Mississippi Governor's Rural Health Task Force

Report delivered to Governor Phil Bryant on September 30, 2019

About

The Mississippi Governor's Rural Health Task Force was formed via executive order in May, 2019 by Governor Phil Bryant in order to bring together industry experts to research, discuss, and suggest needed policy and guidelines for improving Mississippi's rural health.

The task force is focused on three principal areas:

- Sustain and Evaluate the state's current healthcare infrastructure,
- Growing access to quality healthcare services, and
- Transforming current healthcare practices into those that provide more efficient care with patient outcomes in-mind.

Governor's Rural Health Task Force Members

Chairman
Ryan Kelly, Executive Director, Mississippi Rural Health Association

Secretary
Ed Tucker, CPA, CMC, G. Edward Tucker, CPA

Toby A. Butler, Managing Partner, Trilogy Healthcare Solutions

Shannon Coker, Executive Director, Mississippi Dental Association

Kevin S. Cook, CEO, UMMC Health System

Thomas E. Dobbs, III, MD, MPH, State Health Officer, Mississippi Department of Health

Larkin Kennedy, President and CEO, Rush Health Systems

Diana Mikula, Executive Director, Mississippi Department of Mental Health

Tim Moore, President and CEO, Mississippi Hospital Association

Sam Pace, MD Retired Partner/President, Digestive Health Specialists, PA

Joanie Perkins, Chief Compliance Officer, Sunflower Management Group

Courtney Phillips, CEO, South Sunflower County Hospital

Janice Sherman, CEO, Community Health Center Association of Mississippi

Drew Snyder, Executive Director, Mississippi Division of Medicaid

Rachel Chandler Sprinkle, Director, State Office of Rural Health, Mississippi Department of Health

As a result of numerous meetings and in-depth research from the task force, recommendations have been offered to improve Mississippi's rural health landscape. This report describes the problem, the solution, and the measure by which Mississippi can track improvement in each respective area of focus.

After initial discussions, it was decided that the task force should focus its efforts under the parameters of sustaining and evaluating the current healthcare infrastructure, growing access, and transforming current healthcare practices into those of the future. These areas were intended to determine the root causes of Mississippi's rural health issues and provide solutions specific to addressing those solutions. It did not discuss other select considerations, including utilization of specific use taxes and Medicaid reform, among other items, outside of this scope. It should also be noted that this report is the culmination of discussion, research, and majority consensus of the task force. It does not, however, necessarily represent the opinions or viewpoints of every individual member of the task force.

As Mississippi works to grow great access to quality healthcare services and transform into practices of the future, it must first work to sustain and evaluate its current infrastructure. Once Mississippi is able to sustain its current infrastructure, it may then more successfully pivot to new models of care.

The Mississippi Governor's Rural Health Task Force is pleased to present this report for consideration of direction, focus, policy, and legislation to solve Mississippi's rural health challenges and to serve as a solution roadmap for years to come.

Executive Summary

The Governor's Rural Health Task Force was able to discuss the challenges and opportunities available to improve Mississippi's rural health. As the task force focused on the three prescribed focus areas (sustain and evaluate current infrastructure, growing access, and transforming practices), it was understood that some items would transcend all three areas. In addition, it was understood and agreed upon that select strategies would be focused on short-term goals while others would allow facilities to pivot to long-term strategies for meeting future healthcare needs.

The task force understands and recognizes that there is no "one size fits all" solution for all challenges that providers and communities face, but those discussed and recommended will help to solve most issues and allow for development of community-centric solutions.

Sustain and evaluate the state's current healthcare infrastructure
As Mississippi works to grow great access to quality healthcare services and transform into practices of the future, it must first work to sustain its current infrastructure. Once Mississippi is able to sustain its current infrastructure, it may then more successfully pivot to new models of care.

Growing access to quality healthcare services
Access to quality healthcare is essential for quality health outcomes and health equity in Mississippi. Rural health faces a vast shortage of providers and access to specialty services, which negatively affects existing facilities and patients. With an increase in access points to quality healthcare, including primary care, oral and mental/behavioral health, and emergency care, Mississippian's can receive both the treatment and preventive services needed to produce a healthier population. And, as a result, Mississippi will enjoy improved families, a healthier workforce, and less cost in preventive treatment.

Transforming current healthcare practices
As Mississippi works to sustain its current healthcare infrastructure and provide additional access to care, the state must also transform its current rural health infrastructure and practices into those of the future - practices that provide more efficient care with patient outcomes in mind. Future models consist largely of value-based care that delivers higher quality services for patients while leveraging technology and efficiency models to reallocate resources and reduce cost. These new models are more stable, meet the needs of their communities, and provide greater collaboration among multiple healthcare systems. Mississippi must begin to pivot to these new models of support and care in order to meet the needs of our state's future health.

Policy and Strategy Recommendations
The following represents recommendations for strategies, policies and/or legislation that will help to resolve Mississippi's rural health needs:

Keeping Patients Local
It is recommended that retaining patients in the local setting become a central strategy for improving rural healthcare in Mississippi. All hospitals and clinics must make the evaluation and treatment of patients in the local setting a priority, and they must only transport patients to tertiary care centers if higher levels of treatment are needed. Further, both hospitals and clinics must work to identify and create services needed by patients that may be missing from the community but could be reasonably added.

Reduce Cost Through Tele-Emergency Services
It is recommended that rural hospitals strongly consider tele-emergency services as a supporting component for operational integrity and cost efficiency in the emergency department.

Transition Emergency Departments to Capacity-Based Reimbursement
It is recommended that the Mississippi legislature investigate and discuss a mechanism by which the state may adjust current funding or supply funding specifically to support the sustainability of hospital emergency departments for the fixed costs of operations.

Convert MHAP to a Low Income Pool Waiver
It is recommended that the Mississippi Division of Medicaid pursue a CMS 1115 waiver to establish a low income pool waiver for the State of Mississippi, pursuant that the state can establish the required budget neutrality of the waiver.

Reimbursement Challenges from Medicaid Managed Care
It is recommended that the Mississippi Division of Medicaid change its CCO agreements to align with Mississippi law and stringently enforce timely payment contract requirements.

It is recommended that the Mississippi Division of Medicaid establish a collaborative work group with the Division, the CCOs, the Healthcare Financial Management Association, the Mississippi Health Information Management Association and others as deemed necessary to monitor and reconcile claim payment errors reported by providers and pursue process corrections. The Division of Medicaid should delegate to the work group authority to recommend to the Division contractual penalties against the CCOs as appropriate.

Relaxing Medicaid Rural Health Clinic Comingling Regulations
It is recommended that the Mississippi Division of Medicaid should investigate comingling regulations and seek to follow Medicare guidelines.

Hospital and Clinic Staffing Concerns
It is recommended that significant work take place to train or re-train staff in rural clinics and hospitals to meet the needs of those facilities. This should involve outside continuing education and direct consulting, educational institutions revising curriculum to meet modern "real world" demands, and a substantial emphasis on retaining an educated workforce in rural communities.

Increasing the Number of Physicians in Rural Communities
It is recommended that the Mississippi legislature continue to support Mississippi Rural Physician and Dental Scholarship programs as well as increase the scholarship amount for the MRPSP. This increased amount will help to makeup the shortfall created through increased tuition at UMMC and WCUCOM and prevent student from going into debt as a result of their pursuit of going into rural practice.

It is recommended that the Mississippi legislature continue to support the Mississippi Office of Physician Workforce as well as support a growth of additional rural residencies in Mississippi.

Increase Incentives for Training and Hiring Paramedics
It is recommended that Mississippi's community colleges continue to produce quality paramedics to fill the pipeline for employment, and that ambulance providers seek to find funding to increase the salary of paramedics in order to establish a more competitive field of work.

