



MISSISSIPPI
RURAL HEALTH
ASSOCIATION

Crossroads

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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.

How do I find more information about the Mississippi Rural Health Association?

You may find more information at www.msrrha.org

How do I contact the editors?

You may contact the editors by calling Ryan Kelly, Executive Director, at 601.898.3001

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FIGHTING FOR MISSISSIPPI'S RURAL HEALTH

By Ryan Kelly

With increase regulations, a constant fight over a shrinking pool of money, and the toll of keeping up with technology, healthcare can sometimes seem like a battle. Rural healthcare often seems like an uphill battle to say the least. Your Association recognizes all of these challenges and addressed them head-on at our 2014 Annual Conference, held in September at the Jackson Marriott in Jackson, MS.

More than 200 healthcare professionals and vendors attended and heard presentations from speakers of both local and national importance. In order to help better meet your needs, continuing education was offered for physicians, nurses, and clinic/hospital administrators. And, additional educational tracks were offered to build educational offerings that meet discipline-specific needs.

What was the take-away from this conference? Your voices are being heard.

Senator Terry Burton and Representative Bobby Howell were in attendance for our annual legislative forum. These two health leaders well understood the challenges and opportunities facing rural healthcare in Mississippi and are working with their counterparts in Jackson to solve many of these issues.

So what is ahead for rural health in Mississippi? There is still a fight over Medicaid expansion. There is still a great effort to expand telemedicine to each clinic and hospital in rural Mississippi. There is still debate over physician and hospital reimbursement rates. There are task forces launched to determine how to keep our critical access and rural hospitals alive and well. And, there are still ongoing discussions on how to incentivize physicians to live in rural areas and how to better empower physician extenders to perform to their maximum capability.

Rest assured that the staff of the Mississippi Rural Health Association have worked hard to be in the room to advocate for you with each of these issues. We have a seat at the table, and everyone knows that rural health is of maximum importance in Mississippi. My board and I have had the opportunity to speak with Governor Bryant, various legislators, and our Congressmen about your needs. They are very receptive and are working each day to support you.

You can help us by keeping us informed of your needs. Please call or e-mail anytime to let us know what challenges or opportunities you see. You may contact me directly at 601.898.3001 or ryan.kelly@mississippirural.org.

Thank you for your service to Mississippi's citizens. You are soldiers in the fight for good health. Keep up the good work!

Over 200 health care professionals attended the 19th Annual Conference at the Jackson Marriott in September. Thank you to all of those that attended!

TOBACCO MONTHLY INFORMATION SERIES

Each month, the Mississippi Rural Health Association in partnership with the MSDH Office of Tobacco Control have produced a tobacco monthly informational series. This series of posters is sent to rural health clinics and hospitals participating in the program across Mississippi to be displayed in waiting rooms, patient rooms, and other key locations. The posters include tips and tools to help patients stop smoking. The professionally designed posters are eye-catching and themed for the month.



To learn more about this series and the Association's tobacco cessation project, contact:
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WE NEED YOUR FEEDBACK! RURAL HEALTH CLINIC SURVEY

