



CROSSROADS

MAY, 2019 ISSUE

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CROSSROADS MAGAZINE

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

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MISSISSIPPI RURAL HEALTH ASSOCIATION TO LEAD GOVERNOR’S RURAL HEALTH TASK FORCE

In what may turn out to be the best opportunity for improving rural health in recent history, Governor Phil Bryant signed an executive order creating a rural health task force, consisting of fourteen select members from across Mississippi. Along with a number of MRHA members, he has selected executive director Ryan Kelly as the chair of the committee.

The goal of the committee is to determine ways in which the State of Mississippi and industry partners can identify and improve issues in the state’s rural health infrastructure. This may include improvements

to hospitals, clinics, mental and oral health services, telehealth coverage, EMS transportation, and other critical needs as identified.

The committee will report back to the Governor in September, 2019 a full analysis and plan for improvements that will be considered for action in the 2020 legislative session.

If you have comments or suggestions of what may assist rural health in your community, please contact Ryan Kelly at ryan.kelly@mississippirural.org.

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. Contact us at 601.898.3001 with your preferred email address, and you will be added to the Listserv.





NEW 2019 RURAL HEALTH FELLOW COHORT

The Mississippi Rural Health Association has welcomed five new Fellows in its 2019 cohort. The Mississippi Rural Health Fellowship is a way to recognize rural health professionals with at least three years of rural health experience, and who have the desire to grow in the profession and make a difference in their community.

These fellows will review community, legislative, and policy and work to solve many of Mississippi rural health issues. To learn more about the fellows program, visit www.msrrha.org/fellows.



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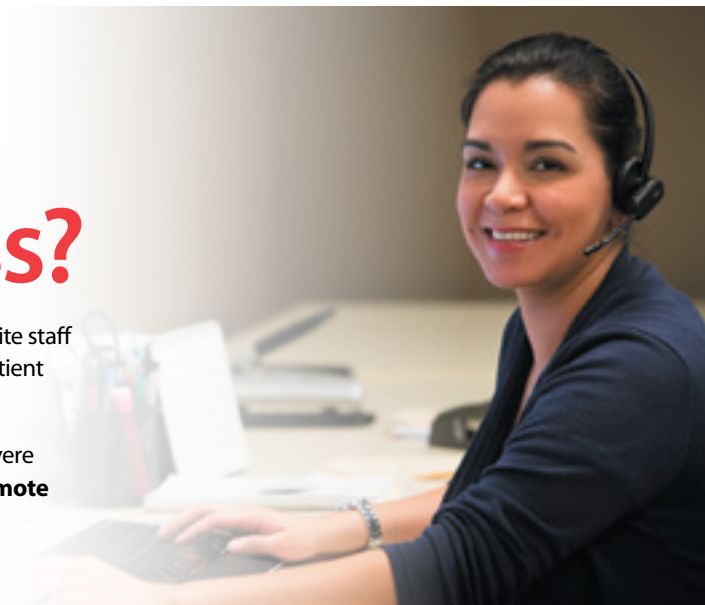


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2019 LEGISLATIVE UPDATE

As the 2019 Mississippi legislative season has drawn to a close, we would like to provide an update on bills that successfully passed that pertain to rural health in Mississippi.

Board of Trustees for Community Hospitals to Pay Same for Health Insurance as Employees

House Bill 273 authorizes the board of trustees for a community hospital who choose to participate in the offered hospital medical benefit plan or health insurance plan to pay the same cost as hospital employees.

Penalize Late Payments of Claims for Health Insurance

House Bill 628 states that if a health insurance claim is not denied for appropriate reasons, the insurer must pay the provider or insured 3% per month after payment was due until the claim is settled. If the insurer repeatedly fails to pay benefits and/or claims and it is deemed the insurer acted in bad faith, the health care provider or insured can recover damages up to 3 times the amount of unpaid benefits.

Improved Access to Healthy Food

House Bill 1132 was signed into law on March 19th. This reenacts the Small Business and Grocer Investment Act and extends the date of the repeal on sections of

the law to 2022. The act authorizes the Mississippi Development Authority to establish a program that increases access to fresh fruits, vegetables, and other affordable healthy food in underserved communities through grants and loans.

Heartbeat Bill

Signed into law on March 21st, Senate Bill 2116 prohibits abortion once there is a detectable fetal heartbeat.

