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Rural Health
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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.

President's 2006 Budget Would Impact Louisiana's Rural Health System

In the President's proposed 2006 budget, a number of critical rural health grant programs have been cut. In Louisiana, these cuts will have immediate and negative impact on health care planning and delivery.

Programs not included in the President's 2006 Budget that have current positive impact and add resources to Louisiana's rural communities include but are not limited to:

- Rural Health Outreach Grants / Network Development / Network Development Planning Grant Program (reduction of 28.6 million)—In 2005, Louisiana received \$450,000 in funding through this program. Results of this program include but are not limited to identification of and implementation of preventive care strategies in 29 rural parishes (counties), the delivery or primary care to rural residents through a program linked to a larger urban tertiary hospital, and the development of a partnership between a historically black university and primary care delivery sites in the northern region of the state.
- Rural Hospital Flexibility Grant Program (reduction of 39.5 million) – In Louisiana, approximately 60% of facilities eligible to convert to Critical Access Hospital status were successful in doing so through the resources available through this program. As a result, these facilities were able to remain open and deliver care to the most rural residents of our state.
- Rural AED Grant Program (reduction of 7 million) – In Louisiana, funding from this program allowed for the placement of AEDs in all Critical Access Hospitals as well as sixty-four other identified sites in rural communities.
- Area Health Education Centers (reduction of 29.2 million) – In Louisiana, the four Area Health Education Centers (AHECs) provide support to all designated rural parishes with programs ranging from recruitment and retention of health professionals, continuing education for health professionals, health career enticement to health education opportunities for high school students to community capacity building.

The Bush administration defends its budget by referencing the rural provisions included in the Medicare Modernization Act (MMA) passed in 2003.

See President's Budget, page 2

A View from the Field . . .

President Bush's fiscal year 2006 budget, sent to congress on Monday, February 7, would, if enacted, be costly to rural Louisiana because of provisions affecting funding for rural health programs and projects.



*Donna Newchurch
Executive Director*

Last year, Congress was responsive to rural residents and reversed the cuts to rural health initiatives proposed by the President. Once again, we must look to our Congressional leaders for support and request inclusion of rural health initiatives in the final 2006 budget.

Just today, I received an e-mail from a board member who had recently returned from DC; she sensed that (especially in the House) there seemed to be more resistance to taking a stand against the President's Budget than in the past.

The outcome of the 2006 budget is in our hands. It is a critical time for rural health leaders to make their voices heard. This is a moment when grassroots calls and action can have a huge impact.

Please take a few minutes—become involved and impact the process by contacting your congressional representative. A sample letter specific to the President's budget is available on the LRHA website. Please take a few minutes to review the letter and add local anecdotal data where appropriate before forwarding to your representative.

The Louisiana Rural Health Association is committed to the continued success of rural health programs and will keep you updated on the 2006 Budget as well as future opportunities to make a difference on critical issues before Congress.

If you have any questions or comments relative to the President's 2006 Budget or other issues, please contact the LRHA office by e-mail (laruralhealth@bellsouth.net) or by calling (985) 369-3813.

President's Budget

(continue from page 1)

While MMA did provide over 19 million dollars in rural provisions, it is important to note that these provisions are spread over a ten year period and were responsive to long-standing inequities within the Medicare Program that had paid rural providers significantly less than urban and suburban providers for the same services. It must also be noted that MMA provisions are specific only to Medicare reimbursement; only Medicare beneficiaries will reap the results of this act.

Thus Louisiana's rural communities with higher rates of childhood poverty and uninsurance, higher rates of uninsured adults, few jobs offering health insurance, higher rates of chronic disease, and a shortage of health care providers will realize few opportunities to improve health care will not be directly impacted by MMA.