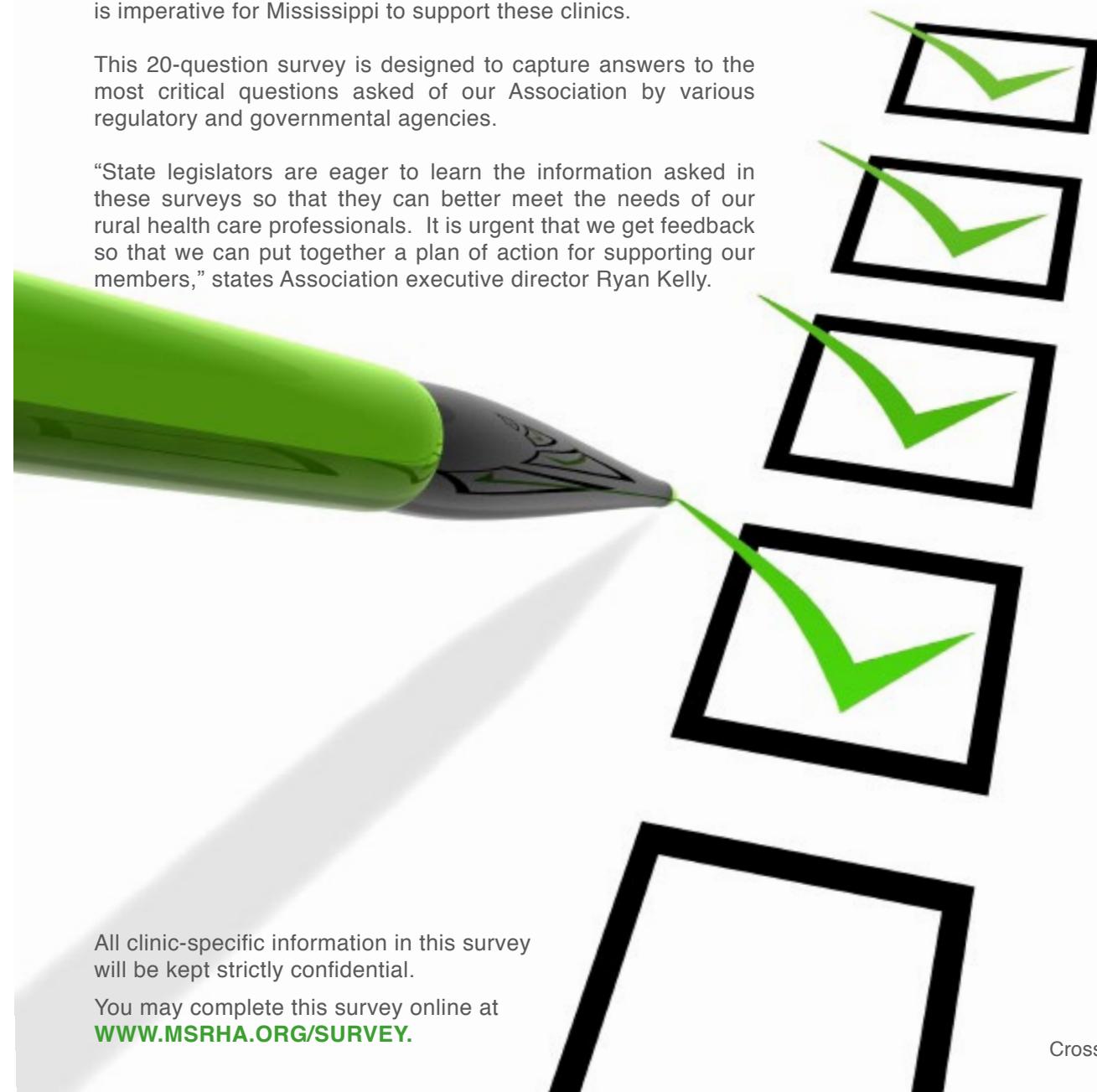
By Perkesa Page

The Mississippi Rural Health Association is currently conducting a survey of rural health clinics in Mississippi. This data collection effort will help us to advocate for Mississippi's rural health clinics on the state and national level.

Currently, data is only collected by state agencies from hospitals and community health centers, but not from rural health clinics. This survey is our opportunity to include rural health clinics as well. When compared to other states, the number of rural health clinics in Mississippi is higher than average. Because of the critical importance that rural health clinics play in primary care, it is imperative for Mississippi to support these clinics.

This 20-question survey is designed to capture answers to the most critical questions asked of our Association by various regulatory and governmental agencies.

"State legislators are eager to learn the information asked in these surveys so that they can better meet the needs of our rural health care professionals. It is urgent that we get feedback so that we can put together a plan of action for supporting our members," states Association executive director Ryan Kelly.



All clinic-specific information in this survey will be kept strictly confidential.

You may complete this survey online at WWW.MSRHA.ORG/SURVEY.

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ANTIBIOTICS: APPROPRIATENESS MINIMIZES RESISTANCE

By Mary Atkinson Smith,
DNP, FNP-BC | Starkville Orthopedic Clinic

Antibiotic resistance contributes to a significant burden on the healthcare system from economic, quality, and safety standpoints. Research has proven that antibiotics are prescribed unnecessarily and misused by patients 50 percent of the time. The main factors that contribute to antibiotic resistance are inappropriate prescribing of antibiotics by healthcare providers and misuse of antibiotics by patients. In the United States, as many as two million people develop life-threatening infections each year caused by bacteria that have resistant properties and up to 23,000 deaths a year are directly related to antibiotic resistant infections. It has been estimated that antibiotic resistance is responsible for as much as 20 billion dollars in healthcare-related costs yearly, with costs related to lost productivity being close to 35 billion dollars each year.

