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FINAL MACRA RULE RELEASED
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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MRHA GIVES RURAL HEALTH CHAMPION AWARDS TO LEGISLATORS
By: Ryan Kelly

The Mississippi Rural Health Association recognized three legislators for rural health excellence during the association business meeting in October. Senators Angela Hill and Terry Burton were awarded the Rural Health Champion awards for their dedicated work for rural health quality and support over the previous year. In addition, Congressman Gregg Harper received the Congressman of the Year award for his work with federal legislation including telemedicine and rural hospital initiatives. The association congratulates these legislators for their dedication to rural excellence and looks forward to a strong partnership in the future.

NEW ASSOCIATION DIRECTORS ANNOUNCED

This year marked the most competitive ballot that we have ever seen. We thank you for voting for your preferred candidates. We had a large number of members voting, so we do appreciate the dedication.

We are pleased to announce new officers for 2017-2019

Michael Nester
Administrator
H.C. Watkins Memorial Hospital

Gregg Gibbes
CEO
Covington County Hospital

Wanda Jones
Director of Continuing Education
William Carey University

Paula Turner, MRHF
Coordinator for Rural Health Strategy
North Mississippi Health Services

Augusta Bilbrow
Director, Heart Disease, Stroke, and Prevention Program
Mississippi State Department of Health

USM BEGINS STUDENT CHAPTER OF MISSISSIPPI RURAL HEALTH ASSOCIATION
By: Marianna Lunsford

The University of Southern Mississippi held the first meeting of their student chapter of the Mississippi Rural Health Association on Thursday, October 27, 2016.

The meeting was open to all USM students interested in a career in healthcare. The USM student chapter of the Mississippi Rural Health Association will assist students in learning more about career opportunities and the rural health landscape.

Any USM student interested in becoming a member should contact the chapter president, Brian Long, at brian.long@usm.edu.

PHYSICIAN JOB BOARD

The Association’s new Physician Job Board is up and running. In partnership with PhysicianCareer.com, this job board opens opportunities to recruit physicians to your practice from across the country. Best of all, we will post the positions for you at no cost.

Visit the Job Board at physiciancareer.com/mrha

Would you like to submit a job for inclusion? Contact Ryan Kelly at ryan.kelly@mississippirural.org with the details of the position. There is no cost for MRHA members to use this resource.
ATTENTION ALL PROVIDERS:

Effective October 10, 2016, Magnolia Health changed the out-of-network benefit for all MississippiCAN provider types to 50% of the State Medicaid fee schedule. If you are interested in joining the Magnolia provider network, please visit magnoliahealthplan.com and locate the Provider section to find out how.

Providers may also contact the Provider Services Call Center at 866-912-6285 for more information. Thank you for your continued support of Magnolia members!

NEW MARKET TAX CREDITS

HOPE has applied for an allocation of New Market Tax Credits and expects an announcement to award the credits soon. If HOPE receives an award, we would like to work with a Rural Health Clinic or Hospital that is rebuilding or expanding their facilities. A NMTC project receives equity from the credits that can be used for the facility and reduces the amount of money the Rural Health Center needs to borrow. The optimal size deal for NMTC purposes is over $5 million and under $25 million.

If you would like more information about credits and how they can help you, please call Phil Eide 601.944.4148

QUITMAN COUNTY HOSPITAL CLOSED

Residents in North Mississippi are now looking to find a new way to receive emergency medical services after the Quitman County Hospital closed in September. The Quitman County Hospital was the county’s only local hospital.

Hospital officials said the hospital shut down due to insufficient funding. Employees were notified the week before the closure.

The hospital’s kitchen is still working in order to supply meal for the nearby nursing home facility.

YOUR 2017 UNITEDHEALTH PREMIUM DESIGNATION PROGRAM LETTER COMING IN NOVEMBER

By: United Healthcare

If you are a physician or practice administrator in a market where the UnitedHealth Premium designation program is available and practice in one of the Premium-eligible medical specialties, you will receive a letter with your Premium designation in early November. The Premium notification letter for physicians includes your Premium designation along with instructions on how to access your Premium assessment reports. The designations are publicly displayed on January 4, 2017. Prior to the effective date of the designations, we will provide time for you to review your assessment results and request reconsideration, if applicable. The updated Premium designations are based on a new time frame of processed claims (January 1, 2013 – March 31, 2016).

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CHS SELLS FOUR RURAL HOSPITALS IN DEBT-REDUCTION EFFORT

By: Dave Barkholz

Struggling Community Health Systems has agreed to sell three rural hospitals in Mississippi and one in Florida as part of its plan to pare debt and underperforming hospitals.

Not-for-profit Curae Health is buying 95-bed Merit Health Gilmore Memorial in Amory, Miss., 112-bed Merit Health Batesville in Batesville, Miss., 181-bed Merit Health Northwest Mississippi in Clarksdale, Miss. and 126-bed Highlands Regional Medical Center in Sebring, Fla.