FCC Releases New Order, Including New Definition of "Rural"

On December 15, 2004, the FCC released a final order that changed the definition of "Rural" for purposes of the Rural Health Care Support Mechanism. According to the new FCC rural definition, a Health Care Provider is designated as rural or urban by its US census tract. This is effective for the 2005 Funding Year which starts July 1, 2005. If all census tracts in a county are rural or urban, it is unnecessary to know the tract because the entire county is designated as rural or urban. If this is not the case, determine the census tract by calling the regional census bureau office or visit the FFIEC Web site. HCPs which have been receiving support, but become ineligible under this new definition, will have grandfathered eligibility for three years, to ease the transition.

Please visit <http://www.rhc.universalservices.org/Download/2004/doc/FCC-04-289A1.doc> for a Word document of the actual FCC order.

Medicare Drug Benefit and Medicare Advantage Program Final Rules

CMS is pleased to announce the publication of the Medicare Drug Benefit and Medicare Advantage Program final rules.

This is a very special time for Medicare beneficiaries, full of many exciting program improvements and enhancements. Right now through the MMA, CMS has the best opportunity ever to make the Medicare program more personalized and up to date, and to keep it up to date. Two major steps towards fulfilling that opportunity are right here in the final regulations: the Medicare Drug Benefit and the Medicare Advantage Program (Titles I & II of the MMA). Along with the coverage up to date with 21st Century prevention-minded medicine.

To help navigate the regulations, CMS is providing easy-to-use tools through a newly established website:

<http://www.cms.hhs.gov/medicarereform/pdbma/>. This user-friendly website not only has a "General Information" link to the press releases, issue papers, fact sheets, and full copies and summaries of both regulations, but also has select information for groups such as States, Tribal Governments, Medicare Advantage Plans, Prescription Drug Plans, Providers and Partner organizations. Simply follow the menu and select the area that best matches your area of interest.

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.

Riverland Medical Center Joins Effort to Improve Access to Prescription Drugs

FERRIDAY, LA – Committed to improving the health care of Concordia residents, Riverland Medical Center recently joined the Louisiana Access to Benefits Coalition (ABC) – a rural Louisiana Medicare outreach and education program created by Louisiana Department of Insurance's Senior Health Insurance Information Program (SHIIP) and Louisiana Rural Health Association (LRHA). The sole purpose for Riverland's action was to provide civic-minded volunteers an environment from which they can counsel older, less fortunate residents about accessing prescription drugs at a price they can afford.



Dufrene leads training for new Concordia Parish Medicare Counselors

As the first member hospital in Louisiana's Access to Benefit Coalition, Riverland also took on the added role as a SHIIP sponsoring organization. In this capacity, Riverland will be able to assist Concordia residents with their questions about Medicare, Medicare's Prescription Drug Benefit (starting in 2006), and Medigap insurance.

Louisiana Department of Insurance SHIIP representative Vicki Dufrene recently went to the hospital to train the 8 volunteers recruited by Billy Rucker, Assistant Administrator for the Hospital, to serve as Medicare counselors. The volunteers that completed the training were Marie Cowan, Herman Stuckey, Marjorie Bowman, Mark Hollis, Glenda James, Sue Freeman, Lori Guillory, and Polly Miley.

According to William Rucker, Hospital Assistant Administrator, "We found what we were looking for - volunteers from our Parish that want to give back and hopefully make a difference in someone's life. We are proud to have these people on board." Rucker continued by stating that Riverland is committed to improving the health of Concordia Parish and this is one more step in that direction.

Louisiana ABC is a unique partnership formed to reach out to, educate and enroll Medicare beneficiaries with lower incomes in Medicare's new prescription drug savings program including the annual \$600 credit, and other public and private programs available to help them better afford their prescription drugs.



Dufrene & Rucker

Any Louisiana Rural Hospital that is interested in assisting their community access affordable prescription drugs can do so by contacting Erin Watson, Louisiana Rural Health Association at (985) 369-3813 or emailing her at lrhamembership@bellsouth.net. Participation in this innovative program is free and the benefits to the community are immeasurable.