Establishment of MS Foster Care Fund

Passed on March 28, Senate Bill 2196 established the Mississippi Foster Care Fund and provides additional criminal assessment on drug offenses to be allocated to this fund.

Include Psychiatry Students in MS Rural Physicians Scholarship Residency Program

Senate Bill 2524 amends the Mississippi Rural Physicians Scholarship Residency Program to include a licensed psychiatrist in the Mississippi Rural Physicians Scholarship Commission and to include fourth-year medical school or osteopathic school students interested in practicing psychiatry in rural Mississippi to be considered for the program.

U.S. Senator Cindy Hyde-Smith (R-Miss.) recently stressed the need for federal action to address the risk of rural hospitals closing in Mississippi and other rural states.

Hyde-Smith raised the rural hospital issue at a Senate Labor, Health and Human Services, and Education Appropriations Subcommittee hearing Thursday on the FY2020 budget request for the U.S. Department of Health and Human Services (HHS).

“We must keep working to find strong actions that we can take to help rural hospitals in Mississippi stay open. Rural hospital closures have reached a very critical point in our state,” Hyde-Smith said following the hearing. At the hearing, Hyde-Smith told HHS Secretary Alex Azar about her growing concerns regarding rural healthcare in Mississippi, which has more rural hospitals at risk of closing than any other state. She cited recent reports showing half of all rural hospitals in Mississippi are at high financial risk of shutting their doors.

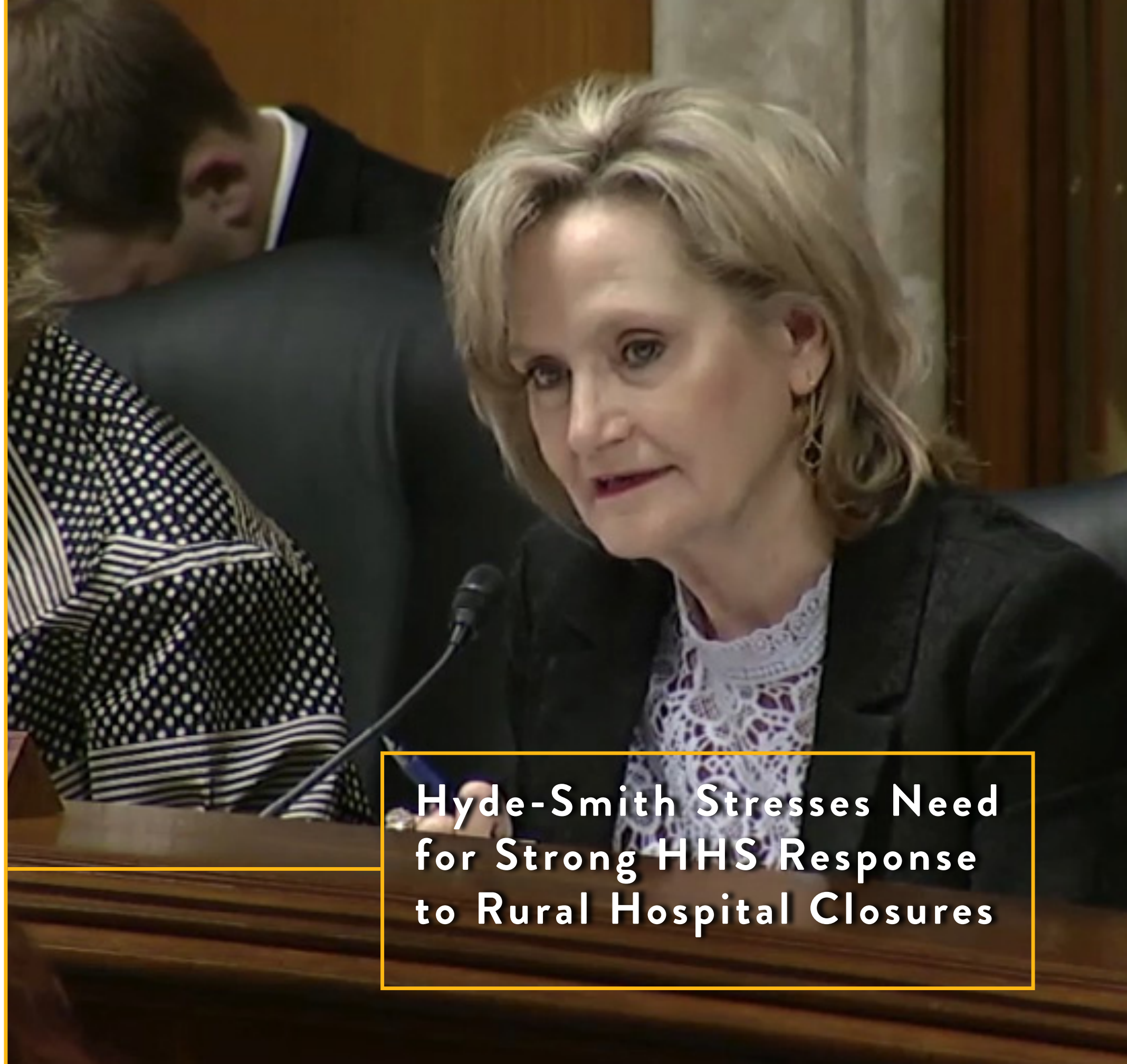
“When a hospital closes, the whole community is affected in so many ways, not only the employment there. Most importantly, it means no more access to emergency care for the community’s residents,” Hyde-Smith said. “In an emergency, timely care is of essence, and having close-by access to them can truly mean life or death.”