Inappropriate prescribing is described as the prescribing of antibiotics for viral or self-limiting bacterial infections such as those that lead to acute infections of the respiratory tract. Several factors contribute to the practice of inappropriate antibiotic prescribing among healthcare providers. These contributing factors include lack of awareness or utilization of evidence-based guidelines that address appropriate antibiotic prescribing, pressure or influence from patients to prescribe an antibiotic, and perceived lack of time for patient education regarding appropriate antibiotic prescribing. Continuing education efforts to further educate clinicians on appropriate antibiotic prescribing are necessary when it comes to improving the quality of health care.

Hospitals may also contribute to the improvement of antibiotic prescribing

by encouraging optimal treatment of infections and reducing antibiotic related adverse events through the implementation of antibiotic stewardship programs (ASPs). A hospital ASP assists clinicians with improving quality of care and patient safety by increasing the incidence of appropriate antibiotic prescribing for therapeutic and prophylaxis purposes. Additional benefits of a hospital ASP include a reduction in the rate of antibiotic resistance and generation of significant cost-savings. Beginning in 2014, the CDC recommended all acute care hospitals execute ASPs.

The misuse of antibiotics among the public also plays a role in the development of antibiotic resistance. Common examples of behaviors that contribute to the misuse of antibiotics include not completing the full course of antibiotics as prescribed, taking leftover antibiotic prescriptions, and cultural beliefs pertaining to antibiotic use. Another common example of antibiotic misuse is saving unused antibiotics to take later for another illness or to share with family members who are ill. These examples of misuse can result in the wrong antibiotic being taken and can also lead to the development of antibiotic resistant bacteria.

We must take the initiative to minimize the development of antibiotic resistance in rural health care if we are determined to improve the health of rural Mississippians. How can each of us play a part in this? Improvement can be achieved if each of us will make a commitment to educating ourselves, and the public, regarding the importance of appropriate antibiotic prescribing and use.

MISSISSIPPI DIVISION OF MEDICAID ROLLS OUT LONGITUDINAL, CLAIMS-BASED CLINICAL INFORMATION IN PROVIDER ACCESS

BY ESTABLISHING A MASTER PATIENT INDEX (MPI) AND LONGITUDINAL PATIENT RECORD FOR OVER 750,000 MEDICAID/CHIP BENEFICIARIES, MISSISSIPPI IMPROVES PATIENT SAFETY AND CARE

BY NANCY BARTON MARINI | MEDEANALYTICS

Mede Analytics and the Mississippi Division of Medicaid (Mississippi DOM) have launched a clinical data repository and associated web application, MedeProvider Access (Provider Access). Leveraging MedeAnalytics' robust analytics platform and Medicaid Management solution for the patient identities, Mississippi DOM now has a single-identifier for each of Mississippi's 750,000 active Medicaid beneficiaries, which provides a single best record for all Medicaid beneficiaries. Using the single best record, provided through the Provider Access web application, Medicaid providers can access claims-based, clinical information for any of their Medicaid beneficiaries, allowing administrators to easily manage a patient's longitudinal record and improve patient safety and care.

Specifically, Provider Access grants providers insight into their Mississippi Medicaid patients longitudinal claims-based clinical information, including the ability to:

- View historical, claims-based, clinical information for Medicaid patients over a seven (7) year time period.
- Access patient's medication history and monitor their filling habits—including pharmacy name(s)

- and location(s).
- Conduct unofficial pre-authorization of claims, including vision, dental and medical by reviewing historical, paid and denied claims.
- Reduce duplicative therapies by viewing each patient's longitudinal, claims-based, clinical history—including when and where acute episodes of care and immunizations were received.
- Perform reconciliations for proactive fraud detection and billing practices—especially for medications, immunizations and episodes of care.
- Coordinate care by exporting .pdf files of patient claims records.