Improved Access to Drug Coverage and Lower Cost Health Plans for Beneficiaries in Rural Areas

The Medicare Modernization Act (MMA) made many changes to the Medicare Program that will benefit beneficiaries in rural areas. By 2006, the MMA will provide America's seniors and disabled with a substantial new drug benefit. This access to prescription drugs will improve the health of millions of Americans but will especially benefit those in rural areas. Low-income seniors and people with a disability in rural areas who have limited means will have access to comprehensive coverage, with no or limited premiums and deductibles and low or nominal cost-sharing.



CMS is implementing the drug benefit in a way that permits and encourages a range of options for Medicare beneficiaries to augment the standard Medicare coverage, regardless of where they live. These options include facilitating additional coverage through employer plans, Medicare Advantage—Prescription Drug (MA-PD) plans and/or prescription drug plans (PDPs), and through charity organizations and State pharmaceutical assistance programs.

The MMA also authorized a new system of regional preferred provider organization (PPO) plans to bring new plan choices to rural areas and give those beneficiaries the same options that their urban counterparts have enjoyed. A recent market study found that even the most rural of states like Montana, the Dakotas, and Wyoming have three or more risk-bearing PPOs operating in the commercial insurance market, but very few operate in the Medicare program.

To meet this goal envisioned by the MMA, CMS announced the establishment of 26 Medicare Advantage regions for the new regional PPOs to participate in throughout the country. The regions have been designed to maximize access to plans and providers especially for beneficiaries in rural areas who have traditionally had fewer Medicare plans from which to choose. The establishment of the regions will bring not only more choices, but also more benefits and more savings to millions of Medicare beneficiaries. Now Medicare beneficiaries should be able to save on their health care and prescription drug needs either by joining a Medicare health plan in their local area that offers a drug benefit and other medical benefits or by staying in fee-for-service Medicare and enrolling in a stand-alone prescription drug plan to save on their drug costs.

For the full report, go to our website at www.lrha.org.

LRHA Awarded \$284,000 Grant for Community Network Planning

Louisiana Rural Health Association was awarded \$284,000 from Southeast Louisiana AHEC and HRSA through the Better Health for the Delta State Rural Health Network Development Grant program. The purpose of the Better Health for the Delta program is to provide grants to strengthen the ability of rural community organizations to develop and implement successful multi-parish network projects that address local health care needs in rural Louisiana Delta parishes. The goals are in direct alignment with those established for Healthy People 2010.



Over the past three years, the Louisiana Better Health for the Delta Consortium (referred to as the Delta State Rural Development Network in Phase I) has implemented a systematic approach to the support and empowerment of community partnerships. The Phase I program accomplished this through the development of a Request for Proposal (RFP) process that set forth a clear vision and defined operational requirements. In addition, through the provision of ongoing technical assistance in a learning community environment, the Delta project has helped community partnerships to understand the process of working together to achieve a common cause. This new community partnership infrastructure has created opportunities for communities to improve access to quality health services in rural Louisiana. They are the vehicles for achieving more efficient delivery of services, reducing duplication of services, and identifying new resources to collectively address healthcare access problems.

During Phase II, the Better Health for the Delta Consortium will strengthen previously funded organizations and refine the organizational process established during Phase I. Phase II activities will expand on the successes of the single parish network model by supporting, through an RFP process, the development of "multi-parish network clusters" comprised of 3 to 6 parishes (5 anticipated cluster applications) working collectively to address health related issues that impact all community members in the cluster parishes. Consortium members will advertise funding opportunities and provide technical assistance to currently funded communities to support the organization of network clusters. These network clusters will apply for funding through a Request for Proposal process with oversight from the Consortium. Subcontracts will be awarded to a lead applicant agency with a demonstrated history of fiscal management. Extensive technical assistance will support the development and refinement of cluster networks and their interventions.