CHS said it would use proceeds of the sales to reduce debt. Terms were not disclosed.

“We are highly invested in the success of our affiliated hospitals, and we are considering how to best position them for the future,” said CHS CEO Wayne Smith.

“These four hospitals provide quality care and are important in each of their communities. They will benefit from alignment with a smaller organization specializing in the operation of rural hospitals. Divestiture of these assets advances our strategy to focus on a portfolio of larger hospitals and regional healthcare systems.”

Curae is based in Clinton, Tenn. and operates three hospitals in Alabama.

CHS said the deal is expected to be completed in the fourth quarter pending all customary regulatory approvals.

Franklin, Tenn.-based CHS is the nation’s second-largest, investor-owned hospital company with 159 hospitals.

The system is plagued by $15 billion in debt that is far higher than its peers. That’s despite raising $1.2 billion earlier this year through a spinoff of troubled Health Management Associates.

The system has suffered an earnings and stock price slump since last fall. CHS is being dragged down by the performance of hospitals acquired in 2014 as part of its blockbuster $7.6 billion purchase of Health Management Associates.

CHS is coming off a $1.43 billion, or $12.90 per share, loss from continuing operations in the second quarter, after taking a non-cash write-down of goodwill on the sinking value of hospitals it bought over the years. Excluding the one-time adjustments, adjusted EBITDA in the second quarter fell to $563 million compared with $769 million in the year-earlier quarter. Revenue also declined by 6% to $4.6 billion.

CHS said this month it had found five buyers for 12 hospitals that it had for sale.

CHS Chief Financial Officer Larry Cash said the company expects to raise $850 million from the sale of the 12 hospitals.

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MEDICAL BOARD DIRECTOR SETS NEW COURSE FOR AGENCY
By: Jack Weatherly

Transparency may not seem a top priority for an enforcement agency. But it is for Dr. John Hall, new executive director of the Mississippi Board of Medical Licensure.

Toward that end, Hall says that the board will do away with the $25 fee for going beyond a generic description of a board action against a physician such as “licensee executed an Agreed Order Not to Renew or Seek Reinstatement of his MS medical license.”

Consumer Reports in April ranked Mississippi last among 65 medical licensing boards in the nation. The board started working toward improving the website before the Consumer Reports survey came out, according to Dr. Virginia Crawford, then interim director. Crawford said at the time that the matter of the fee was undecided.

Hall’s goal is to have the new website up by spring. He said he wants to empower Mississippians by providing them with the best information.

The number of Mississippi physicians licensed and practicing is less than 5,000, Hall said. In recent years, narcotic pain reliever abuse has gotten out of control across the country, and Mississippi has not been unscathed, he said. Pain reliever prescription abuse in Mississippi is probably “well under 5 percent,” Hall said.

Pain management became a focal point for physicians in the late 1980s and early 1990s, Hall said.

“It was well-intentioned but ultimately bad,” he said.

A Brandon physician, Dr. Steven Tincher, was arrested recently by Brandon police and charged with two counts of trafficking a controlled substance stemming from abusing “his privilege to write and issue prescriptions,” according to The Clarion-Ledger.

Hall emailed the Mississippi Business Journal “concomitant with Dr. Tincher’s arrest, investigators from [the medical licensure board] procured a surrender of his license. He is no longer a Mississippi physician.”

In the 90 days Hall has been director, about a half-dozen doctors have surrendered their licenses and another half-dozen licenses have been indefinitely suspended.

Another problem on the agency’s radar is doctors trading drugs for sex, Hall said.

Hall, 57, who holds medical and law degrees and a master of business degree, is paid $250,000 a year for his new job, which he says half of what he was paid in working as chief clinical officer for Executive Health Resources, a research division of Optum, the analytics and intellectual property side of United Health Group, not to be confused with UnitedHealthcare, a large insurer.

“People think I worked for big insurance. I did not work for big insurance,” he said.

Dr. Charles Miles, president of the board, said in an interview, “We were very excited to get someone with an M.D., JD and MBA. He was more than we could’ve hoped for. I’ve been very impressed with what John’s done.”

“We interviewed five, maybe six, candidates and got numerous applications, and all of them were very qualified,” Miles said.

Hall had been professor of anesthesia and pediatrics and bioethics and humanities at Blair Batson Children’s Hospital, and chief of anesthesiology at the hospital.

In another matter, Hall has voiced support for legislation to offer a framework for the practice of telemedicine.

Hall said in an earlier interview that it would be “extraordinarily commendable” for the Legislature to take on a “tough set of concerns” that are “continuously evolving.”

“I would like to see us adopt some statutes that guide me where I can build rules that will protect the public from bad medicine,” said Hall, who is licensed to practice in Mississippi but is not a member of the Medical Association, which adamantly opposed proposed legislation backed by Teladoc Inc. a telemedicine provider.