“It is our mission to ensure that the Medicaid-eligible population has access to quality care in the most cost-efficient and comprehensive manner possible,” said Rita Rutland, Deputy Administrator of the Office of Information Technology Management (iTech). “To increase efficiency while improving care, we need to offer Medicaid providers a full 360 degree, instantly accessible view to a high volume of data.” Provider Access offers the 360 degree view of Medicaid patients.

Looking into the future, Mississippi DOM plans to integrate with external stakeholders, including the state Health Information Exchange (HIE), to support statewide clinical data exchange.

“Mississippi DOM has become a model agency for

its counterparts across the nation,” said Andrew Hurd, MedeAnalytics Chairman and CEO. “We are proud to be working hand-in-hand with Mississippi DOM as they expand the project to the state HIE and continue minimizing costs while increasing the quality of care for beneficiaries.”

All Mississippi Medicaid Providers, and supporting staff are eligible to use Provider Access, which is provided free of cost, by the Mississippi Division of Medicaid. Interested parties should contact the MS Division of Medicaid's Clinical Advocate for more information and registration contact Nancy Barton Marini at nancy.bartonmarini@medeanalytics.com or 662.231.7715.



Picture features the Family Medical Clinic in Crystal Springs Mississippi.

IS THERE A DOCTOR IN YOUR TOWN?

By Bonnie Carew, Mississippi State University Extension Service

Mississippi is first in the nation in heart disease mortality rate, second in the prevalence of adult diabetes, second in cancer mortality rate and, contributing to all, the second “fattest” state in the nation with over two-thirds of adults and almost half of our youth overweight or obese. Compounding these statistics is limited access to care in a state with one-third less physicians per 1,000 people than the national average. The bottom line in Mississippi is simple to read: more people per capita, develop potentially fatal diseases than elsewhere in the country, and, when they do, it is more difficult for them to secure the care they need.

No matter which side of the aisle you sit on in all the recent health care discussions, the one point of common agreement is the need for more primary care medical professionals. With that need in mind, Mississippi State University Extension Service developed the Rural Medical Scholars program to encourage interested, academically talented high school students between their junior and senior years to pursue a medical career.

The program, funded by Extension Service and the State Office of Rural Health, enables students to spend five weeks at Mississippi State during the summer,

take two pre-med courses, gain college credit, and spend four afternoons shadowing physicians to help answer that all important question, “Is this really what I want to do with my life?” The program has been in operation since 1998 and 70% of our graduates are engaged in or pursuing health-related careers. Thirty-five have gone on to medical school and twenty-four of those have graduated and are practicing physicians today. Seventy-one percent of the graduates headed towards primary care and two thirds stayed within Mississippi. This past summer twenty-three Scholars began their journey to a possible future in medicine.

Do you know an aspiring physician?

Help set them on the path to their future and encourage them to apply to the Scholars program. For more information, please contact Bonnie Carew, MSU Department of Food Science, Nutrition and Health Promotion, at 662.325.1321, bcarew@ext.msstate.edu, or visit the program website at www.RMS.msucare.com. Dates and an application for the 2015 summer program will be posted in mid-late November.

MISSISSIPPI RURAL SCHOLARSHIP PROGRAM GROWING MORE PHYSICIANS

By Jake Donald, Mississippi Rural Physician Scholarship Program

Since its inception in 2007, the Mississippi Rural Physicians Scholarship Program’s (MRPSP) main focus has been to identify students who are passionate about reaching the underserved in Mississippi and sending them back to their roots to be primary care physicians. The scholars represent the program well, and the program’s third and fourth scholars to begin practicing – Dr. Laura Jackson Miller and Dr. Dustin Gentry – are no exception. Both being rooted in rural MS, Dr. Gentry calls Kosciusko home but now practices at Winston Medical Center in Louisville, and Dr. Miller has set up shop at Family Medical Clinic in Crystal Springs just ten miles from her hometown of Hazlehurst.

Through direct funding mostly from the state and other private organizations, the scholars are eligible for \$120,000 during their medical school training totaling \$1.59 million a year, which can be an advantage when faced with medical school expenses. Dr. Miller explains the impact of the program for her personally, “Initially for me, it was financial stability and assistance. However, now that I have been involved in the program from the graduate side, it does allow students to connect with residents and physicians in their chosen specialties and in rural or underserved areas. I think this connection and networking is a fantastic benefit because it provides both networking opportunities and support system.”