Azar assured Hyde-Smith, “We’re working on this.” “You have repeatedly raised with me the concerns about rural hospital access in Mississippi, and in part because of your efforts I have created a task force across HHS to help come up with all ideas that we can around how we can address the hospital crisis,” Azar said.

The Secretary listed ongoing review of HHS programs, policies, and rules to determine their effectiveness in supporting access to rural health care and hospital financial survivability.

“Let me give you some ideas. One of them we just were discussing, which is telehealth. How can we help make sure that we’re expanding access into rural America because we’ll end up consolidating everyone living in urban areas if we can’t provide them healthcare in rural America,” Azar said.

“We also have to make sure that our regulations at CMS [Centers for Medicare and Medicaid Services] or otherwise are not creating artificial barriers to economically viable models of hospitals in rural America. Are we trying to force a 1960s model of hospitals through our payment systems and other regulations onto rural America?” he said.



Hyde-Smith Stresses Need for Strong HHS Response to Rural Hospital Closures



RURAL MEDICAL & SCIENCE SCHOLARS

The Rural Medical & Science Scholars program helps rising high school seniors determine if they want to pursue health-related careers and shapes students’ interest and understanding of medicine, health-related disciplines, and other STEM fields. The program aims to ensure a strong and passionate workforce for the long-term goals of improving Mississippi’s economy and increasing access to healthcare.

The Scholars participate in a 4 week summer program at Mississippi State University. They take two college-level courses (Introduction to Health Professions and

Applied Public Health Sciences), spend a few afternoons, “shadowing physicians, dentists, and other health care professionals” in a hospital or clinical setting, tour a major medical facility, and attend practical learning workshops that are relevant to a career in health or science. To help launch their career, a study skills and communication/ critical thinking workshop kicks-off the program.

Contact Ann Sansing at
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THE ER WAS CLOSED. THE AMBULANCE WASN’T CLOSE. THIS IS HOW YOU DIE IN RURAL MISSISSIPPI

By Giacomo Bologna, Clarion Ledger

Shyteria Shardae “Shy” Shoemaker was sitting on a bed in her Chickasaw County home when it happened.

The 23-year-old mother, who family members say could talk to just about anyone she met and who loved to argue, couldn’t breathe.

Shoemaker gasped for air, stood up and opened the bedroom door.

Then, she collapsed.

Shoemaker, who was pregnant with her second child, was only an eight-minute drive from Trace Regional Hospital in Houston when 911 was first dialed. But that didn’t matter since the hospital shuttered its emergency room in 2014.

The only ambulance in the county that night was almost a half-hour away.

More than an hour later, in a neighboring county, Shoemaker was pronounced dead.

Her death made the front page of the Chickasaw Journal. Residents say everybody in the county is talking about the young mother’s death and questioning why their emergency room shut down.

Houston Fire Chief Jonathan Blankenship said city leaders had meeting after meeting to prepare for the emergency room’s closure.

“We miss it,” Blankenship said. “It’s vital to our community.”

It’s unclear, though, if residents of Chickasaw County realized what they had lost — until now.

