



**Louisiana  
Rural Health  
Association**

# LRHA Update

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### *LRHA Mission Statement:*

*To serve as a unified voice for the promotion of rural health care through advocacy, education, and leadership.*

## LRHA Efforts Increase Enrollment in Louisiana

On December 12, 2004 CMS made online enrollment into Medicare's Prescription Drug Discount Card available to all of the Senior Health Insurance Information Programs (SHIIP) throughout the nation. Within 2 weeks, Louisiana SHIIP had the third highest enrollment in the country—bested only by Minnesota and Kansas. According to Alan Heumann, Louisiana SHIIP Program Director, the large jump was because of a concentration by his department to enroll low-income Medicare beneficiaries and the partnership with Louisiana Rural Health Association, referred to as Louisiana Access to Benefits Coalition.

Louisiana ABC is a partnership between the Louisiana Department of Insurance and Louisiana Rural Health Association for the expressed purpose of educating and assisting rural Medicare beneficiaries in accessing affordable prescription drugs through Medicare's Discount Card program. LRHA is in the process of recruiting volunteers to serve as Medicare specialists housed with member hospitals that have agreed to be SHIIP counseling sites.

"As rural hospitals sign-up to become SHIIP counseling sites and volunteers complete the SHIIP training we expect our enrollment numbers to increase dramatically," stated Donna Newchurch, Executive Director of LRHA. She continued by saying that the Association's partnership with SHIIP will continue because enrollment will help transition Medicare beneficiaries into Medicare's Part D slated to begin January 2006. "We believe this is an excellent opportunity to eliminate one of the known barriers to improving the health care of rural elderly - affordable prescription drugs," Newchurch concluded.

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## A View from the Field . . .

As you review this issue of the LRHA Update and think back to other issues, you may recognize that LRHA has experienced much growth in programming and staff since its inception twelve years ago. Yet through the efforts of the LRHA Board of Directors and staff, the guiding principle of LRHA - to empower rural citizens to address rural health care issues - has remained constant. From hard-working dedicated founders to a membership of almost four hundred throughout Louisiana and neighboring states, dedicated staff, and several member initiatives, LRHA is still realizing its potential.



*Donna Newchurch  
Executive Director*

It is important to realize that the strength of LRHA remains in the membership; this is not only recognized but embraced by association leaders as well. Association events are designed to empower members while increasing awareness of and finding solutions to challenges in rural health care. I encourage you to maximize your membership in LRHA by becoming involved in LRHA activities and services. Without you, our members, LRHA loses its relevance and we welcome, value, and need your input. LRHA is your organization. I look forward to your participation in the process of preserving and promoting rural health care in Louisiana.

Should you have any questions about membership or programs, please do not hesitate to contact me by calling the office at 985-369-3813. Should you find yourself in or around Napoleonville, please drop in for a visit.

## HHS Announces Regions to Administer New Medicare Prescription Drug Benefit and Medicare Advantage Program

HHS Secretary Tommy G. Thompson announced today that Medicare is taking another step in bringing more choices, better benefits and more savings to millions of Medicare beneficiaries by establishing the regions for prescription drug plans and Medicare Advantage Preferred Provider Organization (PPOs) health plans beginning in 2006.

To help ensure that all Medicare beneficiaries have the opportunity to take advantage of the Medicare prescription drug benefit, the Centers for Medicare & Medicaid Services (CMS) established 26 regions for Medicare Advantage Preferred Provider Organizations and 34 regions for prescription drug plans. Secretary Thompson said the new regions were designed based on extensive public input and expert analysis in order to help people with Medicare get the best health care coverage options possible.

Beginning in 2006, Medicare beneficiaries will be able to receive drug coverage through a prescription drug plan, if they wish to remain in traditional fee-for-service Medicare, or through a Medicare health plan. In either case, Medicare pays about 75 percent of the beneficiary's premium. The prescription drug benefit will rely on market competition to make sure Medicare beneficiaries have the greatest possible access to the drugs they need at the lowest possible cost. Beneficiaries who are enrolled in an employer-sponsored plan will be able to remain in that plan if they wish.