It’s no surprise that both Gentry and Miller chose to practice family medicine because of their passion for having longitudinal patient relationships as Miller explains. “I love the depth and breath of medicine,” Miller said. “I like being able to treat children, their parents, and their grandparents all in the same day. Family medicine is the only specialty that allows me to see anything and everything.”

The scholars can choose the rural area where they would like to practice. Through a careful screening process, the program seeks students primarily from

rural areas that have a sense of responsibility and commitment to rural communities. While MRPSP does not limit applicants from urban areas, it’s more likely scholars familiar with rural benefits and challenges will stay in rural communities. Gentry says on choosing Louisville as his practice location, “It’s been great! We are still recovering from the devastating tornado that destroyed the hospital. We are working out of a temporary hospital that is really functional. I’ve been here for 3 weeks and have already had 3 admissions and have seen a lot of people in the clinic. The people of this town have been so kind and I am amazed at their strength and resilience.”

Because Miller chose to be close to her hometown of Hazlehurst, she’s no stranger to that area. “I’ve already seen a great variety of patients, many of whom I’ve known since childhood,” Miller said. “The benefit of returning to my home county and close to my hometown is that I can work with and treat friends and family. It is also nice to ‘come home’ and try to have a positive impact on the community.” Miller’s enthusiasm and passion not only for family medicine but for her hometown is why MRPSP even exists. MRPSP’s vision is that these new physicians will get involved in their communities and plan to stay there long-term.

Executive Director Wahnee Sherman explains, “By the year 2017, MRPSP will have more than 25 practicing physicians in the state. The program is a long-term commitment to healthcare and economic development in Mississippi. A doctor has an average economic impact of \$500,000 to \$2 million.” The impact of MRPSP goes further than just providing healthcare to underserved areas – it’s about being an active member of their communities and playing a role in making that community a better place to live.

For more information about MRPSP, contact director Wahnee Sherman or associate director Jake Donald at 601.815.9022.

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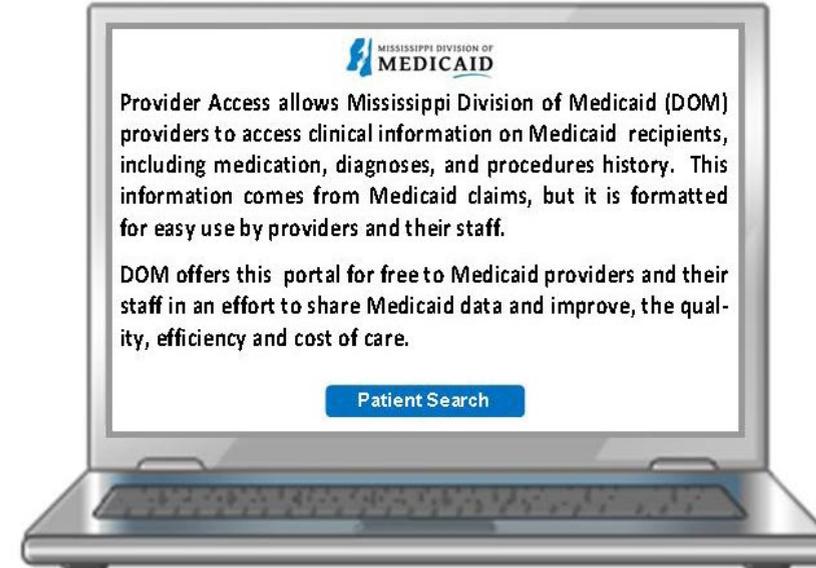


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/ HOW DO I REGISTER? /

Contact our **Clinical Advocate**:

Nancy Barton-Marini

E nancy.bartonmarini@medeanalytics.com

T 662—231—7715



Mississippi Rural Health Association Calendar of Events

February 12, 2015

Continuous Quality Improvement in the Health-
care Setting Workshop
Starkville, MS

March 13, 2015

Rural Health Clinic Workshop - Billing/Coding
Greenwood, MS

March 17, 2015

Capitol Day
Jackson, MS

May 7, 2015

TeamSTEPPS / Teambuilding Workshop
Jackson, MS

May 8, 2015

Rural Health Clinic Conference
Jackson, MS

June 12, 2015

Rural Health Clinic Workshop - Improve your
policy and procedure manual
Jackson, MS

September 30, 2015

Rural Health Clinic Workshop
Complete your program evaluation
Jackson, MS

October 1-2, 2015

20th Annual Conference
Jackson, MS

The monthly webinar series will continue in 2015. Dates for webinars will be announced soon.
Register for events at www.msrrha.org/events.