See *Better Health for the Delta*, page 7

Bossier City Site of Rural Health Clinic Education Event

The 2005 Rural Health Clinic Education Event, *Rural Health Clinics: Putting the Pieces Together*, was held on January 24 and 25, 2005 at the Horseshoe Casino and Hotel in Bossier City, LA. Over 100 people, including members and non-members of LRHA attended the symposium. The pre-conference event - "*How to Start a Rural Health Clinic*", offered by the Department of Health and Hospitals Bureau of Primary Care and Rural Health (BPCRH) proved to be very successful as it received rave reviews from all in attendance. Manuals containing beneficial information regarding Rural Health Clinic establishment were accessible to every one. If you are interested in obtaining a manual, please contact Beth Millet, Rural Health Officer, DHH Bureau of Primary Care and Rural Health, (225) 342-1889.

State and national updates specific to Rural Health Clinics were addressed, as well as Medicare reimbursement, bioterrorism information, and funding opportunities. Immediately following the conference, the initial meeting of the newly established Rural Health Clinic Constituency Group was held to discuss key issues concerning the delivery of care and reimbursement caps as well as the election of a Constituency Chair. The meeting was well attended by participants and providers. Additionally, the Louisiana Rural Health Information Technology Partnership (LRHITP) held an Advisory Committee meeting, post-conference. LRHITP is an unincorporated association of critical access hospitals and healthcare organizations that has been awarded funding through the Agency for Healthcare Research and Quality (AHRQ) to implement an Emergency Department Electronic Medical Record System. The lead agent for the grant is Assumption Community Hospital, located in Napoleonville.

If you were unable to attend, but would like to receive copies of provided handouts, or if you have any questions regarding the meeting, please call the LRHA office at (985) 369-3813 or email Erin Watson, lrhamembership@bellsouth.net.

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.

- Medicare Modernization Act - Changes Affecting RHCs

Sec. 410— Effective 1/1/2005 RHCs and FQHCs can provide services to patients in a covered Part A SNF stay and bill as an RHC/FQHC service. The CMS Central Office has clarified that this provision also applies to patients in swing beds since they are treated the same as SNF patients. CR 3575 issued 12/10/04 currently limits this expansion to services of physicians, PAs and NPs.



Sec. 611—Effective 1/1/2005 Medicare provides coverage under Part B for an initial preventative physical examination (IPPE) for new beneficiaries provided during the first 6 months after the date the individual was covered for Medicare Part B. This is also known as the “Welcome to Medicare” physical exam. This physical exam will be allowable in the RHC setting as well as the physician’s office setting. This new benefit also includes an EKG. Usual coinsurance and deductible rules will apply. CR 3638 issued 12/22/04 says that for RHCs and FQHCs the IPPE will be billed as an encounter with no HCPCS coding required. The EKG technical component will be separately billed as a non-RHC/FQHC service at the same time as the physical exam service using the new G-code (G0367).

Sec. 612—Effective 1/1/2005 Medicare provides coverage of screening tests for cardiovascular disease. Three tests will be covered: total cholesterol test, cholesterol test for high density lipoproteins, and a triglycerides test, once every 5 years and only following a 12-hour fast. CR 3411 issued 12/17/04 gives instructions.

Sec. 613—Effective 1/1/2005 Medicare provides coverage of diabetes screening tests 82947—glucose, quantitative, blood (except reagent strip), 82950—post-glucose dose (includes glucose), and 82951—tolerance test (GTT), three specimens (include glucose) once every 12 months for persons at risk for diabetes. See the November 15, 2004 Physician Fee Schedule regulation for more details on the definition of “at risk” and the frequency allowed. Billing instructions have not been issued yet.