"Our decisions about regions reflect our goal of making sure that all 42 million Medicare beneficiaries will have access to high-quality, affordable drug coverage and health plan choices," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "These regions provide us with the strongest foundation possible to get affordable and comprehensive new coverage in place quickly, so seniors and people with disabilities can get the most from Medicare's new, up-to-date benefits."

CMS also announced that in its final rule it expects to announce how the adjustment will be made to regional health plans based on the county of residence of beneficiaries who actually enroll in the plan. Thus payments made to plans would be higher in high-cost counties.

In determining the regions for the Medicare Advantage and prescription drug plans, CMS relied on input from beneficiary and consumer groups, along with health plans and organizations experienced in providing drug coverage -- including pharmacy benefits managers, physicians, hospitals, pharmacists and other interested parties. CMS held a series of public meetings and calls, and reviewed hundreds of written comments.

With this extensive feedback and input, CMS considered the following factors in setting up Medicare Advantage regions:

**See New Medicare Prescription Drug Benefit and Medicare Advantage Program, page 3**

### Save the Date!



**28<sup>th</sup> ANNUAL  
CONFERENCE**

**MAY 19-21, 2005 • NEW ORLEANS  
Sheraton New Orleans Hotel  
NATIONAL RURAL HEALTH ASSOCIATION**

**Attend the 11th Rural Minority and  
Multicultural Health Conference,  
"State of the States' Rural Racial and Ethnic Disparities:  
Yesterday, Today and Tomorrow",  
May 18, preceding the NRHA Annual Conference.**

**On the Web : [www.NRHArural.org](http://www.NRHArural.org)**

## **New Medicare Prescription Drug Benefit and Medicare Advantage Program** (continue from page 2)

- **Eligible Population:** The goal is to make sure all Medicare beneficiaries have the opportunity to enroll in a PPO, including those in small states and rural areas. The regions need to be large enough to support strong networks, yet small enough to support plans entering right away;
- **Plan Entrants:** The goal is to provide beneficiaries the greatest amount of choice by encouraging the largest number of insurers possible to participate. A region needed to have potential plan entrants, especially some with a history in multi-state regions. Also important was the potential availability of plans that already have insurance licenses and already providing regional services for federal employees or other Americans.
- **Limited Cost Variations:** Lower variations in costs within a region will encourage more plans to participate.
- **Preserving current Medicare patient flows:** In many areas, Medicare beneficiaries cross state lines to seek health care. The Medicare Advantage regions preserve this patient flow as much as possible. Those who enroll in Medicare PPOs will still be able to access providers out of the region in which they reside.

### **SAVE THE DATE**

#### **Rural Health Clinic Educational Event**

**January 24-24, 2005  
Horseshoe Casino and Hotel  
Bossier City, LA**

#### **LRHA Spring Conference Factors and Opportunities Effecting Rural Health Delivery: External and Internal**

**March 8-9, 2005  
Horseshoe Casino and Hotel  
Bossier City, LA**

**For more information, please contact the  
LRHA office at (985) 369-3813.**

If your organization has an article or activity coming up that you would like published in the LRHA Update, please contact Paula Schouest at (985) 369-3113 or [lrhaeducation@bellsouth.net](mailto:lrhaeducation@bellsouth.net).

## **2005 Strategic Priorities Identified by Board of Directors**

On July 30, 2004, the LRHA Board of Directors met in Baton Rouge to develop and define strategic priorities for 2005. The full day retreat was well attended by board members and professionally facilitated by Rudy Gomez of SSA Consultants. A formal Strength, Weaknesses, Opportunities, and Threats (SWOT) analysis was conducted and a workplan to achieve identified priorities was developed.