NEW STATE LEGISLATION: THE SMALL BUSINESS AND GROCER INVESTMENT ACT

By Marla Stuart, CPA, MBA, MPH(c)

The Small Business and Grocer Investment Act was approved by Governor Bryant in April, 2014 and became law on July 1. The act authorizes the Mississippi Development Authority (MDA) to establish a funding program aimed at encouraging grocery stores to locate in areas currently lacking in places to buy fresh food. The act does not allow the use of state funds but rather anticipates that MDA will locate other sources to fund grants and loans to qualified businesses.

Background

The bill was first introduced in 2013 in response to recommendations issued by the Mississippi Grocery Access Task Force. The task force, which consisted of multiple organizations led by The Partnership for a Healthy Mississippi and the National Grocers Association, reached the following conclusions:

- Providing better access to nutritious and affordable food will help improve the health of Mississippi residents.
- When people have convenient access to supermarkets, they eat more servings of fruits and vegetables and are more likely to maintain a healthy weight.
- If given the means to overcome the high preliminary costs associated with store development, grocery stores in lower-income communities can be sustainable enterprises, thereby increasing the economic vitality of neighborhoods.
- Supermarkets and grocery stores create quality jobs and contribute to the revitalization of urban and rural communities.

The task force issued nine recommendations, one of which was to “develop a grant and loan program that supports the development, renovation and expansion of grocery stores and other retailers selling healthy food in underserved areas.” The bill ultimately passed in 2014 seeks to do just that.

Which Communities Could Benefit?

Large swaths of both rural and urban Mississippi have been identified by various researchers as lacking in access to healthy foods. For example, a 2012 report issued by the Food Trust, *Food for Every Child: The Need for More Supermarkets in Mississippi*, maps grocery sales volume compared to population density and identifies areas all over the state, including not only rural counties but also more populated areas,

where residents do not have ready access to a grocery store.

The USDA’s Economic Research Service employs another approach to identifying underserved areas, based on relative driving distance to the nearest grocery store and/or the availability of public transportation. Similar to results shown in the Food Trust report, the USDA mapping tool also shows many underserved areas throughout Mississippi, both urban and rural, with the largest of these in the Delta and in central and southwestern portions of the state.

The Small Business and Grocer Investment Act references the Mississippi Department of Revenue’s county ranking system to determine areas that may benefit under the provisions of the act. This ranking system is based on each county’s relative unemployment rate and per capita income. Under the act, only those counties that fall in the lower two-thirds of this ranking (Tier II and Tier III counties) will qualify. This system of determining eligibility will help ensure counties most in need economically will benefit. However, many communities meeting the definition of underserved with respect to grocery stores are located in Tier I counties and therefore will not be able to benefit from the law.

Conclusion

Similar programs established in other states, including Louisiana, Pennsylvania, and California, are successfully achieving their objectives. For example, since Pennsylvania created the first statewide program of this kind in 2004, it has approved over 90 food retail projects and is credited with creating over 5,000 jobs and increasing access for approximately 500,000 people. Mississippi’s recent passage of the Small Business and Grocer Investment Act may be an important first step toward similar success.

CDC ISSUES STRONGER SAFETY STANDARDS FOR HEALTHCARE WORKERS HANDLING EBOLA

By Steven Ross Johnson, Modern healthcare

Conceding its previous Ebola safety protocols failed in Dallas, the Centers for Disease Control and Prevention issued more robust standards aimed at better protecting workers who confront Ebola and other deadly infectious diseases.

CDC Director Dr. Thomas Frieden said late Monday that the new guidelines were designed to increase the margins of safety for healthcare workers. He acknowledged that the previous recommendations, which were first issued in 2008 and last updated this past August, did not work in the case of Texas Health Presbyterian Hospital Dallas, where two nurses were infected while treating Ebola patient Thomas Eric Duncan.