Sec. 413—Effective 1/1/2005 in most instances Medicare will automatically pay the quarterly 10% HPSA bonus for physician services furnished in a primary care geographic HPSA. This does not apply to RHC services, but can apply to physician (but not PA/NP/CNM) services furnished away from the RHC (e.g., hospital). Since zip codes for the service location are now required as part of the billing process, if the zip code is fully within a geographic HPSA, it will no longer be

See MMA Changes, page 6

Insurance Implications of Charity Care Lawsuits

- from McNeary, Inc. *Insights*

In recent months, dozens of class action lawsuits have been filed by the Oxford, MS based Scruggs Law Firm (of tobacco law suit fame) and several other notable firms. While allegations vary, most allege the defendants overcharge uninsured patients for care, use accounting tricks to exaggerate the amount of charity care they provide, and engage in overly aggressive tactics to collect the bills. While original actions were filed in Federal Court, the latest wave of activity has taken place in state courts.

Potential insurance coverage for claims of this nature should be addressed by your director’s & officer’s (D&O) liability policy. Since D&O policies do not have many standard or uniform terms, coverage will be dependent upon your actual policy language and its applicability to the specific allegations against your hospital.

In the event you are served with a suit, you should immediately file a claim with your directors’ and officers’ liability insurer. Virtually all D&O policies contain a requirement that the insured provide prompt notification of potential claims. Insurance carriers may contend their ability to defend a suit was prejudiced by a delay in notification and applicable coverage could be denied or limited if a claim is not reported promptly.

Once a D&O claim is filed, a hospital can expect a lengthy “reservation of rights letter” from their carrier or its law firm saying it will defend the claim, but is reserving its rights to deny coverage later. These letters will often identify the key coverage issues that may be present in the litigation. Possible key coverage issues in cases of this nature may be centered on anti-trust, non-monetary, punitive, or exemplary damages, dishonest or fraudulent acts, and breach of contract.

In order to protect your facility from possible future actions, it is advisable to seek advice from your state hospital association and the AHA. Helpful recommendations may include:

- Review current charges to ensure they are reasonably related to both the cost of the service and to meeting all of the community's healthcare needs;
- Provide financial counseling to patients about their hospital bills;
- Have understandable written policies to help patients determine whether they qualify for public assistance or hospital-based assistance programs.
- Make sure that all staff members, who work closely with patients, are educated about hospital billing, financial assistance, and collection policies and practices.

Without question, it will take years before these lawsuits and their associated issues are settled. In the meantime, hospitals would be prudent to review their D&O insurance coverage and consider appropriate measures to improve their billing, accounting, collection, and charity care policies with these lawsuits and issues in mind. For a more expansive white paper on this topic please contact Mark Francis at 800/729-4149 or via e-mail francism@mcneary.com.

Senator Jackson Presented with the Outstanding Legislator of the Year

The Louisiana Rural Health Association presented awards in recognition of leadership, service, and innovation to individuals who made a significant impact on the rural health system held in Lafayette, LA on October 25, 2004. Senator Lydia Jackson received the Outstanding Legislator of the Year Award; Susan Moreland presented the award to Jackson on January 24 in Bossier City.



Senator Lydia Jackson co-authored many bills specific to rural issues and was instrumental in Senate Bill 690. Jackson also presented at the LRHA Spring Education Event in Bossier City; at this event she proved that she was familiar with rural issues as well as several LRHA members who are in her district. She serves on the Judiciary C, Finance, Health and Welfare, and Local and Municipal Affairs Committees. Prior to joining the Senate last year, Jackson served as a State Representative. She is the Vice President of Community Outreach for Hibernia Bank. She also served as a Legislative Assistant to Senator J. Bennett Johnson. She is a graduate of Harvard-Radcliffe. She serves on the board of several non-profit organizations including but not limited to: The ARC of Caddo Bossier, Highland Area Partnership, Shreveport-Bossier Service Connection, and the Foundation for the Mid South.

Donna Newchurch presented outstanding legislators of the year to Senator Lydia Jackson

Med Job Louisiana Update

Med Job Louisiana will hold a Regional Recruitment Social in Monroe on March 12, 2005 from noon to 4 p.m. at Kiroli Park in West Monroe. The social will be held in conjunction with the Louisiana State University Health Sciences Center's Monroe Family Practice Residency Program and will provide an opportunity for family medicine residents to meet and network with potential employers in the state.



