest/divert certain payer sources (especially non-payers) whenever possible. Under the CAH umbrella of services, this would mean every payer source except Medicare. The same is not true for hospital-associated profit centers like DME companies. Otherwise, consider diverting and divesting certain outpatient services.



VERMA: MEANINGFUL-USE OVERHAUL IS COMING

By Virgil Dickson, Modern Healthcare

CMS Administrator Seema Verma said her agency is planning on overhauling its meaningful-use requirements, after years of provider complaints that the program was too burdensome and hard to implement.

Specifically, the CMS is looking to reduce time and compliance costs associated with the program. Verma didn't provide any additional details during her speech at HIMSS' annual conference. A CMS spokesman did not return a request for comment on additional details on when or how meaningful use requirements would be overhauled.

Verma also unveiled two new initiatives, including the MyHealthEData program to make it easier for patients to obtain and share their medical records.

"It is extremely rare for different provider systems to be able to share data," Verma said. "In most cases ... it's in the financial interest of the provider systems to hold on to the data for their patients."

The CMS plans to require providers to update their systems to ensure data-sharing and to allow a patient's data to follow them after they are discharged from the hospital.

"It's overdue and very exciting," said Dr. Ira Nash, the executive director of Northwell Health Physician Partners, a New York City-area group with 2,800 clinicians. "Data about patients should be patients' data."

Verma also unveiled Medicare's Blue Button 2.0, a web application that provides a secure way for Medicare beneficiaries to access and share their personal health data in a universal digital format.

The application will allow patients to access and share their healthcare information, previous prescriptions, treatments and procedures with a new doctor; such sharing can reduce duplication in testing and provide continuity of care.

"We cannot effectively transition to value-based care unless we give both a provider and a patient all clinical and coverage data at the point of care to inform decisions," said Jeff Micklos, executive director of the Health Care Transformation Task Force, in a statement about the new initiatives. The task force represents both hospitals and insurance companies.

The agency's moves come just weeks after President Donald Trump signed a funding bill that included measures to ease meaningful-use requirements and expand telehealth access for



Medicare beneficiaries.

The meaningful-use bill, introduced last summer, could make meeting electronic health record meaningful-use requirements easier since they no longer have to become stricter over time.

That's a change to the way things have been since the HITECH Act was passed. The statute required the HHS secretary to make meaningful-use stipulations increasingly "stringent."

With that provision of the HITECH Act, legislators intended ever-increasing regulations to encourage providers to improve their use of EHRs. But in reality, providers have faced

uncertain and unstable requirements and deadlines, and some have had trouble getting EHRs in place at all.

In certain cases, providers struggling to meet the meaningful-use requirements have filed for hardship exemptions. The stated goal of the bill is to reduce those exceptions—or, in other words, to increase the number of providers who succeed in meeting requirements.

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FROM THE RURAL HEALTH BLOG

NEW MEDICAID REGULATIONS

ON NPS PRESCRIBING DME

By Ryan Kelly, From the Rural Health Blog

Nurse practitioners throughout Mississippi recently received letters from the Mississippi Division of Medicaid stating that they are no longer able to prescribe durable medical equipment (DME) due to a change in the CMS regulations for DME under hospice regulations. This was a shock to many, and it prompted many meetings throughout the state to figure out the “what” and “why” behind this. As we have investigated and been part of the discussions around this, we have learned much. Here is a brief summary.

The origin of this language appears to stem back to the passage of the Affordable Care Act in 2008. Language from the ACA changed CMS guidelines to require that only physicians are eligible to order DME – a change from what was previously allowed. At that time, Mississippi had just recently submitted and received approval for our new Medicaid technical language.

This language had stayed in effect until this year, 2018, where Mississippi Medicaid filed its new State Plan Amendment (SPA) 17-0001 in response to the passage of the 2018 Medicaid technical bill. This new language this year was approved by CMS with one caveat, that the DME portion of home health is changed to meet their standing guidelines as stated by the ACA in accordance with 42 CFR 440.70.

Representatives from the Mississippi Division of Medicaid had lengthy conversations with CMS to determine the cause of this change, and to fight for the state’s providers. It turns out that CMS actually asked Mississippi Medicaid to not only enforce the new policy effective immediately, but to actually back-bill providers for a period of time for improperly ordering DME, despite the fact that it was done according to Mississippi-approved policies. Mississippi Medicaid fought hard for Mississippi providers, and it prompted CMS to compromise on not



requiring the retroactive refunded payments, but rather kicked out the effective date to September 1, 2018. At and after this date, only physicians will be eligible to order DME.

As I mentioned, there have been numerous conversations around this and many considerations of how to fix it. We are likely looking at a short-term fix and a long-term fix, but more investigation is underway with other states that have already dealt with the issue and found resolution. In order to not disrupt the work that is being done, I will hold back from detailing the solutions that are being discussed at this time. I can say that the goal, though, is to find a way that is legal and medically compliant to allow NPs to continue to order DME.

We are monitoring the situation closely and have a “seat at the table” with discussions. Hopefully there will be headway soon before this takes full effect on September 1, 2018 so that we do not hamper the good work that is being done to treat patients in Mississippi that have a need for basic DME.

Please contact Ryan Kelly at 601.898.3001 for questions or additional information.



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WWW.MSRHA.ORG/EVENTS

PUBLIC NOTICE FOR SPA 18-0013 RURAL HEALTH CLINIC (RHC) PHYSICIAN ADMINISTERED DRUGS



Pursuant to 42 C.F.R. Section 447.205, public notice is hereby given to the submission of a Medicaid State Plan Amendment (SPA). The Division of Medicaid, in the Office of the Governor, is submitting SPA 18-0013 Rural Health Clinic (RHC) Physician Administered Drugs. Effective July 1, 2018, and contingent upon approval from the Centers for Medicare and Medicaid Services (CMS), the Division of Medicaid will begin reimbursing RHCs outside of the encounter rate for the administration of physician administered drugs covered and reimbursed through the pharmacy benefit.

<https://medicaid.ms.gov/public-notice-for-spa-18-0013-rural-health-clinic-rhc-physician-administered-drugs/>



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