Statewide Single Source Credentialing
It is recommended that the Mississippi Department of Insurance create a single, statewide credentialing application meeting NCQA standards that must be utilized by all insurance companies licensed in the State of Mississippi. Such may be a single platform for data input by providers that will transmit NCQA – approved fields directly to insurers for verification and approval.

Retaining Dentists in Rural Areas
It is recommended that full funding and support of the Mississippi Rural Dental Scholarship Program is retained and made (formerly referenced in this document).

Supporting the Donated Dental Services Program
It is recommended that a source of funding for the Donated Dental Services Program is determined in order to continue the coordination of volunteer dental services in rural Mississippi. As a result, coordination of volunteer dental services should be prioritized for rural Mississippi counties.

Leverage Tele-Dentistry Services for Greater Oral Health Outreach
It is recommended that existing facilities are utilized to their maximum capacity in connection with a potential tele-dentistry programs to ensure that rural areas are addressed in regards to dentistry, and that consideration be made by the Mississippi

State Board of Dental Examiners to utilize tele-dentistry statewide for growing access to preventive treatment and screenings for oral health needs.

Increased Medicaid Funding for Dental Services
It is recommended that the Mississippi Division of Medicaid consider increased reimbursement for vital oral health services in rural areas.

Leverage Tele-Pharmacy Services for Increased After-Hours Pharmacy Access
It is recommended that existing facilities are utilized to their maximum capacity in connection with a potential tele-pharmacy services, as that the Mississippi Board of Pharmacy consider a revision to policies and rules that will allow tele-pharmacy to provide backup coverage to existing pharmacies wishing to provide after-hours coverage for patients.

Strengthen Rural Integration of the Mobile Crisis Response Teams
It is recommended that a formal connection is made by the Mississippi Department of Mental Health and peer healthcare associations to strengthen the partnership between the mobile crisis response teams and rural facilities.

Growing Access to Psychiatry Through Tele-psychiatry Services
It is recommended that a significant growth in tele-psychiatry services take place, with an emphasis that rural health facilities, including clinics, hospitals, and county health departments, should consider adoption and implementation of such services.

Intensive Community Outreach and Recovery Team (ICORT)
It is recommended that a continued support and growth of the ICORT program take place through the Mississippi Department of Mental Health for adults with severe and persistent mental illness.

School-Based Telehealth
It is recommended that needed rules and regulations are altered to allow the Mississippi Division of Medicaid to provide reimbursement for telehealth services in the school-based setting.

Creating Stable Funding for EMS Transport
It is recommended that a statewide system be developed to better organize Mississippi's ambulance systems. This may take place with multiple companies offering services, but the means by which these services are paid must become more efficient and consistent.

It is recommended that a study be conducted to analyze whether a set property tax allocation on the county level could fully subsidize both EMS truck and helicopter coverage statewide, resulting in no out of pocket cost for patients while providing substantially better ambulance coverage in rural Mississippi.

It is recommended that the State of Mississippi should consider leveraging the EMS services line in the state trauma fund as a Medicaid match.

Providing Additional Health Coverage with Ambulance-Based Telehealth
It is recommended that EMS providers begin to equip ambulances with telemedicine services and train paramedics with the skills needed to use such services in order to create more efficient and effective emergency treatment for improving patient outcomes.

Non-Emergency Medical Transport
It is recommended that a focus on non-emergency transport services for all conditions not requiring access to emergency transport services, including those affecting social determinants of health.

It is recommended that alternative sources of funding should be explored (i.e. USDA funds) for growing and sustaining non-emergency medical transportation systems.

Appropriate Utilization of Services
It is recommended that Mississippi healthcare entities, providers, and peer organizations continue to educate the public on the appropriate use and access of emergency transport services, non-emergency transport services, hospital emergency departments, preventive services, and other available services in the community.

Mississippi Rural Hospital Transition and Improvement Grant Program
It is recommended that the Mississippi legislature create a funding pool in the form of the Mississippi Rural Hospital Transition and Improvement Grant Program under the direction and administration of the Mississippi State Department of Health. This fund may include a combination of federal, state, and local matching funds. Coupled with long-term debt financing, these funds could transform struggling, outdated rural hospitals into facilities that better serve their communities. Funding of this program should be substantial, allowing hospitals to apply for funding to resolve major one-time infrastructure improvements or financial reorganization.

Develop Hospital 'Centers of Innovation' Across Mississippi
It is recommended that hospitals transition from delivering moderate-level care among all available services to coordinating with neighboring facilities for development of "Centers of Innovation" in a regional format for greater efficiency and quality of care. Such coordination should be supported by the Mississippi State Department of Health, the Mississippi Division of Medicaid, and peer healthcare associations.

Leverage the Strength of Accountable Care Organizations (ACOs) and Clinical Integrated Networks (CINs)
It is recommended that rural facilities strongly consider inclusion in the statewide ACOs, and that funds such as the state FLEX grant continue to be utilized to help fund ACO infrastructure needs.

Have the Mississippi Division of Medicaid and Private Insurers Investigate Incentives for Participation in Patient Centered Medical Homes

It is recommended that rural facilities move to adopt PCMH certification. In return, it is recommended that the Mississippi Division of Medicaid and private insurers seek to investigate the impact of providing funding incentives to facilities for adopting certified PCMH status.

Consider Financial Stabilization with Global Budgeting

It is recommended that a formal committee be established by the Mississippi Legislature or Governor's Office to specifically investigate the Global Budgeting model, analyzing its effect on Mississippi hospitals and clinics. This committee should consist of representative from all public and private insurance providers in the State of Mississippi, as well as representatives from the healthcare industry.

Encourage Healthcare Data Mining and Risk Stratification

It is recommended that a committee be established to specifically investigate the creation of a universal risk stratification tool to be used on an annual basis by all Mississippi health insurance companies in order to allow providers to improve directed scores as dictated by the stratification tool.

The task force concludes that with the aforementioned policy changes in Mississippi, it will create a more stable healthcare system with a focus on improving facilities infrastructure, care structure, and efficiency. Mississippi will move faster toward a value-based system that rewards positive outcomes and reduces cost by leveraging technology and data.

It is the anticipation of the task force that by following these policy recommendations, Mississippi will increase in national healthcare rankings as a state improving patient outcomes and the economic success of its healthcare system. By measuring success with designated benchmarks, Mississippi will be able to ensure that positive action is being taken, and it will allow the state to modify this plan as environmental or regulatory situations change in the coming years.

Background

Mississippi has an estimated 2019 population of 2,968,118, according to the U.S Census Bureau. Of this, an estimated 1,595,263 are living in rural areas. Mississippi has 64 rural hospitals, 183 federally qualified health centers, 181 rural health clinics, and 90 local health departments. Rural Mississippians have a 65% insurance rate, compared to urban Mississippians at 67%. This compares to the national average of 91.2%. (rates as of 2017)

Mississippi's rural hospitals are struggling financially. There have been five Mississippi hospital closures since 2010. An additional four Mississippi rural hospitals declared bankruptcy in 2018. This trend signals a decline in access to health care services for rural Mississippians.

The Mississippi State Department of Health, Office of Rural Health and Primary Care houses the State Rural Health Plan. In this plan, it identifies the state's health care priority areas include disease prevention, health promotion, health protection, healthcare for specific population groups (i.e.,mothers, babies, the elderly, indigent, uninsured, the disabled, persons with developmental conditions, and minorities), availability of adequate health workforce throughout the state, health disparities, mental health needs, and enhanced capability to respond to public health emergencies.

These priority areas correspond with the recently established state health improvement plan known as UpRoot, which established the priority areas of increased educational attainment, creating a culture of health, reducing rates of chronic disease, and improving infant health.

