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Chairman Aderholt, Ranking member DeLauro, and members of the committee, it is an honor to appear before you to share, from my perspective, a portion of the challenges rural communities encounter while in pursuit of reasonable access to health services. I thank the committee for the opportunity to testify before you today and anticipate a thoughtful and productive discussion.

My name is Tearsanee Davis, and I currently serve as the Director, Clinical Programs and Strategy at the University of Mississippi Medical Center, Center for Telehealth in Jackson, Mississippi. Additionally, I am a dually certified nurse practitioner, trained in family practice and psychiatric mental health. I am a native of Durant, Mississippi, Holmes County, the poorest county in the poorest state as of 2019. My testimony today is drawn from my personal and professional experiences while living and working in rural Mississippi, as well as my knowledge of efforts aimed to alleviate rural residents' access to quality care.

Many factors contribute to disparities in health such as unavailability of needed resources, socioeconomic issues, and lack of knowledge. Funding made possible by committees such as this enable us to implement programs, test models of care, and integrate innovation into practice in Mississippi that have a national impact. In addition to concerns that affect rural communities, I will share how the University of Mississippi Medical Center (UMMC), a Telehealth Center of Excellence as designated by the Health Resources and Services Administration (HRSA), and its

partners have worked diligently to address the issues that continue to plague our state. There is more work to do.

Provider Shortage While there is still a massive shortage of physicians, this problem has extended to include many other healthcare professionals. A poll conducted in 2022 revealed that 23% of nurses are considering leaving and less than 45% currently work in the hospital setting[1]. The Association of American Medical Colleges predicts that the U.S. could face a shortage of 37,800 to 124,000 physicians by 2034[2]. These shortages directly affect the health of the community. Rural hospitals continue to fight to remain open, despite efforts to recruit and retain highly skilled clinicians. These shortages result in fewer services being offered locally, more transfers to other facilities, and unnecessary delays in care. Since the early 2000s, UMMC has honored its commitment to increasing rural access to highly skilled medical professionals through the use of Telehealth. The Telemergency program provides remote support to more than 20 critical access emergency departments across the state. The UMMC Center for Telehealth continues to be instrumental in bridging the gaps due to shortages or maldistribution of providers and nurses. Thanks to funding from the Federal Office of Rural Health Policy Office for the Advancement of Telehealth, we have supported rural hospitals and clinics by providing Telehealth specialty consultations such as neurology, psychiatry, and critical care in rural emergency departments as well as in inpatient settings. Federal funding through the Telehealth Network Grant Program (TNGP) has made this possible. Although challenges remain, more people are receiving the care they need in their local communities.

Payor Challenges Payor challenges are not unique to rural providers, but they do contribute to fewer providers choosing to practice in rural primary care clinics. Center for Medicare & Medicaid Services (CMS) reimbursement rates are not increasing with the rate of inflation. The latest

consumer price index measure showed that healthcare experienced a 7.7% increase in overall cost[3]. In rural areas, this margin grew significantly more due to the demand for nurses and the lack of supply. CMS has not increased its rate of provider pay to match this increase, resulting in an overall reduction in provider reimbursement[4]. Additionally, providers are having difficulty keeping up with the varying tasks include entering social determinants of health codes (z-codes), meeting compliance measures in the clinic or hospital, meeting value-based outcome measures, attending cybersecurity trainings, handling downloads and denials of services, and fighting Medicare and private insurance audits. Lastly, more Medicare beneficiaries are moving to Medicare Advantage (MA) plans[5]. The challenge is that they are not subject to the value-based care promoted through CMS, as they are a private plan funded with Medicare dollars. The MA plans do not provide the same level and guarantee of benefits as original Medicare. They pay providers less, and often times will actually mislead clients / patients into a false understanding of benefits. This is ultimately hurting both providers and patients. A strict requirement of guaranteed payment, reduction of down codes and denials, and significant client / patient education is needed in order to allow for a positive outcome for patients.