MISSISSIPPI LEADS INNOVATION IN TELEHEALTH AND DIGITAL HEALTH TECHNOLOGY ADOPTION

By Katrina Rios, emocha

It is no secret that greater patient engagement yields improved health outcomes. For example, the Commonwealth Care Alliance of Massachusetts had more than 51 touchpoints with their members over a 24 month period. This resulted in a 22 percent drop for in-patient admissions, a 14 percent decrease in emergency room visits, and a 5 percent reduction in total cost of care, which their Chief Innovation Officer Dr. John Loughnane highlighted during this year’s Medicaid Managed Care Conference. Other areas of the health system, such as health department tuberculosis programs, have been connecting daily with patients for decades to achieve near perfect rates of treatment completion while achieving cost savings for states. However, until recently, there have been no mechanisms to compensate for this critically important effort.

Reimbursement for virtual communication with patients.

The recent creation of ‘virtual communication’ billing codes by the Centers for Medicare & Medicaid Services (CMS) seeks to compensate regular, quick touchpoints with patients. Unlike telehealth or remote patient monitoring codes, new CMS codes G2010 and G0071 reimburse providers for reviewing 5-minutes of recorded photo or video data and

communicating back to the patient within 24 hours.

The intention of this new code was clearly outlined by Administrator Seema Verma. At the 2019 CMS

creation of the virtual communications code in the Medicare fee schedule has set the stage for state-level Medicaid programs, such as California, and commercial insurers, such as United Healthcare and certain Blue Cross Blue Shield plans, to adopt these codes in their fee schedules to improve clinical quality in a cost-effective manner. Digital health leadership in Mississippi

On March 20, 2019, the Mississippi Telehealth Association convened leaders from across the state to discuss the role telehealth, virtual communications, and remote patient monitoring have in improving care for Mississippians. It is the only state-based, membership-driven telehealth organization in the country with core objectives rooted in creating initiatives to:

- Increase patient adoption of new technology
- Provide greater access to care in rural areas
- Advance patient-centered telehealth policies
- Provide a forum for business to business development

emocha co-presented during a reimbursement break out session with the Mississippi Division of Medicaid at this conference. Approximately 700,000 Medicaid beneficiaries receive care financed by the agency each year and there



is a proactive effort to increase telehealth adoption, particularly to serve beneficiaries in rural areas. Given broadband internet limitations in much of the state, livestream communication can be a barrier to care, but asynchronous -- or store-and-forward -- technology can be better utilized to improve care in rural areas.

Improving medication adherence with emocha’s asynchronous video platform is an ideal use case for leveraging new virtual communication codes. The platform has been shown to improve outcomes while reducing costs over prolonged periods of time. emocha can decrease healthcare costs associated with nonadherence that are largely assumed by the state across a number of patient populations.

Furthermore, having a daily touchpoint with patients to improve medication adherence presents the opportunity to proactively intervene on social determinants of health to connect people to services they need, such as transportation or nutritional counseling. Early experiences with Medicaid plans in other states show how emocha works collaboratively with federally qualified health center partners to holistically improve adherence to oral diabetes medication.

“With the evolution and innovation in healthcare today, platforms that can deliver quality, seamless care in a fast and efficient manner is pivotal,” said Ryan Kelly, the Executive Director of the Mississippi Telehealth Association. “Telehealth serves as one of the primary outlets for consistent innovation and


growth, and the results show that it is positive for the patient, the provider, and the facilities delivering care. We fully expect telehealth in its many forms to be the future of healthcare that is now beginning to emerge.”

Healthcare continues to be radically redesigned at a rapid pace. Mississippi is leading the way in making care more efficient, equitable, and accessible by engaging with physicians as well as policy, industry, and patient leaders to push innovation forward.

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MISSISSIPPI ONE OF TEN STATES LEADING THE NATION IN ENCOURAGING WELL-ROUNDED, ‘HEALTHY SCHOOLS,’ REPORT FINDS

By Jackie Mader, Hechinger Report

The report, released by several organizations including the nonprofit Robert Wood Johnson Foundation, Child Trends, the Institute for Health Research and Policy at the University of Illinois at Chicago and EMT Associates, Inc., analyzed state statutes and regulations relating to ten domains of health, including nutrition, social services, employee wellness and family engagement. Mississippi’s statutes and regulations were found to be “comprehensive” in six of these domains, including health education and employee wellness. The state is the only one in the nation to comprehensively cover employee wellness in its policies.