Mississippi defines a rural area as: 1) a Mississippi county that has a population less than 50,000 individuals; 2) an area that is less than 500 individuals per square mile; or 3) a municipality of less than 15,000 individuals. *SOURCE: Miss. Code Ann. § 41-3-15*

A recent study published by Navigant stated that 48%, or 31 of Mississippi's 64 rural hospitals, are at "high financial risk," meaning they have a combination of poor profits, high debt and low cash reserves. In rural Mississippi communities, hospitals tend to serve as the hub and the central point around which health care services are provided. Other essential aspects to care include federally qualified health centers, rural health clinics, mental and behavioral health centers, dental practices, pharmacies, and other clinical structures that serve rural patients.

Impact of Rural Hospital Closures

As rural hospitals form the backbone of a communities access to care, the impact of rural hospital closures are particularly devastating to a community as well as the infrastructure surrounding the hospital. The following details the impact of an unplanned hospital closure:

1. Reduced access to health care, most critically the reduction in access to life saving emergency services. Losing rural emergency services is exacerbated by the distance from rural communities to larger facilities in more populated communities.

2. Loss of jobs. Rural hospitals are often the largest or one of the largest rural community employers.

3. Reduced viability of the employment base, as each hospital closure produces decreased per capital income by four percent (4%), and increased unemployment by 1.6% in communities already struggling economically. This includes both direct hospital-related jobs, and other jobs related to businesses affected by the loss of those direct hospital jobs and related business decline.

Factors Causing Financial Stress, Ultimate Bankruptcy and/or Closure of Rural Health Facilities

The task force has identified multiple "root causes" of financial stress on rural health facilities, including:

1. Declining rural populations. There are fewer jobs in rural communities today versus what the communities enjoyed decades ago. This has led to young citizens leaving rural communities for urban areas resulting in a disproportionately older and unhealthy population.

2. Health care out-migration, resulting from a limited access to specialties, a perceived higher quality of care in urban areas, and a difficulty in recruiting health care professionals in rural communities.

3. Regulatory burden. There is an ever-increasing number of requirements from regulatory agencies and insurers, which adds substantial non-patient-centric cost in a system where resources are already scarce.

4. Rising emergency department cost and declining utilization. There are fixed costs associated with operating an emergency department with 24/7/365 coverage. With these costs set, reimbursement for services is no longer adequate, especially when considering the efforts to decrease ER utilization.

5. Unintended consequences of population health and Accountable Care Organization payment models on small hospitals. Value-based payment models are conceptually good, making the most sense in urban areas, where capacity restraints exists and emergency departments are often over-utilized. But as stated above, moving patients from a rural hospital ER to a primary care setting can cause under-use of ER capacity that the community still needs, thus actually duplicating costs of care in many cases and jeopardizing small hospitals' ability to sustain critical services

6. Reimbursement decline. Medicare payments for physicians have not increased in 10 years, despite practice cost increases. Further, Medicare "sequestration" withholds 2% of payments, which results in critical access hospitals that are cost-based reimbursed at 101% of care to now only receive 99% of "allowable" cost for Medicare patients. This payment method creates a self-liquidating business model. This, coupled with reimbursement penalties and stricter insurer contracts, results in significant revenue decline.

7. Revenue Cycle complexity and challenges. The shift to managed Medicare and Medicaid have placed often significant challenges for timely reimbursement. This, in addition to the aforementioned complex and ever-changing payer requirements, makes it more difficult to adjudicate claims and receive timely payment.

8. Disproportionate aged and low-income populations. These high-risk populations tend to have negative health conditions and often have multiple chronic conditions.

9. Limited access to capital to maintain and update aging facilities and equipment and maintain regulatory requirements. The number of regulatory requirements placed on rural facilities has increased substantially, including electronic medical records, HIPAA, data and security, and many more. With declining revenues and increased costs, hospitals have little to no margin to invest back in the facility for capital improvements, technology upgrades, increased salaries to hire industry-trained staff, training for existing staff, and a variety of other issues necessary to complete its mission.

10. Advances in care delivery. Healthcare has seen significant advances in technology and care delivery, but such has created surgical trends from inpatient to outpatient, and payers are now driving surgical patient discharges straight to home care, bypassing swing bed services and other hospital-based services that were traditionally revenue-generators for rural facilities.

11. Provider scarcity and decline in traditional physician practice. Primary care physicians have begun to shift to a clinic-only practice model, with no inpatient practice requirements. This lack of available hospitalists has created significant coverage issues for small rural hospitals. This trend means that rural communities must compete for primary care recruits with urban practices where hospitals provide full-time inpatient hospitalist coverage. Small rural hospitals simply cannot afford full-time hospitalist coverage. In addition, most rural hospitals and clinics rely on very small medical staffs. This means that the loss of even one provider creates a drastic reduction in access to care for rural patients.

12. Lack of paying patients. As Mississippi has an insured rate well below the national average, a large number or rural patients do not have insurance to pay for costly care. This results in a large burden of uncompensated care among hospitals and clinics that often must be absorbed as "charity care" by the facility. Most rural facilities already operate on very thin margins without the ability to absorb non-pay patients.

Sustain and evaluate the state's current healthcare infrastructure

As Mississippi works to grow great access to quality healthcare services and transform into practices of the future, it must first work to sustain its current infrastructure to ensure that no further losses occur. Once Mississippi is able to sustain its current infrastructure, it may then more successfully pivot to new models of care.

The following are topics of consideration and recommendation on behalf of the task force for ensuring the Sustain and Evaluate of Mississippi's current healthcare infrastructure.

Keeping Patients Local

Healthcare "out-migration" is a significant issue in rural Mississippi today. Mississippi's clinics and hospitals must address this out-migration and work to keep patients local if care can be delivered in the local setting.

Rural clinics face challenged with keeping patients local largely due to specialty services available in urban areas. With only a limited spectrum of services available in rural clinics, patients often drive longer distances to receive care where these specialty services "may" be needed. Strategies for extending specialty care into rural areas via telehealth and traveling specialists must take place to keep outpatient services local, and therefore keep patients local.

Hospitals face a similar issue with local patients. Often, patients that voluntarily transport themselves to a hospital will opt for a larger, urban center rather than a local facility. This is due in part to the lack of specialists in the rural facility, but often it is due simply to a flawed perception of the quality of care delivered in a rural facility.

In addition, rural hospitals that triage patients are often reluctant to treat patients in the local setting due to uncertainty of the ability to treat, and this results in a patient being transported unnecessarily to tertiary facilities. This problem not only creates a backlog of patients at the urban centers, but it substantially reduces the inpatient revenue opportunities at the local facility and increases utilization of an under resourced and over-used emergency transport system.

A recent study from the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services (HHS) shows that rural hospitals outperform their urban counterparts on Medicare's value-based purchasing program and in reducing hospital-acquired infection. Keeping patients

local not only improves the direct bottom line of hospitals, but it also allows them to leverage programs such as 340(b) to capture additional revenue that can offset uncompensated drug costs and needed services.

New and advanced systems of delivering care such as the tele-hospitalist program and tele-emergency program allow local providers to have consultation services and back-up services on-demand, giving them confidence in their decisions to treat locally or transport to tertiary care settings.

Hospitals and clinics must focus on both increasing admissions from their local patient population as well as retaining patients in the local facility where care can be delivered.

By keeping patients local, hospitals and clinics increase revenue, decrease the burden on emergency transportation, and increase the overall health and outcomes of the patient.

It is recommended that retaining patients in the local setting become a central strategy for improving rural healthcare in Mississippi. All hospitals and clinics must make the evaluation and treatment of patients in the local setting a priority, and they must only transport patients to tertiary care centers if higher levels of treatment are needed. Further, both hospitals and clinics must work to identify and create services needed by patients that may be missing from the community but could be reasonably added.