That measure sailed through the House, but stalled in a Senate committee.

Teladoc has said it will pursue similar legislation in the upcoming session of the General Assembly, which starts in January.

While enforcement is a major part of his job, making it clear to physicians what is expected of them, in terms of compliance, starting with making it easier to get a medical license by reducing red tape.
The Centers for Medicare and Medicaid Services (CMS) released its hotly anticipated 2,400-page Medicare Access and CHIP Reauthorization Act (MACRA) Final Rule on Friday. The rule, now open for comment, finalizes the new payment and healthcare quality reforms for those physicians seeking reimbursement for services by Medicare. “The policy released today is the first step in a multi-year journey in which we are particularly focused on allowing physicians to transition at their own pace, continuing to get feedback from the field, providing meaningful support, and improving the program over time,” wrote CMS Acting Administrator Andy Slavitt in a blog post announcing the final rule’s release.

While CMS claims MACRA will better reward providers for quality patient care and eventually lower costs, some physicians have expressed concern that the changes in payment enacted by the rule could put them out of independent practice. MACRA received strong bipartisan support in Congress as it repealed the Sustainable Growth Rate (SGR) payment formula that increasingly reduced Medicare payments to clinicians. It was signed into law by President Obama in April 2015. However, MACRA also replaced the SGR with MIPS and Advanced APMs, which serve as an alternative to MIPS.

Eligible clinicians impacted by MIPS and Advanced APMs include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. The impact on health information management professionals—better healthcare documentation and information governance will likely be needed in order to comply with MACRA, since providers will need to prove through their health records that services were not just rendered but actually lead to quality care.

The final rule addresses concerns expressed by smaller physician practices about the flexibility of participation in Merit-based Incentive Payment Programs (MIPS) and Advanced Alternative Payment Models (APMs), the two primary programs included in MACRA for shifting physicians from a fee-for-service payment model to a quality-centric payment model. To avoid penalties, physician practices must choose to participate in the MIPS program or the APM.

According to Slavitt’s blog post, “Other than a 0.5 percent fee schedule update in 2017 and 2018, there are very few changes when the program first begins in 2017. If you already participate in an advanced APM, your participation stays the same. If you aren’t in an advanced APM, but are interested, more options are becoming available. If you participate in the standard Medicare quality reporting and Electronic Health Records (EHR) Incentive Programs, you will find MIPS simpler. And, if you see Medicare patients, but have never participated in a Medicare quality program, there are paths to choose from to get started. The first couple of years are aimed at getting physicians gradually more experienced with the program and vendors more capable of supporting physicians. We have finalized this policy with a comment period so that we can continue to improve the program based on your feedback.”

CMS also is rolling out a new Quality Payment Program website that will explain the new program and help clinicians easily identify the measures and activities most meaningful to their practice or specialty.

According to Slavitt, CMS gathered input for the final rule via a “listening tour” involving 100,000 stakeholders and received 4,000 comments on the draft rule. The rule changes go into effect on January 1, 2017.

Visit the Journal of AHIMA website in the coming weeks for full analysis of the final rule and its direct impact on health information management professionals.
The office of the national Coordinator for Health IT has finalized a rule that will give it more oversight over certifying electronic health records and other technologies that store, share and analyze health information for consumers. The rule also give the ONC the authority to ask developers to pull noncompliant products from the market.

The ONC first proposed increasing its role in the certification, review, and testing of health IT products in a draft rule released this past March. The agency received 48 comments by its May 2 deadline.

The ONC would now have the power to decertify health IT products that don’t comply with regulations or are found to pose a risk to public health of safety, for example, if they caused medical errors.

Response to the rulemaking was mixed. The American Medical Association supported the ONC’s idea to use corrective actions to resolve patient safety and security issues involving an IT product. However, the trade group was concerned about the suspension or termination of an IT product’s certification.

That action “may have serious repercussions for physicians and patients. Without these tools, physicians and patients may be unable to access necessary information or coordinate care,” the trade group said in a letter commenting on the draft rule.

In response to the comment, the agency emphasized termination is a last resort. It also added a new, intermediate step in the direct review process called “proposed termination.” That will give health IT developers a chance to resolve issues regarding a non-conformity prior to decertification.

The College of Healthcare Information Management Executives, a trade group that represents chief information officers at hospitals, praised the rule for addressing clinicians’ concerns about the usability of EHRs. Other members worry that some systems fail to calculate quality measurement data correctly, jeopardizing the accuracy of information that is increasingly tied to payment and penalties for providers.

The Electronic Health Record (HER) Association felt the ONC’s proposed rule inappropriately expands the agency’s legal authority.