Med Job Louisiana is planning a number of events for the upcoming year. In the Spring, they are having a Regional Recruitment Social in Lake Charles. A New Doc on the Block is scheduled in Lafayette and a Regional Recruitment Social in Shreveport are both scheduled for the summer. On August, 26 and 27 the Medical Job Fair of Louisiana will be held in New Orleans. In the fall a Regional Recruitment Social will be held in Alexandria.

Med Job Louisiana multi-event packages maximize recruiting dollars. Those interested in participating in these or any other events should contact Clay Coco, Med Job Louisiana Events and Marketing Coordinator at (337) 497-0492 ext. 16.

MMA Changes (continue from page 5)

necessary to use the modifier. More information is in the November 15, 2004 Physician Fee Schedule regulation including the list of allowable zip codes. Billing instructions are available.

CMS clarifies that psychiatrists furnishing services in a mental health HPSA are entitled to the 10% HPSA bonus. Psychiatrists furnishing services in mental health HPSAs that do not overlap with primary care geographic HPSAs are the only physicians eligible to receive the 10% bonus in mental health HPSAs.

Sec. 413—Effective 1/1/2005 Medicare pays a quarterly 5% payment for physician services provided in a physician scarcity area. Like the HPSA Bonus provision, this does not apply to services in an RHC but can apply to RHC physician services provided away from the RHC. This provision does not include services provided by dentists, podiatrists, optometrists, or chiropractors, but only M.D.s and D.O.s. There will be two categories of scarcity: primary care (GP, FP, internal medicine, OB or GYN) and specialty care (all other specialties). The scarcity areas will be determined by the ratio of physicians to Medicare beneficiaries. Only those counties with the lowest ratios that represent 20 percent of the total number of Medicare beneficiaries residing in the counties will be considered for the scarcity payment. In addition, the law also requires that CMS also identify areas that are rural census tracts of a MSA (as determined under the most recent modification of the Goldsmith Modification) as equivalent areas. The most recent modification is the new Rural-Urban Commuting Area codes (RUCAs) developed by HRSA's Office of Rural Health Policy. As with the HPSA bonus payment changes, this payment will also be automated to the fullest extent possible, based upon the zip code of the service location. The November 15, 2004 Physician Fee Schedule regulation has more details and the list of allowable zip codes.



*Region III Health Consortium Members (and LRHA members!)
Troy Brown, Raymond Jetson-DHH Long Term Care Deputy,
Stacy Fontenot, Donna Newchurch, Keith Poche, PA/C and
Wayne Arboneaux*

Better Health for the Delta

(continued from page 4)

Phase II will employ the following key strategies to achieve the Better Health for the Delta goals.

1. Convene and maintain Consortium membership and meetings to oversee all initiatives. This consortium will be known as the Better Health for the Delta Consortium (Consortium).
2. Develop the Phase II Request for Proposals, and refine the established process to award contracts to community-based organizations for network projects that directly address targeted unmet local health needs and have the potential to be national in scope.
3. Provide technical assistance and training to Delta network communities to increase the likelihood of successful outcomes and future successes.
4. Provide technical assistance to garner more federal, state and foundation funding for rural health initiatives in Louisiana.
5. Support the development, expansion, and sustainability of multi-parish comprehensive healthcare networks.
6. Monitor program performance to ensure grantees meet operational and programmatic goals.
7. Support the periodic assessment of community needs, resources and best practices research to guide the prioritization and development of successful approaches to improve community health care access and status.

For more information on the Better Health for the Delta—Phase 2 grant awarded, contact the LRHA office at (985) 369-3813.

Statewide Tobacco Summit

The Louisiana Campaign for Tobacco Free Living is holding the 2005 Summit for Tobacco-Free Living on Wednesday, March 23, 2005 from 9 a.m.—5 p.m. at Southern University in Baton Rouge. There is no cost to attend.