Mississippi did particularly well in the areas of health education, which includes requiring a healthy eating and nutrition curriculum in all grade levels, and incorporating social and emotional learning in some grade levels. The state also scored well in health services, which include requiring preventive health screenings across grade levels. The state’s policies regarding nutrition environment and services, counseling, psychological and social services, and community engagement were rated “moderate.”

In the counseling, psychological and social services domain, the report found Mississippi’s statutes and regulations failed to address school-based mental health services, professional development for mental health, or professional development for trauma. The state’s lack of school-community and interagency partnerships and failure to address community use of

public school facilities earned it a score of 40 percent in community involvement, well below the national average of 67 percent.

The report is part of a larger initiative from the Centers for Disease Control and Prevention and the nonprofit group ASCD to push schools to address physical, mental and social well-being. These supports in nonacademic areas ultimately help children perform better academically.


Various schools in Mississippi have been recognized for initiatives to improve health among their students. Despite the many policies highlighted in the report, the state has long struggled with persistent issues like food insecurity and poverty which can negatively impact a child’s health and well-being. Many of the state’s children also lack access to mental health care.

Data Dive:
Mississippi was one of nine states, including Louisiana and South Carolina, with stagnant funding for state-funded pre-K programs in the 2016-17 and 2017-18 school years, according to a new report by the Education Commission of the States. Several other southern states increased their funding: Alabama raised its funding by 20 percent, North Carolina increased funding by over 9 percent and Georgia upped funding by almost 2 percent. Nationwide, funding for pre-K increased by 3.42 percent during that time period.







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TELEHEALTH FIRM COMES TO MISSISSIPPI - COMBINES VIRTUAL DOCTOR VISIT WITH MEDICINE ON THE SPOT

Margie Manning, St. Pete Catalyst

A telemedicine station that allows users to make a virtual visit to the doctor and get their prescriptions at the same time hits the market today.

OnMed launched its OnMed Stations Tuesday morning, after six years in stealth mode.

The stations are interactive computer kiosks in a private enclosure with internet connectivity for medical consultations and for processing and dispensing pharmaceuticals.

Two units will go live in a rural hospital and a rural health center in Mississippi next month, said Austin White, president and CEO and a founding partner of the Clearwater company.

OnMed has letters of intent with six other clients. The stations also can be used in the workplace, at airports, colleges and hotels, among other locations.

“We think we have an opportunity to disrupt the healthcare system,” White said.

White and other OnMed founders have worked together previously at a sister telehealth company, MD Plus. Healthcare in the U.S. involves three key issues — access, cost and quality of care — White said.

“It doesn’t matter how much healthcare costs or who’s paying for it, or how good your physician is, if you can’t access it,” he said. “We look at telehealth as an access point.”

The idea for OnMed grew out of a

personal experience by Leonard Solie, who is chairman of the board of the company. After waiting three days for a doctor’s visit, he had to pick up a prescription at the pharmacy, where he had to wait another 90 minutes.

“He was standing around for an hour and a half, waiting to get his medication, so he walked outside to pick up a movie from Redbox, and the idea hit him — Why would we not do this as a matter of course, having the doctor and the nurse and pharmacist all in the same consultation and dispense the medication?,” White said.

The national average to get a doctor’s appointment is 21 days, White said. People without insurance have to rely on walk-in clinics or emergency rooms, which is costly and exposes sick people to other illnesses.

That was a key factor in developing OnMed.

“We were insistent on the encounter being private, very clean and sanitized and with state of the art technology ... When you are talking to the live medical assistant or the live nurse or doctor, it looks like you are standing there speaking to them,” White said.

The OnMed Station has privacy glass that goes opaque when the station is in use, and 3D facial recognition for positive patient identification. The high-def camera allows a physician to look down a patient’s throat or examine skin lesions. There are non-intrusive medical devices to collect a patient’s vitals, and thermal imaging is used to provide body temperature

and diagnose infection. The unit has anti-microbial surfaces and ultra-violet lighting is used to sanitize the consultation room.

“All of the diagnostic equipment we use is FDA-cleared or approved,” White said. “We want it clean, we want it secure and we also want the best diagnostic equipment in the marketplace in the OnMed station.” The data is captured in an electronic medical record that can be shared with a patient’s primary care physician.