The potential costs of this rule for health IT developers, the ONC and healthcare providers may be as much as $650 million, with an annual cost of $6.5 million.
PATIENT-IDENTIFICATION ERRORS PERSIST, BUT ARE PREVENTABLE
By: ECRI Institute

In its newest analysis of patient safety errors, ECRI Institute PSO today releases a Deep Dive review of reported events involving patient identification. The risk of failing to associate the right patient with an action, referred to as wrong-patient errors, is significant and may be driven by increasing patient volume, frequent handoffs among providers, and increasing interoperability and data sharing among IT systems.

A key take-away from ECRI Institute’s research is that most, if not all, wrong-patient errors are preventable. Most patient identification mistakes are caught before care is provided, but the events in this report illustrate that others do reach the patient, sometimes with potentially fatal consequences. About 9% of the events led to temporary or permanent harm or even death.

“Although many healthcare workers doubt they will actually make a mistake in identifying their patients, ECRI Institute PSO and our partner PSOs have collected thousands of reports that show this isn’t the case,” says William M. Marella, MBA, MMI, ECRI Institute executive director of PSO Operations and Analytics. “We’ve seen that anyone on the patient’s healthcare team can make an identification error, including physicians, nurses, lab technicians, pharmacists, and transporters.”

Analysis of the reported events illustrate that:

- Incorrect patient identification can occur during multiple procedures and processes, including but not limited to patient registration, electronic data entry and transfer, medication administration, medical and surgical interventions, blood transfusions, diagnostic testing, patient monitoring, and emergency care.
- Patient identification mistakes can occur in every healthcare setting, from hospitals and nursing homes to physician offices and pharmacies.
- No one on the patient’s healthcare team is immune from making a wrong-patient error.
- Many patient identification errors affect at least two people.

For example, when a patient receives a medication intended for another patient, both patients—the one who received the wrong medication and the one whose medication was omitted—can be harmed.

ECRI Institute PSO reviewed more than 7,600 wrong-patient events occurring over a 32-month period that were submitted by 181 healthcare organizations. The events are voluntarily submitted and may represent only a small percentage of all wrong-patient events occurring at the organizations.

Given that correct patient identification is fundamental to safe care, the Joint Commission has made accurate patient identification one of its National Patient Safety Goals since 2003 when the first set of goals went into effect. The Joint Commission is not alone in advocating for safe practices to ensure correct patient identification. The National Quality Forum lists wrong-patient mistakes as serious reportable events and also considers patient identification as a high-priority area for measuring health information technology (IT) safety.

Mainstream media has also called attention to the issue. Despite the attention given to correct patient identification, mistakes continue to occur. ECRI Institute PSO’s new report highlights solutions that have worked for other healthcare organizations.

The ECRI Institute PSO Deep Dive: Patient Identification executive summary is available for free download at www.ecri.org/patientid. The full report and companion evidence review are available to all ECRI Institute PSO and partner PSO members and for purchase by non-members. Hospitals can also participate in a confidential INsight™ Assessment on patient identification to help them assess opportunities to reduce errors and improve patient safety. Additional research will be shared with the public by the Partnership for Health IT Patient Safety in early 2017.

For questions about this topic, or for information about purchasing the report, please contact ECRI Institute PSO by telephone at 610.825.6000, ext. 5558; by e-mail at pso@ecri.org; or by mail at 5200 Butler Pike, Plymouth Meeting, PA 19462-1298, USA.
Physicians and non-physician practitioners must use the revised CMS-855R (Reassignment of Benefits) application beginning January 1, 2017. Medicare Administrative Contractors will accept both the current and revised versions of the CMS-855R through December 31, 2016. The revised form makes the primary practice location section optional. However, this information is shared with other programs, such as the Physician Compare Initiative, to help beneficiaries identify your practice.

Visit the Medicare Provider-Supplier Enrollment webpage for more information about Medicare enrollment.

CMS FINALIZES QUALITY PAYMENT PROGRAM

On October 19, The Centers for Medicare & Medicaid Services (CMS) released a final rule with comment period implementing the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) incentive payment provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), collectively referred to as the Quality Payment Program (QPP) that affects over 600,000 clinicians providing Medicare Part B services. CMS also launched a new QPP website to explain the program and help clinicians identify the measures most meaningful to their practice or specialty.
2016 Rural Hospital + Rural Health Clinic Workshop

Friday, November 18, 2016
Lake Terrace Convention Center
Hattiesburg

8:00 a.m. - 12:00 p.m.

Instructor
Patty Harper, RHIA, CHTS-IM,
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Topics
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Cost is $100 for members and $125 for non-members.

Mississippi Rural Health Day Reception
12:00 p.m. - 1:00 p.m.

In celebration of Mississippi Rural Health Day, the Association will host reception to honor Governor Bryant and the clinics and hospitals in Mississippi that have shown exceptional quality.

There is no cost to attend the reception.
Business to business casual attire.