Emergency Department Utilization and Financial Support

Most hospitals have significant losses in their emergency departments (ERs / EDs) due to the high cost of services. Rural hospitals have some of the worst losses due primarily high fixed cost of being available 24/7/365 and low numbers of patients utilizing ER services due to small population size, limited available service for serious problems, and efforts to treat patients outside of emergency settings. These constraints are placing a significant burden on hospitals by which they are operating emergency departments by supplementing losses from other revenue-generating services.

<u>Reduce Cost Through Tele-Emergency Services</u>
Tele-emergency programs with nurse practitioners substituted for physician coverage have been found to significantly reduce the average ER cost in low acuity settings but provide an acceptable level care. This model utilizes nurse practitioners trained under emergency room physicians, and leverages telehealth connectivity to connect the nurse practitioner to their emergency room physicians when an emergency is presented. The patient is treated, stabilized, and transported to a facility of higher tertiary care if needed.

A challenge with the tele-emergency model is workforce training. It is also difficult to obtain aggregated ER cost data. Such data would be helpful to benchmark cost savings.

It is recommended that rural hospitals strongly consider tele-emergency services as a supporting component for operational integrity and cost efficiency in the emergency department.

Transition Emergency Departments to Capacity-Based Reimbursement

Most Mississippi patients utilize the emergency department of a hospital because of a catastrophic injury or emergency condition that results in emergency transportation. Emergency rooms must be prepared 24/7/365 to handle emergency patients with a built-in "surge capacity" for unexpected conditions that require more beds and more care than ordinarily needed.

This capacity comes at a cost. Although it is understood that deferring patients from the ER is preferred, the fact remains that facilities must cover the fixed cost of staffing an ER in preparation or anticipation of a need.

In order to properly cover the cost of such access, a solution is needed to allow hospitals to receive cost-based payments that are, at minimum, equivalent to the cost of minimum staffing and service delivery. There are several mechanisms by which Mississippi may accomplish this goal.

It is recommended that the Mississippi legislature investigate and discuss a mechanism by which the state may adjust current funding or supply funding specifically to support the sustainability of hospital emergency departments.

Convert MHAP to a Low Income Pool Waiver

Nine US states currently have Medicaid-funded uncompensated care pools. These pools, which are time limited, are created through Medicaid Section 1115 demonstration waivers. Funds in these pools go directly to health care providers. These pools were created to help hospitals with funding shortfalls. Three factors produce these shortfalls:

- Hospitals covering the cost of care when uninsured people seek care at emergency rooms
- Hospitals providing charity care
- Hospitals absorbing "bad debt" from unpaid medical bills

It is recommended that the Mississippi Division of Medicaid pursue a CMS 1115 waiver to establish a low income pool waiver for the State of Mississippi, pursuant that the state can establish the required budget neutrality of the waiver.

Reimbursement Challenges from Medicaid Managed Care

The Mississippi Division of Medicaid has currently contracted with three Coordinated Care Organizations or "CCOs" providing managed care for the Medicaid population. These include United Healthcare, Magnolia Health, and Molina. Providers have reported that CCOs have frequently delayed payments or provided incorrect payments for services rendered. Although the Division of Medicaid currently has underway internal investigations to identify and correct the problems, the amount of money denied or incorrectly paid to providers is reported to be substantial. This has led to a strain in the healthcare system.

Currently, Medicaid agreements with the CCOs allows for payment of claims within 30 days of "clean" claim filing (those with all necessary information present on submission). However, most claims are sent electronically and State insurance law requires that insurers pay electronic clean claims within 25 days.

It is recommended that the Mississippi Division of Medicaid change its CCO agreements to align with Mississippi law and stringently enforce timely payment contract requirements.

It is recommended that the Mississippi Division of Medicaid establish a collaborative work group with the Division, the CCOs, the Healthcare Financial Management Association, the Mississippi Health Information Management Association and others as deemed necessary to monitor and reconcile claim payment errors reported by providers and pursue process corrections. The Division of Medicaid should delegate to the work group authority to recommend to the Division contractual penalties against the CCOs as appropriate.

Relaxing Medicaid Rural Health Clinic Comingling Regulations

Currently, Medicare allows exceptions to CMS comingling rules for specialists to rent space from existing rural health clinics to provide additional levels of care. However, the Mississippi Division of Medicaid does not currently allow comingling, therefore limiting the ability of specialists to provide care in outpatient, clinical settings in rural Mississippi. Changing these rules will not adversely affect quality of care or add additional cost to the healthcare system. In fact, relaxing comingling regulations is estimated to slightly reduce the overall cost of care by creating facility space efficiencies.

It is recommended that the Mississippi Division of Medicaid investigate its comingling regulations and seek to follow Medicare guidelines.

Workforce Challenges in Rural Health Settings

Hospital and Clinic Staffing Concerns

Workforce shortages are more likely to exist in rural areas. This shortage of providers, administration and staff has often led to issues with hospital and clinic operations.

Rural hospitals suffer from lack of "economies of scale," meaning that all or nearly all services require a certain "minimum staffing" level to offer even a low volume of services. Further, hospital management is complex and trained hospital management manpower in rural areas is difficult to find.

Rural facilities are held to the same quality and efficiency standard as urban facilities, so they must begin to manage themselves more effectively. Rural facilities must have the financial and workforce resources needed to operate facilities and treat patients in the most effective manner possible.

It is recommended that significant work take place to train or re-train staff in rural clinics and hospitals to meet the needs of those facilities. This should involve outside continuing education and direct consulting, educational institutions revising curriculum to meet modern "real world" demands, and a substantial emphasis on retaining an educated workforce in rural communities.

Increasing the Number of Physicians in Rural Communities

Training Rural Physicians and Dentists / Mississippi Rural Physician and Dental Scholarship Program

In 2007, the Mississippi Legislature authorized the Mississippi Rural Physicians Scholarship Program (MRPSP), creating a unique longitudinal program that identifies rural college students who aspire to return to their roots to practice medicine. In this program, academic enrichment, faculty and physician mentoring and solid medical school financial support enable capable young Mississippians to address the challenge of Mississippi's health care crisis. In 2013, the Mississippi legislature authorized the Mississippi Rural Dentists Scholarship Program (MRDSP) as well to meet the challenge of providing more general and pediatric dentists in rural communities in Mississippi.

Many current Mississippi primary care physicians are reaching retirement age, and it appears that even with the expanding class sizes at the University of Mississippi Medical Center's School of Medicine (UMMC) and William Carey University's School of Osteopathic Medicine (WCUCOM), it may not be enough to meet demand for anticipated physician losses due to retirement and attrition. In addition, most graduates from these programs opt for urban suburban settings rather than rural settings for their practices.

We must not only produce more physicians, we must produce physicians who are choosing primary care, which is the front line of medicine for our state and where we rank last in the nation for patient to physician ratio.

A continued focus on training physicians and dentists from rural areas is needed to provide a better opportunity for those providers to return to their rural communities to practice. Currently, the program includes 41 practicing physicians in rural areas of Mississippi along with 60 physicians in residency training, 64 medical students on scholarship at UMMC and WCUCOM, and 49 undergraduate students. In just the next few years, the program will have more than 60 new primary care physicians for rural Mississippi. The dental program includes 9 practicing dentists along with 9 dental students on scholarship and 19 undergraduates.

It is recommended that the Mississippi legislature continue to support Mississippi Rural Physician and Dental Scholarship programs as well as increase the scholarship amount for the MRPSP. This increased amount will help to makeup the shortfall created through increased tuition at UMMC and WCUCOM and prevent student from going into debt as a result of their pursuit of going into rural practice.