The 100 most commonly prescribed prescriptions are available, although the station won’t have any narcotics or scheduled drugs. The medications will vary depending on the location of the OnMed Station, White said.

The company will accept most major insurance, and Medicare and Medicaid will reimburse for a visit in some cases. OnMed plans to contract with physician groups and train them in telehealth.

“We’re not trying to take over the primary care role,” White said. “We’re trying to facilitate a need when the patient can’t get to their primary care physician or doesn’t have a primary care physician.”

OnMed currently has 14 employees and expects to grow to more than 100 employees within about 18 months. The founders initially funded the company, followed by a small friends and family capital raise. In October, the company finalized a funding round with a large private investor, and has enough capital for the next year, White said.

BRUNSON TO BECOME DIRECTOR OF MEDICAL ASSOCIATION

By Jack Weatherly, Mississippi Business Journal

Dr. Claude Brunson has switched from president of the Mississippi Board of Medical Licensure, which, as much as anything rides herd on physicians, to full-time director of the Mississippi Medical Association, which serves an advocacy role for doctors.

Association Board Chairwoman Dr. Jennifer Bryan said in an association release that “all of the state’s physicians know, today, they have one of their own at the helm. He knows medicine and he knows Mississippi.”

He has been a member of the licensure board and his term ends in 2022.

As of April 1st, he became executive director of the association that claims 5,000 physicians as members and will step down from licensure board at that time.

Previously, he was the first African-American to be president of the physicians’ association. Brunson, an anesthesiologist, is “one of the most active voices in Mississippi in medical and health policy,” the release from the association states. Efforts to reach Brunson for this article were unsuccessful. Since 2010, Brunson has been senior adviser to the vice chancellor of the University of Mississippi Medical Center and leads the external affairs division.

He served UMMC as director of the office of government affairs from 2015 till 2018.

The licensure board and physicians association have been in conflict in recent year over their roles.

Dr. John Hall, former executive director of the licensure board, which declined

Hall said in an email to The Clarion-Ledger after he left that post that “the board has a deep, irremediable conflict of interest that arise[s] directly from its structure. By statute, the board members are nominated by the [Mississippi Medical Association] and appointed by the governor.”

“This leads to the disciplinary body being controlled by the same ‘trade guild’ it’s supposed to regulate. . . . This is fundamentally a legislative problem.”

Dr. Kenneth E. Cleveland was named by the board as executive director about a year ago.

He took the position despite being sued 12 times in Hinds County Circuit Court in a 10-year period. Settlements were reached in some and others were dismissed outright.

Dr. Charles Miles, then-president of the board said that Cleveland was never the subject of a complaint filed with the board, and thus board never looked into the matter in that context.

Some of the other 12 candidates also were targets of lawsuits as well, Miles said. “That’s part of the price you pay for practicing medicine in this litigious society,” he said.

He pushed for a state law to make such a relationship punishable as a felony.

The board did not endorse the effort, which died in committee.





PRESCRIPTION DRUG PRICING

From CSPAN

Chief executive officers from seven prescription drug companies testified before the Senate Finance Committee on drug pricing practices. Members asked the executives how their companies set prices, determine rebates, and why prices for patients vary from country to country. The executives talked about their research and development costs relative to revenues and profits, and each stressed

their commitment to providing all patients the medicines they need regardless of listed prices. Senator Bob Menendez (D-NJ) warned them, however, that there was bipartisan support to ensure drug prices were brought down, and said that if the companies did not address the issue themselves, Congress or President Trump would take action to force them to do so.



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RURAL HEALTH CLINIC MODERNIZATION ACT

Recently, Senators John Barrasso (R-WY) and Tina Smith (D-MN) introduced the bipartisan Rural Health Clinic Modernization Act (S. 1037) to support their strong future. The bill provides regulatory relief for rural health clinics and improves reimbursements, listening to the concerns RHC providers and NRHA have shared. NRHA is proud to support this legislation. "As a doctor from a rural state, I want all patients to have access to high-quality care wherever they live," Sen. Barrasso said. "Rural health clinics have a long record of making sure that folks in rural communities receive primary care close to home. I am proud to help lead this bipartisan effort to strengthen rural health clinics so they will continue to serve patients in Wyoming and across rural America."