The previous guidelines called for healthcare workers to wear a minimum of gloves, a fluid-resistant gown and eye protection. The updated protocols, however, include personal protective equipment that covers the entire body and leaves no skin exposed.

“Dallas shows that taking care of Ebola is hard,” Frieden said. “The way care is given in this country is riskier than in Africa. There’s more hands-on nursing care, and there are more high-risk procedures.”

Frieden said the new guidelines were reviewed by healthcare professionals with experience treating for Ebola in the U.S., as well as personnel from the international medical-relief organization Doctors without Borders.

Other PPE-related recommendations include:

- Wearing two sets of gloves
- Wearing boot covers that are waterproof and go to at least mid-calf or cover the legs
- Single-use fluid resistant or impermeable gown that extends to at least mid-calf or overall without intergraded hood
- Using respirators, including either N95 respirator masks or powered-air purifying respirator (PAPR)

- Single-use, full-face shield that is disposable
- Surgical hoods to ensure complete coverage of the head and neck
- An apron that is waterproof and covers the torso to the level of the mid-calf should be used if Ebola patients have vomiting or diarrhea

Also, new protocols for Ebola care will call for hospitals to name a site manager who will be charged with overseeing all processes and protocols related to that treatment. Healthcare personnel providing care will be required to undergo repeated and rigorous training and show competency in putting on and removing personal protective equipment. The agency recommends a trained monitor actively observe and supervise each worker taking on and off protective equipment.

In addition, Frieden said plans were underway to designate a number of hospitals throughout the country as Ebola care centers where cases would be transferred for treatment. He said a number of facilities have started training personnel to prepare to become a dedicated Ebola care center, but he declined to say how many there would be throughout the country.

On Sunday, National Institute of Allergy and Infectious Diseases Director Dr. Anthony Fauci called for more training of healthcare workers and said the four hospitals in the country considered to be specially equipped to handle Ebola cases are probably not enough. A CDC official last week stated a plan could call for at least one Ebola-designated hospital in each state.

The new recommendations come on the heels of recent criticism the agency has received regarding its handling of U.S. Ebola cases. Frieden said it is still not known exactly how the two nurses, Nina Pham, 26, and Amber Vinson, 29, got infected. “Any infection is unacceptable,” Frieden said.

HHS WITHDRAWS PROPOSED 340B DRUG PRICING PROGRAM “MEGA REGS”: FURTHER GUIDANCE FORTHCOMING

By Elizabeth S. Elson and Anil Shankar, Foley & Lardner

The Department of Health and Human Services (HHS) has withdrawn its greatly anticipated 340B Drug Pricing Program (340B Program) proposed regulations. The proposed regulations, nicknamed the 340B Program “Mega-Regs,” had been drafted by HHS and sent to the White House Office of Management and Budget for review in April, but had not been made available to the public. The withdrawn Mega-Regs were expected to address a variety of critical 340B Program issues, such as the definition of an eligible patient, compliance requirements for contract pharmacy arrangements, hospital eligibility criteria, and eligibility of off-site hospital facilities. The Health Resources and Services Administration (HRSA), within HHS, issued a statement that the agency plans to propose guidance for notice and comment in 2015 that will address key 340B Program policy issues. HRSA also plans to propose regulations related to the following specific 340B Program issues: civil monetary penalties for manufacturers; how the ceiling prices of 340B drugs are calculated; and dispute resolution.

The withdrawal of the Mega-Regs signals a retreat for HHS in an ongoing dispute over the scope of the agency’s authority to issue regulations for the 340B Program. Last May, a U.S. District Court invalidated HHS’ first attempt to issue regulations for the 340B Program, which addressed the treatment of orphan drugs for 340B Program pricing at certain hospital covered entities. The court opinion ruled that HRSA lacked authority to issue the orphan drug rule, and further indicated that HHS lacks authority to issue binding legislative regulations for the 340B Program, except in those areas specifically authorized by Congress. HRSA has subsequently re-issued the orphan drug rule as an interpretive regulation, and this action is currently the subject of a separate court challenge. HRSA’s statement that it will issue regulations addressing only civil monetary penalties for manufacturers, 340B ceiling prices, and dispute resolution tracks language from the court identifying those areas where the agency’s authority to issue regulations is the strongest.