Rural Residencies / Mississippi Office of Physician Workforce

Created by state legislators in 2012, the Office of Mississippi Physician Workforce (OMPW) is working to reduce the shortage of primary care doctors. The office oversees the state's physician workforce development needs by nurturing the creation of family medicine residency programs, fostering the development of a physician workforce in all specialties where they are needed, evaluating the existing workforce, and establishing the state's current and future workforce requirements.

To reach the national average, Mississippi will have to add more than 1,300 primary care physicians, whose specialties include family medicine, internal medicine, pediatrics and obstetrics/gynecology. Mississippi currently has just 64.4 active primary care physicians per 100,000 population, with a U.S. state median of 90.8.

Increasing the number of physician residencies around the state, coupled with the work of the MRPSP for graduating physicians from rural areas, will create significant impact in the ability to retain rural physicians. Physicians in their residency years will often "put down roots" in the communities where they completed that phase of their medical education. When a physician is invested in a community, there is much less desire to leave the community.

It is recommended that the Mississippi legislature continue to support the Mississippi Office of Physician Workforce as well as support a growth of additional rural residencies in Mississippi.

Increase Incentives for Training and Hiring Paramedics

Another major workforce challenge is in regard to the number of paramedics currently working in Mississippi's emergency response system. As of 2012, the MSDH Bureau of Emergency Medical Services reported a total of 1,906 EMT Basics certified in the state; 1,599 EMT Paramedics; and 24 EMT intermediates.

Currently, obtaining a degree as a paramedic requires a two-year degree, but the salary is generally lower than two-year degree-prepared peer professions such as a registered nurse, with much more difficult working conditions. This differential has caused a significant shortfall in the number of paramedics required to operate ambulances. This shortfall causes an increase in cost due to the need to provide overtime for the currently employed paramedics. This, in turn, leads to more frequent burnout from those currently in the profession, exacerbating an already depleted workforce.

It is recommended that Mississippi's community colleges continue to produce quality paramedics to fill the pipeline for employment, and that ambulance providers seek to find funding to increase the salary of paramedics in order to establish a more competitive field of work.

Statewide Single Source Credentialing

Currently, each Mississippi insurance company and their secondary / subsidiary payers have a unique process for credentialing and enrolling providers. Even within the Medicaid program, moving to three CCOs has had the unintended consequence of an increase in credentialing overhead for both providers and payers. Multiple credentialing processes and requirements have caused significant administrative burdens for facilities to credential and enroll providers. This has caused a significant barrier to entry for new providers into Mississippi.

Although it is recognized that each insurer should have the right to enroll or deny providers based on their own set of criteria, there should not be a system-wide duplication in credential verification of providers prior to enrollment. Delays in credentialing can be financially devastating to the provider and harmful to patients who need access to care.

It is recommended that the Mississippi Department of Insurance create a single, statewide credentialing application meeting NCQA standards that must be utilized by all insurance companies licensed in the State of Mississippi. Such may be a single platform for data input by providers that will transmit NCQA – approved fields directly to insurers for verification and approval.

Growing access to quality healthcare services

Access to quality healthcare is essential for quality health outcomes and health equity in Mississippi. Rural health faces a vast shortage of providers and access to specialty services, which negatively affects existing facilities and patients.

With an increase in access points to quality healthcare, including primary care, oral and mental/behavioral health, and emergency care, Mississippian's can receive both the treatment and preventative services needed to produce a healthier population. And, as a result, Mississippi will enjoy improved families, a healthier workforce, and less cost in preventative treatment.

The following are topics of consideration and recommendation on behalf of the task force for ensuring the growth of access to quality healthcare services:

Dental and Oral Health Coverage

Retaining dentists in rural areas

Mississippi currently has 835 general dental practices and 360 specialty dental practices. This is seen as an adequate number of dentists when compared to the state's population, but due to scale and market factors, these practices are heavily localized in urban areas and are not adequately distributed among rural populations. Significant work is needed to retain dentists in rural areas.

It is recommended that full funding and support of the Mississippi Rural Dental Scholarship Program is retained and made (formerly referenced in this document).

Supporting the Donated Dental Services Program

The Mississippi Donated Dental Services program is a coordinated volunteer dental service across the State of Mississippi. More than three million dollars worth of volunteer services are provided each year through this program in the most vulnerable communities in rural Mississippi.

However, funding for a state coordinator position was recently eliminated from the Mississippi Division of Medicaid budget, resulting in a dramatic reduction in the number of volunteer services offered in rural areas. Funding for this position is approximately $60,000 per year.

It is recommended that a source of funding for the Donated Dental Services Program to continue the coordination of volunteer dental services in rural Mississippi. As a

result, coordination of volunteer dental services should be prioritized for rural Mississippi counties.

Leverage Tele-Dentistry Services for Greater Oral Health Outreach

Tele-dentistry has been observed across the nation to provide dental outreach services in areas where a dentist is not physically located. Such could help to provide screenings for children in schools, detect oral health concerns and provide preventive treatments as needed.

Mississippi currently has barriers in place that prevent tele-dentistry from occurring, resulting in an unfilled gap in care in rural communities where a dentist is not physically located. It is important that the Board of Dental Licensure work to address potential in the program and to implement new rules as needed to increase access to care.

It is recommended that existing facilities are utilized to their maximum capacity in connection with a potential tele-dentistry programs to ensure that rural areas are addressed in regards to dentistry, and that consideration be made by the Mississippi State Board of Dental Examiners to utilize tele-dentistry statewide for growing access to preventive treatment and screenings for oral health needs.

Increased Medicaid Funding for Dental Services

The Mississippi Division of Medicaid is generous to support dental services for beneficiaries in Mississippi, as this is not a CMS required service for delivery of the state Medicaid program. Although a very helpful service for patients, the reimbursement levels for providers is often less than the cost of the services delivered. This has created an environment where a reduced number of dentists will enroll as a Medicaid oral health provider.

It is recommended that the Mississippi Division of Medicaid investigate increased reimbursement for vital oral health services in rural areas.

Services

Leverage Tele-Pharmacy Services for Increased After-Hours Pharmacy Access

Mississippi currently has 276 total pharmacy locations in Mississippi, providing access to prescription medication and supplies for patients. In addition to physical pharmacy locations, alternative services such as mail-order delivery has helped to provide needed medication to patients when transportation or access has been an issue.

Tele-pharmacy services are new services that would allow pharmacies to access a remote pharmacist during after hours times for continuing dispensing services. Such may be utilized by both commercial and family pharmacies, allowing them to provide services using a more efficient staffing model when needed. This will allow patients to access prescription medication outside of traditional office hours.

Mississippi currently has barriers in place that prevent tele-pharmacy from occurring, resulting in a barrier for pharmacies to receive backup services by using a telehealth component.

It is recommended that existing facilities are utilized to their maximum capacity in connection with a potential tele-pharmacy services, as that the Mississippi Board of Pharmacy consider a revision to policies and rules that will allow tele-pharmacy to provide backup coverage to existing pharmacies wishing to provide after-hours coverage for patients.

Behavioral / Mental Health Services

Strengthen Rural Integration of the Mobile Crisis Response Teams

The Mississippi Department of Mental Health has developed mobile crisis response teams, designed to help people who are experiencing a situation where the person's behavioral health needs the available resources to effectively handle the circumstances. Deployed in all 82 counties, these teams consist of mental health professionals who provide support to people experiencing a mental health, alcohol and drug, or intellectual and developmental disability crisis.

These teams have become proficient at handling mental and behavioral health crises in rural Mississippi. However, the understanding of their role in the hospital and clinic setting is still not well understood.

It is recommended that a formal connection is made by the Mississippi Department of Mental Health and peer healthcare associations to strengthen the partnership between the mobile crisis response teams and rural facilities.