"We need to do everything we can to make sure that people in rural areas are able to get healthcare," Sen. Smith said. "While there have been significant changes in the health care system, many of the laws focusing on Rural Health Clinics haven't been updated in over 40 years. Our bipartisan bill would fix some of the old rules that are in need of these upgrades. For example, it expands the ability of physician assistants and nurse practitioners to provide care in these clinics. This legislation is really about making sure at the end of the day people are going to be able to get the vital care Rural Health Clinics provide in underserved, rural areas."

Rural Health Clinics (RHCs) were established through the

Rural Health Clinic Services Act of 1977. The purpose of RHCs was to address the shortage of health care providers serving in rural communities, including advanced practice clinicians.

There are approximately 4,100 rural health clinics operating in the United States. Rural Health Clinics are an important part of the rural health care safety net, with facilities heavily dependent on Medicare and Medicaid reimbursement.

The law governing rural health clinics is more than 30 years old. This is why the National Advisory Committee on Rural Health and Human Services recommended updating the statute to meet the needs of the modern health care system.

The Rural Health Clinic Modernization Act:

- Updates how advanced practice clinicians are utilized by RHCs, bringing the statute up to date with current state laws.
- Updates the statute regarding laboratory requirements and delivery of telehealth services.
- Increases reimbursements for RHCs. Currently, RHCs are paid an all-inclusive rate for the care they provide. This rate has not been legislatively updated since 1988. This legislation updates reimbursements to better reflect the quality of care provided by RHCs.



MACPAC WANTS TO CHANGE HOW DSH PAYMENTS ARE CALCULATED

Robert King, ModernHealthcare

A Medicaid advisory panel doesn't want to count third-party costs and payments in the calculation of the Medicaid shortfall for disproportionate-share hospitals, a move that could increase DSH payments to hospitals that serve a high share of Medicaid-only patients. Medicaid and CHIP Payment Advisory Commission members cast 15 votes in favor with one abstention to approve a recommendation to Congress to change the definition of a Medicaid shortfall, or the difference between the cost for providing care to Medicaid patients and the payments for the services. Hospitals have challenged the shortfall's calculation in court.

The commission's proposed definition would exclude the costs and payments for all Medicaid-eligible patients for whom Medicaid isn't the primary payer.

What can be included in a shortfall has a major impact on the amount of DSH payments that a hospital can receive. Under federal law, a DSH payment to a hospital cannot exceed the shortfall amount.

The CMS said in guidance in 2010 that the third-party payments, such as payments from Medicare or private insurance, should be counted in the Medicaid shortfall calculation. The agency codified this position in a proposed rule in 2017.

The commission believes that the new definition would be simpler for hospitals.

Currently when a hospital enrolls a Medicaid patient with private insurance, then the surplus the hospital gets for those patients reduces the DSH payment the hospital can receive, according to commission staff.

The panel shrugged off concerns from hospital groups to wait until after a lawsuit surrounding DSH payments makes its way through the courts.

A federal judge ruled last year that the CMS had to vacate a final rule that required hospitals to deduct any Medicare or commercial insurance reimbursements from their DSH allotment. Hospitals have argued that the CMS didn't have the authority to issue the rule in 2017 and the CMS appealed the ruling in April 2018.

"There is ongoing litigation and not settled policy yet," said Shannon Lovejoy of the Children's Hospital Association at the meeting. "This needs to play out a little more in the court system before we can get a handle on this."

The CMS has pulled the 2010 guidance and is not enforcing the 2017 rule.

Hospitals could be on the hook to pay back millions of dollars to the CMS if the rule survives. Missouri hospitals estimate they could have to pay back nearly \$96 million to the federal government based on 2011 and 2012 DSH allotments alone.

Commission members believed the litigation shouldn't prevent a recommendation and that Congress needs to change the statute to reverse the effects of the court ruling.

"I am not persuaded that waiting on the judicial system to correct bad policy is good policy," said commission member Dr. Sheldon Retchin, a professor of medicine and public health at Ohio State University.

If Congress changed the statute and addressed the shortfall definition then it "could settle the water and create some certainty that would be beneficial to the community at large," added Chair Penny Thompson, a consultant who formerly served as deputy director of the Center for Medicaid and CHIP Services at the CMS.

Congress is expected to pass legislation this year to delay \$4 billion in cuts to DSH payments that go into effect on Oct. 1. However, some Republican senators have floated updating the DSH payment



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