The withdrawn Mega-Regs would have addressed a number of key policy issues outside these circumscribed areas, including the definition of “patient” that establishes those individuals who are eligible to receive 340B Program drugs, and limitations on the use 340B Program contract pharmacy arrangements. HRSA’s statement indicates that it is likely to attempt to publish guidance on some of these topics in 2015, and will open up this guidance for public comment. However, the guidance will not be published as formal regulations. Covered entities and other stakeholders should be prepared to review the proposed guidance and to submit comments within the timeframes specified by HRSA. Stakeholders should also be aware that the issuance of non-regulatory guidance could lead to further challenges on the scope of HHS’ authority, which may be lead to further litigation.

2015 is shaping up to be a critical year for the 340B Program. In addition to the forthcoming guidance and regulations, the Government Accountability Office (GAO) is studying 340B and non-340B hospitals’ sources of revenues and margins and how they have changed over time, and comparing 340B and non-340B hospitals’ Medicare Part B drug reimbursements and how those have changed over time. Additionally, the Office of Inspector General (OIG) plans to assess the risk of duplicate discounts for 340B-purchased drugs paid through Medicaid managed care organizations (MCOs) and States’ efforts to prevent them, as well as to review how much Medicare Part B spending could be reduced if Medicare were able to share in the savings for 340B-purchased drugs. These reports will be highly anticipated by stakeholders interested in the future of the 340B Program, and could prompt legislative action by the new Congress. We will continue to monitor these critical developments and provide updates on significant issues impacting the 340B Program.

THE COMPLIANCE TEAM JOINS QUAD A FOR RURAL HEALTH CLINIC ACCREDITATION

By Ryan Kelly

A common question asked of our Association is regarding the vendors available to complete rural health clinic (RHC) surveys for CMS certification.

For an RHC to enter into a provider agreement with the Medicare program, the RHC must first be certified by a state survey agency as complying with the conditions or requirements set forth in section 1861(aa) of the Social Security Act and 42 CFR part 491. Thereafter, the RHC is subject to regular surveys by a state survey agency to determine whether it continues to meet these requirements. However, there is an alternative to surveys by state agencies. Certification by a nationally recognized accreditation program can substitute for ongoing state review.

The Mississippi State Department of Health has encouraged clinics that wish to complete the surveys early (outside of the schedule of MSDH) to work with a CMS recognized accreditation program. And for years, Quad A has been the only vendor available.

However, effective July 2014 a new vendor is now available. The Compliance Team serves Mississippi Rural Health Clinics and is working to help alleviate the backlog of rural health clinic accreditation surveys. If you attended our 19th Annual Conference in September, you likely had a chance to visit with The Compliance Team and learn about their availability to assist your clinic.

For more information on The Compliance Team, contact:
Kate Hill
Director of clinical services
khill@TheComplianceTeam.org
215.654.9110



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SOUTH CENTRAL TELEHEALTH FORUM 2015

"Telemedicine Across the Lifespan"

JOIN US ON MARCH 2 FOR A FORUM ON
TELEHEALTH & TELEMEDICINE
PRE-CONFERENCE WORKSHOPS ON MARCH 1

FEATURED KEYNOTE



- Keynote by Reimbursement Expert **Nina Antoniotti, RN, MBA, Ph.D.**, Telehealth Program Director, Marshfield Clinic Telehealth Network
- **Full-Day General Conference, Monday, March 2, 2015 in Jackson, MS**
- Sessions hosted by **regional experts**, such as:
 - Dr. David Charles, Vanderbilt University (Tennessee)
 - Dr. Whit Hall, University of Arkansas for Medical Sciences (Arkansas)
 - Dr. Kristi Henderson, University of Mississippi Medical Center (Mississippi)
- **Networking Night, Sunday, March 1**
- **Solution-focused** Exhibition Hall
- Optional **Pre-Conference Workshops** (*separate registration required*)
- **Continuing Education Credits** will be available
- **Lunch on March 2 included** and made possible ^{NEW!} by the generous support of the **Mississippi Telehealth Association**

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