Growing Access to Psychiatry Through Tele-psychiatry Services

Mississippi currently has 14 mental and behavioral health centers and 135 actively practicing psychiatrists, most of which work in urban areas. This critical shortage of available providers is a huge contributor toward the gap in access to mental and behavioral health care in rural Mississippi.

However, the growth of tele-psychiatry services offers a very efficient and effective way to grow services in areas that may not be able to support a full-time practice otherwise. Many patients have been known to report a preference to tele-psychiatry services over in-person psychiatry services due to the reduced stigma of receiving such services in a primary care setting.

It is recommended that a significant growth in tele-psychiatry services take place, with an emphasis that rural health facilities, including clinics, hospitals, and county health departments, should consider adoption and implementation of such services.

Intensive Community Outreach and Recovery Team (ICORT)

The Intensive Community Outreach and Recovery Team (ICORT) focuses on adults with severe and persistent mental illness and aligns a streamlined team around these patients that is more cost effective than the traditional Program on Assertive Community Treatment, which is more costly and involves more professionals. The ICORT program is more effective in rural settings by leveraging fewer providers and creating a more efficient care plan. There is currently a pilot of this program in Region 2.

It is recommended that a continued support and growth of the ICORT program take place through the Mississippi Department of Mental Health for handling adults with severe and persistent mental illness

School-Based Telehealth

One of the greatest opportunities that Mississippi has to improve access to care is through telehealth services. As already mentioned, telehealth services may extend providers into areas where access is not currently found. Such an opportunity is found at the school-based setting.

Currently, school-based clinics are not eligible through the Division of Medicaid to provide telehealth to students and receive reimbursement for said services due to site of service and presenting provider regulations.

Select rule and policy changes with the Mississippi Division of Medicaid state code will allow a huge increase in access to primary care services, which would allow students to stay in school, parents to stay at work, and provide quicker care which will help to alleviate the spread of illness in a dense population. Such would continue Mississippi's position as a national leader in telehealth delivery services.

It is recommended that needed rules and regulations are altered to allow the Mississippi Division of Medicaid to provide reimbursement for telehealth services in the school-based setting.

Emergency Medical Transportation (EMS)

One of the greatest challenges to Mississippi's rural health is receiving access to ambulance transportation. There is currently no statewide ambulance service or coordinated ambulance services, as each county manages its own ambulance contract without significant coordination with surrounding counties.

There are currently several very robust ambulance companies in Mississippi that serve extended networks in a multi-county range. This allows a greater coordination of resources to cover areas that have a high need. At the same time, some counties have very limited coverage with less sophisticated ambulance networks that are unable to leverage extended resources to fill needs as they arise, leaving rural patients waiting extended periods for life-saving emergency transportation to arrive.

<u>Creating Stable Funding for EMS Transport</u>

The cost of one ambulance, including personnel, is approximately $900,000 per year. Ambulance services are usually paid by commercial insurance, with a small amount reimbursed through Medicare, Medicaid, and with limited county support. As rural citizens have less commercial coverage than urban, this places a natural pressure on ambulance companies attempting to survive in rural Mississippi.

Sparse geographic populations in rural areas create longer ambulance runs, therefore increasing the cost of each run and tying up the ambulance teams for longer periods. The result is thinner coverage of multiple counties and the likelihood that patients will go extended time before an ambulance arrives. These delays can be the difference in life and death.

Paying for the fixed cost of standby coverage is essential to maintaining a successful emergency transport system.

It is recommended that a statewide system be developed to better organize Mississippi's ambulance systems. This may take place with multiple companies offering services, but the means by which these services are paid must become more efficient and consistent.

It is recommended that a study be conducted to analyze whether a set property tax allocation on the county level could fully subsidize both EMS truck and helicopter coverage statewide, resulting in no out of pocket cost for patients while providing substantially better ambulance coverage in rural Mississippi.

It is recommended that the State of Mississippi should consider leveraging the EMS services line in the state trauma fund as a Medicaid match.

Providing Additional Health Coverage with Ambulance-Based Telehealth

Services are emerging that provide specialty and emergency care for paramedics in ambulances to improve patient stabilization prior to arrival at emergency departments. As ambulances are equipped with greater technology, integrating telemedicine capabilities into the ambulance may help to improve patient outcomes and better allow emergency providers to treat the patient faster when arriving at the hospital.

It is recommended that EMS providers begin to equip ambulances with telemedicine services and train paramedics with the skills needed to use such services in order to create more efficient and effective emergency treatment for improving patient outcomes.

Non-Emergency Medical Transport

Non-emergency transportation is found in Mississippi's urban areas, and in limited capacity in rural areas. The limited scope of rural non-emergency transportation is not enough to fulfill the many needs for such services by rural patients.

Mississippi must place an emphasis on non-emergency transport options, where patients needing "wheelchair transport" can utilize a non-emergency van rather than a higher-cost ambulance. In addition, such services would help to provide transportation for those facing negative social determinants of health. Providing transportation where otherwise unavailable would help patients to access healthy foods, access wellness and preventative services, and be more empowered to control their own health outcomes. Services could include the use of local transport companies, additional services from EMS providers, or alternative options.

It is recommended that a focus on non-emergency transport services for all conditions not requiring access to emergency transport services, including those affecting social determinants of health.

It is recommended that alternative sources of funding should be explored (i.e. USDA funds) for growing and sustaining non-emergency medical transportation systems.

Appropriate Utilization of Services

Access to care does not just mean the availability of services, but also the utilization of appropriate services. Too often patients are utilizing higher cost services such as emergency departments when the primary care setting is far more suited for their individual needs. There must be a distinct focus on educating patients as to the most effective and available points of care for their individual needs. By providing

better education for patients, facilities will be able to reduce cost and provide higher levels of care.

It is recommended that Mississippi healthcare entities, providers, and peer organizations continue to educate the public on the appropriate use and access of emergency transport services, non-emergency transport services, hospital emergency departments, preventive services, and other available services in the community.

Transforming current healthcare practices

As Mississippi works to sustain its current healthcare infrastructure and provide additional access to care, the state must also transform its current rural health infrastructure and practices into those of the future - practices that provide more efficient care with patient outcomes in-mind.

Future models consist largely of value-based care that delivers higher quality services for patients while leveraging technology and efficiency models to reallocate resources and reduce cost. These new models are more stable, meet the needs of their communities, and provide greater collaboration among multiple healthcare systems.

Mississippi must begin to pivot to these new models of support and care in order to meet the needs of our state's future health.

Mississippi Rural Hospital Transition and Improvement Grant Program

Most of Mississippi's rural hospitals were constructed using Hill-Burton funding in the 1950's, and many of the facilities have received few visible updates since that time. As a result, the perception of our rural hospitals is that they deliver outdated, inferior care to their urban counterparts. Quality scores and patient outcomes show that this perception is not reality, and rural hospitals that have been able to rebuild or repurpose their facilities have demonstrated significant increases in census.

However, as most of Mississippi's rural hospitals are financially distressed, they do not have a margin available to leverage for significant facility improvements or restructuring. Additionally, rural hospitals must meet the same regularity requirements for the Promoting Interoperability Program as other hospitals, yet often do not need the additional technology functionality contained in required, expensive system upgrades, nor do they have the available infrastructure such as

adequate broadband to support. As a result, this often leads to a "piece meal" solution to a rural hospital's technology and electronic medical record, which affect productivity, revenue cycle integrity, access, and quality of care.

Mississippi's rural hospitals need a funding pool available to them for directed, specific construction and repurposing projects. Such may include rebuilding facilities, redesigning layouts for modern healthcare service delivery and greater efficiencies, or "right sizing" the facility for modern community needs. Such may include increasing or decreasing the size of a hospital, or in select cases, converting a struggling hospital to an after-hours clinic with specialty services.