Behavioral Health Mental Health America created a ranking system that weighs the prevalence of mental illness in the state with the accessibility to mental health services. States ranked 1-13 have lower mental illness and higher access to services, while states ranked 39-51 have a higher prevalence of mental illness and lower rate of access to care. Mississippi ranks 36th[6]. Understanding how access to mental health services was measured would prove valuable. An analysis of the supply of behavioral health providers per 100,000 people in rural and urban U.S. counties revealed that there is there are almost 3 times more providers per 100,000 people practicing in urban areas than there are in rural areas[7]. An additional consideration is that a number

of those counted may not be providing direct patient care services, may not accept government funded health coverage, or may not accept insurance coverage at all. In 2015, several FQHCs partnered with UMMC to provide behavioral health services to their patients using Telehealth. This allowed us to leverage behavioral health providers to the extent the rural clinics needed them. It eliminated the need for the clinics to recruit and retain these providers, but most importantly provided access to evidence based care in rural communities. This model of care reduces the stigma around seeking care for mental health concerns. Considering disparities with transportation, child care, employment options, and financial constraints rural and/or low-income residents experience; community health centers and rural health clinics have become increasingly important and have a need to expand services further.

Maternal Health Mississippi has major challenges in its maternal health care delivery and health outcomes. In a ranking completed by the United Health Foundation, Mississippi ranked worst in infant mortality, low birthweight, children in poverty, per capita income, and its economic hardship index[8]. The state also ranked 49th in teen births, food insecurity, and preventable hospitalizations; 47th in its low birthweight racial gap, and 46th in percentage of residents who are uninsured. Continue support for innovative strategies to improve these statistics is important since every county in the state is designated by HRSA as a Health Professional Shortage Area (HPSA). Thanks to the Office for the Advancement of Telehealth's (OAT), UMMC is testing a model to help expectant mothers in rural areas reduce their risk of pregnancy complications such as preterm births. Expectant mothers are monitored remotely and screened for Social Determinants of Health (SDoH), mental health needs, and domestic abuse. If needed, mothers use the direct to consumer (DTC) platform to access mental health and urgent care providers remotely. They are able to have low acuity maternal fetal medicine visits in their homes. By evaluating innovative models of care

like this, we hope to encourage policy changes that increase access to more preventive services and reduce infant and maternal mortality in at-risk populations, particularly in rural areas. This, and other programs like the Rural Maternity and Obstetrics Management Strategies (RMOMS) Program (RMOMS) aim to build networks, leveraging telehealth and specialty care so that ALL will have a chance at a healthy life.

School Telehealth In March 2022, the Mississippi Department of Education entered into a partnership with UMMC Center for Telehealth to provide urgent care and behavioral health services, along with lifestyle coaching and education to all students in K-12 and charter schools in the state. This funding was timely as the pandemic affected access for many schoolchildren. A third of the way through implementation, we have enrolled, 64 out of 100 school districts which translates to 166,600 students. School-based care means healthier students, decreased absenteeism due to minor illness, less time off work for parents due to illness of a child, and access to care for those in areas where there are few provider clinics. Prior to the pandemic, schools were not a recognized site of service for MS Medicaid. This prevented providers from billing for services if the students were at school. Although this was changed recently, there is still the issue of equity. For the program to be effective and sustainable, a model of care must be constructed that considers that all students may not be covered and those that are may still have difficulty paying copays and deductibles. Currently this program is completely funded by MDE, but we are hoping there is additional funding to allow us to continue to serve students statewide without regard for their ability to pay.

Thank you for allowing me to share my perspective. I look forward to any further opportunities to discuss the challenges rural communities face and possible solutions for alleviating the strain on the healthcare system.

References

1. Rossi S. Mississippi Hospitals Navigate COVID Related Challenges. *JMSMA*. 2022;63(6 / 7).
2. American Association of Medical Colleges. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Published June 2021. Accessed April 27, 2022. https://www.aamc.org/media/54681/download
3. ttps://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/#Cumulative%20percent%20change%20from%20June%202014%20in%20producer%20price%20index%20(PPI),%20health%20care%20services,%20not%20seasonally%20adjusted
4. https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1770-f
5. https://www.forbes.com/sites/forbestechcouncil/2023/01/04/beyond-burnout-a-breaking-point-in-healthcare/?sh=ffa2d927e38a
6. https://mississippitoday.org/2022/05/28/data-dive-mental-health-report/
7. National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI), 2021.
8. United Health Foundation. America's Health Rankings. https://www.americashealthrankings.org/explore/annual/state/MS Accessed March 16, 2021.