At the October meeting of the LRHA Board of Directors, the outcomes of the Strategic Priorities Session were presented to the newly elected Board Members and adopted by the entire board. Additionally, the Executive Committee has continually addressed the priorities in Executive Committee conference calls and meetings.

At the retreat, Board Members determined that one of the strategic priorities for LRHA should be the development of Constituency Groups (CG) within LRHA to better serve the members. Activities under this priority include but are not limited to the research of organizations that employ the CG model for their members; presentation of this model to the current board; and the formation of a CGs within LRHA.

The Board also determined that LRHA should develop and / or establish an advocacy Network Committee that would allow for greater responsiveness to the members and result in greater representation of the members at the advocacy level. Activities under this priority include but are not limited to designing the scope of activities for the committee; determining who would participate in the network; and the development of committee activities.

The Strategic Priorities identified at the 2004 retreat will be formally revisited by the Board of Directors at the 2005 Strategic Priorities Retreat to be held February 17, 2005 in Alexandria.



**March 21-23, 2005  
Grand Hyatt Washington  
Washington, DC**

**Registration Deadline is  
February 28**

**To get an agenda or to register, go to  
[nrharural.org](http://nrharural.org)**

**If you are planning to attend, please notify the  
LRHA Office at (985) 369-3813 so that we can  
Coordinate our Capitol Hill visits.**

# Increased Payments to Rural Hospitals

*Rural Roads, September 2004*

Acute care hospitals around the nation are due to receive an increase in Medicare revenues in fiscal year 2005 for the care they provide to Medicare beneficiaries during inpatient stays. The payment increases are the result of a final inpatient prospective payment system for acute care hospitals that will take effect for discharges on or after October 1, 2004.


In addition to establishing updated payment rates, the final rule provides significant financial relief to rural hospitals, and for the first time in the history of Medicare, creates a link between quality services to Medicare beneficiaries and payment for those services. Almost all of the acute care hospitals plan to start reporting quality measures to qualify for the full 3.3 percent increases in their payments. This means that, in 2005, patients will be able to get information on the quality of care at their local hospitals for such conditions as heart attacks and pneumonia.

The final rule implements major payment and policy changes for acute care hospitals required by the comprehensive Medicare Modernization Act of 2003. "The bottom line, particularly for rural hospitals, is significant increases in hospital payment rates. And the bottom line for Medicare beneficiaries is greater access to high-quality inpatient care." said CMS Administrator Mark B. McClellan, M.D., PhD. CMS projects that the combines impact of the inflation update and other proposed changes will yield an average 6.2 percent increase in payments for rural hospitals in fiscal year 2005.

The final rule addresses the impact of the new Metropolitan Statistical Area (MSA) definitions on hospital geographic classification. The MSAs, which were developed by the Office of Management and Budget on the basis of 2000 census data, will replace the currently used Metropolitan Statistical Areas and the New England County Metropolitan Areas, which reflect 1990 data. As a result of these changes, a number of hospitals, currently located in rural areas, will benefit from being classified into areas with higher payment rates. The MSA changes also have an impact on hospitals that are entitled to automatic geographic reclassification because they are located in rural counties whose workforces tend to commute to adjacent urban areas.

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The final rule also implements a number of provisions in the MMA designed to help critical access hospitals (CAHs), as they serve rural beneficiaries. For example, these hospitals can now designate up to 25 beds or beds that may be used for either acute or post-acute care (called swing beds). Now CAHs can also set aside units of up to ten beds each to be used exclusively for inpatient rehabilitation and psychiatric services. These units, which would not count toward the CAH's 25-bed maximum, will be paid as if they were distinct parts of acute care hospitals, and will have to meet the same standards as units in acute care hospitals. In addition, payment for both inpatient and outpatient services rendered by critical access hospitals has been increased from 100 percent of reasonable costs. Finally, CAHs that are in a county that is now classified as urban will be permitted to retain their CAH status for two years.

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