It is important that an aspect of any funding take into account the hospitals' ability and directive to transform into a more value-based, cost efficient model that drives preventive services and opens new opportunities to access to care in a community. This would look different for each community as each would have unique needs and populations needing such services.

Any application for funding should take into account both greater sustainability of the facility as well as a focus on value-based care. In addition, any application should account for a 5-10 year master plan of the facility to detail implemented changes and the improvements that will occur as a result.

In 2017, Rep. Sam Mims and a bi-partisan delegation in the Mississippi House of Representatives supported a measure to create the Mississippi Rural Hospital Transition and Improvement Grant Program. This program would accomplish the goals set forth in this directive.

It is recommended that the Mississippi legislature create a funding pool in the form of the Mississippi Rural Hospital Transition and Improvement Grant Program under the direction and administration of the Mississippi State Department of Health, or the Mississippi Division of Medicaid as deemed appropriate. This fund may include a combination of federal, state, and local matching funds. Coupled with long-term debt financing, these funds could transform struggling, outdated rural hospitals into facilities that better serve their communities. Funding of this program should be substantial, allowing hospitals to apply for funding to resolve major one-time infrastructure improvements or financial reorganization.

Develop Hospital 'Centers of Innovation' Across Mississippi

As Mississippi's hospitals have a severe lack of resources, they must designate those resources toward programs that have the best opportunity for success and that meet the needs of the majority of the patients in the community. To this extent, rural hospitals should not knowingly duplicate services of a nearby facility when one of them could better supply those services to both communities.

Hospitals need to work with peer facilities (including non-hospital facilities) to develop "Centers of Innovation." This would allow facilities to focus on the in-patient and out-patient services most needed, and coordinate with surrounding facilities to transport patients to the services offered that best meet the needs of the patient. This coordination would work best in a formal organizational structure such as an ACO or CIN, but may also take place outside of such a structure through informal agreements.

By diverting valuable resources into the most revenue-generating, community-needed services, hospitals may increase capacity and bring a higher level of care to their patients. This will result in greater revenue, increased patient outcomes, and increased patient satisfaction.

It is recommended that hospitals transition from delivering moderate-level care among all available services to coordinating with neighboring facilities for development of "Centers of Innovation" in a regional format for greater efficiency and quality of care. Such coordination should be supported by the Mississippi State Department of Health, the Mississippi Division of Medicaid, and peer healthcare associations.

Leverage the Strength of Accountable Care Organizations (ACOs) and Clinical Integrated Networks (CINs)

Accountable Care Organizations and Clinical Integrated Networks have shown great success in rural states by organizing facilities and patients into manageable populations for facilities to use value-based outcomes as the driving indicator of success. This model receives most participation from hospitals and federally qualified health centers, but it is also utilized by rural health clinics and other entities.

In Mississippi, existing ACOs are only for Medicare patients. It is possible to extend ACOs to Medicaid and commercially insured patient populations to further efforts for quality care. Facilities are incentivized with shared savings bonuses, and insurers pay fewer dollars in care due to savings in the system. The downside to ACOs is the high burden of reporting and non-patient centric services and personnel, which require a large start-up investment and start-up business risk. ACOs are beginning to emerge through collaboration among rural areas.

Medicare has already established several ACO methodologies and it already shares patient data with ACOs to facilitate success. Commercial and self-insured employer ACOs are more difficult due to the following:

- The number of claims databases are scattered among multiple commercial payers and third-party administrators with disparate data elements and formats.
- There is no one ACO format for the commercial and self-insured employer market, so negotiation is more complex.
- Employed members use less health care than Medicare patients, so the ACO techniques that are successful for Medicare patients may or may not have benefits exceeding the ACO care management costs.

An additional benefit of the ACO and CIN is that networks may be able to leverage purchasing cost and contract negotiation for reduced pharmaceutical cost, improved insurer contracts, and other bundled services. In addition, these entities focus on the social determinants of health of their designated patient populations and encourage a focus on keeping patients healthy, which includes their living environment and lifestyle issues.

The Mississippi Hospital Association and the Community Healthcare Association of Mississippi recently started a statewide ACO network, which includes most rural hospitals, FQHCs respectively. Including more rural providers and patients under these networks can help to provide network data for patient outcomes and allow administrators and officials to 'drill down' to the core issues more effectively.

It is recommended that rural facilities strongly consider inclusion in the statewide ACOs, and that funds such as the state FLEX grant continue to be utilized to help fund ACO infrastructure needs.

Incentivize Participation in Patient Centered Medical Homes

The Patient-Centered Medical Home (PCMH) is a care delivery model whereby patient treatment is coordinated through the patient's primary care physician to ensure the patient receives the necessary care when and where it is needed, in a manner the patient can understand. The Patient Centered Medical Home is a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Several payers in other states have initiated increased reimbursement for services for facilities adopting the certified PCMH status (i.e. Alabama Medicaid). Such can be the same in Mississippi, where payers can reward quality care with enhanced payments for PCMH facility services.

It is recommended that rural facilities move to adopt PCMH certification. In return, it is recommended that the Mississippi Division of Medicaid and private insurers seek to investigate funding incentives to facilities adopting certified PCMH status.

Consider Financial Stabilization with Global Budgeting

CMS is exploring and piloting a new concept called the Global Budget. This concept is currently being piloted in Pennsylvania, Maryland, and Vermont.

The global budget is a three-year look-behind average of the insurer's "spend" at each facility, and averaged over the period as a payment per month. Adjustments are made on an annual basis for fluctuations in patient volume and expense.

The upside to the global budget model is that healthcare facilities enjoy a stable incoming stream that simplifies the revenue-cycle challenges, and they have a natural incentive to provide quality, low-cost care in order to save money and keep profits. From the insurer's perspective, they can better predict their payment schedule and shift the risk to the provider, better ensuring profitability. There should be little difference observed from the patient.

After limited investigation from the task force, it was undetermined as to whether Global Budgeting would be beneficial to Mississippi's healthcare system. It was seen to show promise, but there are several key issues that need to be further investigated to determine its long-term impact.

It is recommended that a formal committee be established by the Mississippi Legislature or Governor's Office to specifically investigate the Global Budgeting model, analyzing its effect on Mississippi hospitals and clinics. This committee should consist of representative from all public and private insurance providers in the State of Mississippi, as well as representatives from the healthcare industry.

Encourage Healthcare Data Mining and Risk Stratification

There is a need in Mississippi for substantially more system-wide data for tracking patient health outcomes, monitoring patient migration patterns between facilities, and providing directed prevention toward the highest risk patients. A systematic data mining coordinated effort is needed to allow all facilities to have the data and tools they need to decipher data into measurable performance measures and strategies for improvement both patient health and facility health.

In addition, the risk stratification factors enforced by each public and private insurer in Mississippi cause healthcare providers and facilities to be forced to monitor and report nearly hundreds of points of data. It becomes nearly impossible

for all but the largest healthcare systems to track and improve data scores when so many are enforced by insurance companies.

It is recommended that a committee be established to specifically investigate the creation of a universal risk stratification tool to be used on an annual basis by all Mississippi health insurance companies in order to allow providers to improve directed scores as dictated by the stratification tool.

It is further recommended that the Mississippi State Department of Health become the clearinghouse for obtaining and distributing healthcare data for hospitals and clinics in order to allow them to improve functionality and patient health improvement.

Tracking Progress

The task force feels strongly that Mississippi should track the progress of the aforementioned policy recommendations to ensure the success of this plan. Tracking should take place through the Mississippi State Department of Health and Mississippi Department of Mental Health for applicable categories. These agencies will not be tasked with leading these efforts, but rather tracking any data-driven progress as a result of the efforts in accordance with their individual data tracking efforts currently in place.

The following are recommended points of data with suggested levels of improvement.

Financial stability

Improve each Mississippi hospital's total operating margin above 1.4%
This is a Moody's Baa median/lowest investment grade, as tracked by several financial studies analyzing financial health.
Begin immediately, complete by December 2021

Improve every hospital and clinic's daily cash on hand to more than 78.5 days
This figure represents half of Moody's Baa median, as tracked by several financial studies analyzing financial health.
Begin immediately, complete by December 2021

Improve hospital debt to capitalization ratio to less than 49.8%
This figure represents Moody's noninvestment grade grouping median, as tracked by several financial studies analyzing financial health.
Begin immediately, complete by December 2021

Investigate the global budgeting concept for Mississippi
A task force dedicated to global budgeting should be established to investigate the impact of the streamlined revenue cycle process in Mississippi.
Establish in 2020, with findings presented by December 2020

Lower the cost of Emergency Department's
Hospitals should leverage opportunities with tele-emergency or by other means to reduce cost. Hospitals should work to reduce the cost of operation of emergency departments up to 25%.
Begin immediately, complete by 2022

Mississippi Rural Hospital Transition and Improvement Grant Program
This grant program should be passed by the Mississippi legislature and placed into administration at full funding through the Mississippi State Department of Health. Hospitals may then begin to apply for funding to enact capital improvements, undergo organizational and structural improvements / changes, etc. Up to 5 applications should be received each year detailing the hospital's desired improvement with a 5-10 year improvement plan outlined as part of the application.
Begin July 2020, continue ongoing

Growing Rural Access

Establish school-based telehealth programs
Establish a minimum of three school-based telehealth programs
Begin immediately, complete by December 2020

Reduce Urban vs Rural Disparities
Leverage population health and preventive screenings through value-based health to reduce urban vs. rural health disparities by 25%
Begin immediately, complete by December 2022

Transition Hospitals and Clinics to Value-Based Care
Prepare a minimum of 75% of Mississippi's hospitals, rural health clinics, and federally qualified health clinics to participate in either an Accountable Care Organization (ACO), a Clinically Integrated Network (CIN), or a Patient Centered Medical Home (PCMH)
Begin immediately, complete by December 2022

Increasing locally-delivered services
Rural healthcare services should becoming increasingly available and utilized. By analyzing claims data, Mississippi should see a 25% increase in available rural services.
Begin immediately, complete by 2022

Establish a sustainable statewide EMS network
Mississippi should work to build a statewide EMS transportation network using current EMS providers with the capacity to grow. Funding for this program should occur as a partnership between counties and insurers, with full funding provided for both truck and air transportation at no cost to the patient.
Begin immediately, complete by 2024

Education and Outreach

Train rural providers to screen for suicide risk
Train at least 50 providers to screen for suicide risk using MS Department of Mental Health toolkits.
Begin immediately, complete by December 2020

Partner hospitals and Mobile Crisis Response Teams
Strengthen the partnership between rural hospitals and local mobile crisis response teams in order to improve patients' health. This should result a minimum of 100 new calls to the response teams, 50 face-to-face visits, and 100 diversions from a more restrictive environment including emergency rooms, jails, etc.
Begin immediately, complete by December 2021

Provide Consulting and Support for Rural Hospitals
Due to the complexity of revenue cycle optimization, reimbursement programs, contracts and services, documentation, and utilization needs, it is recommended that Mississippi's five most struggling hospitals are identified and receive direct consulting services to assist with hands-on, holistic improvements to structure and function. This consulting should be coordinated through the MSDH State Office of Rural Health.
Begin identification immediately, complete by December 2021

Develop a leadership / board training system
To provide additional C-suite and provider leadership training, a course or curriculum should be established to train at least 50 rural hospital and clinic leaders in Mississippi.
Begin immediately, complete by December 2021

Regulatory

Creation of a statewide single source for credentialing services
The Mississippi Department of Insurance should create a fully-functional statewide online tool for credentialing providers, that should be used by all insurance companies (both public and private) operating in the State of Mississippi.
Begin immediately, complete by December 2022.

References

1. Mississippi Population 2019 (Demographics, Maps, Graphs). (n.d.). Retrieved from http://worldpopulationreview.com/states/mississippi-population/
2. U.S. Census Bureau QuickFacts: Mississippi. (n.d.). Retrieved from https://www.census.gov/quickfacts/MS
3. Rural Health Information Hub. (n.d.). Retrieved from https://www.ruralhealthinfo.org/states/mississippi
4. Half of Mississippi's rural hospitals at risk of closing, report says. (2019, April 19). Retrieved from https://mississippitoday.org/2019/02/27/half-of-mississippis-rural-hospitals-at-risk-of-closing-report-says/
5. Directory of Local Health Departments. (n.d.). Retrieved from https://www.naccho.org/membership/lhd-directory?searchType=standard&lhd-search=&lhd-state=MS
6. Ellison, A. (n.d.). State-by-state breakdown of 85 rural hospital closures: Of the 26 states that have seen at least one rural hospital close since 2010, those with the most closures are located in the South, according to research from the North Carolina Rural Health Research Program. Retrieved from https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-85-rural-hospital-closures.html
7. US Census Bureau. (2017, September 12). Health Insurance Coverage in the United States: 2016. Retrieved from https://www.census.gov/library/publications/2017/demo/p60-260.html
8. More hospital bankruptcies. (2018, September 23). Retrieved from https://www.northsidesun.com/opinion-editorials/more-hospital-bankruptcies#sthash.VGILaDro.dpbs
9. Navigant rural hospital report (February, 2019). Retrieved from https://www.navigant.com/insights/healthcare/2019/rural-hospital-sustainability
10. Access to Care in Rural America: Impact of Hospital Closures. (n.d.). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193569/
11. Holmes, G. M., Slifkin, R. T., Randolph, R. K., & Poley, S. (2006). The Effect of Rural Hospital Closures on Community Economic Health. *Health Services Research*, *41*(2), 467-485. doi:10.1111/j.1475-6773.2005.00497.x
12. Explainer: Medicaid Uncompensated Care Pools. (2015, May 21). Retrieved from https://familiesusa.org/product/explainer-medicaid-uncompensated-care-pools

13. Managed Care. (n.d.). Retrieved from https://medicaid.ms.gov/programs/managed-care/
14. Mississippi Rural Physicians Scholarship Program Home. (n.d.). Retrieved from https://www.umc.edu/Office%20of%20Academic%20Affairs/For-Students/Academic%20Outreach%20Programs/Mississippi%20Rural%20Physicians%20Scholarship%20Program/Mississippi%20Rural%20Physicians%20Scholarship%20Program.html
15. About Us. (n.d.). Retrieved from https://www.ompw.org/OMPW/About-Us/About-Us.html
16. 15 Miss. Code R. § 9-99-1.5.8. (n.d.). Retrieved from https://casetext.com/regulation/mississippi-administrative-code/title-15-mississippi-state-department-of-health/part-9-office-of-health-policy-and-planning/subpart-99-mississippi-state-rural-health-plan/chapter-1-mississippi-state-rural-health-plan/subchapter-5-health-workforce/rule-15-9-99-158
17. Mississippi Dental Demographics. (n.d.). Retrieved from https://dentagraphics.com/mississippi-infographic
18. Community Mental Health Centers. (n.d.). Retrieved from http://www.dmh.ms.gov/service-options/community-mh-centers/
19. Telepsychiatry Mississippi. (n.d.). Retrieved from https://www.e-psychiatry.com/pro/telepsychiatry_mississippi.php
20. Psychiatric inpatient capacity. (n.d.). Retrieved from https://www.nri-inc.org/media/1319/tac-paper-10-psychiatric-inpatient-capacity-final-09-05-2017.pdf