Dr. Stanton Glantz, University of California, will be the keynote speaker at the Summit. Dr. Glantz is a national expert in the health effects of tobacco and secondhand smoke and is one of the founders of the Americans for Nonsmokers' Rights. Dr. Glantz is also a film producer and author of several books, most notably *The Cigarette Papers*, which has played a key role in the ongoing litigation surrounding the tobacco industry. Dr. Glantz's keynote speech will focus on "Secondhand Smoke: Biology, Economics and Politics".

Concurrent sessions at the Summit will include *Case Study: Best practices from a peer state's SHS program, Resources to assist in tobacco control and SHS prevention, and the Importance of eliminating health disparities in LA*, amongst others. Afternoon sessions will include regional action planning and educate attendees on ways to build momentum for creating SFEs in your community.

Partners for the summit include Dr. Fred Cerise, Secretary of Louisiana Department of Health and Hospitals, Southern University, and Louisiana Public Health Institute.

For more information and to register online, visit <http://www.tobaccofreeliving.org>

NRHA Testifies on Medical Liability Reform Tells House Committee Multi-Sector Approach Needed

Washington, D.C —February 17,

2005.) Hilda R. Heady, president of the National Rural Health Association (NRHA), testified this morning before the House Committee on Small Business regarding issues rural Americans face due to rapidly rising medical malpractice costs. Large jury awards, big settlements, and other financial losses to medical insurance companies are triggering rapid increases in the costs of liability insurance premiums. As insurance becomes unaffordable or unavailable for rural providers, doctors are forced to leave their practice and drop vital services. In rural and underserved communities, where access to quality care is already limited, rising liability costs are creating a crisis situation.



"In rural communities across the country, exorbitant malpractice insurance costs are driving providers out of business," said Heady. "they are either shutting down their practices, or moving to states with lower premiums caused by caps on non-economic damages."

In her testimony, Heady cited several examples from her home state of West Virginia of communities losing valuable physicians across state borders where insurance premiums are much lower. As a result, many rural communities have been left without OB or orthopedic services, among other specialties. In areas where service still exists, options are very limited. Heady told members of the committee that a multi-sector approach was needed to address this crisis.

"The medical community, legal community, insurance community, and consumers are all invested in this problem and each has a piece of the solution." Heady added. "Congress must bring all these sectors together to solve this crisis once and for all."

The full testimony can be found at www.nrharural.org/pagefile/liabilityTestimony.pdf

The Louisiana Campaign for Tobacco-Free Living
sponsors the

2005 Summit for Tobacco-Free Living

WHEN: Wednesday, March 23, 2005
9 a.m.— 5 p.m.

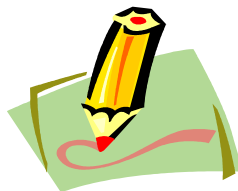
WHERE: Southern University
Baton Rouge, LA

No cost to attend. For more information and to register online, visit <http://www.tobaccofreeliving.org>

S F F E
SMOKE - FREE ENVIRONMENTS
A Firsthand Look at Secondhand Smoke

Medicare Contractor Provider Satisfaction Survey – Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) recently announced the launch of the Medicare Contractor Provider Satisfaction Survey (MCPSS), a new initiative designed to collect data on provider satisfaction with and perceptions about the services provided by Medicare Fee-for-Service (FFS) contractors. The MCPSS was sent to a random sample of approximately 8,200 Medicare FFS providers in January 2005.



The survey gives providers the opportunity to rate their Medicare contractor on seven administrative functions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider reimbursement. The CMS values the opinions of the Medicare physician and provider community and understands the important role that FFS contractors play in representing the Medicare program to providers. **The MCPSS represents an important opportunity for providers to be heard.**

Westat, a survey research firm, is administering the MCPSS. Providers who received the survey notification packet can access the survey instrument on a secure Internet Web site or may request a paper copy and submit their responses via mail or fax. All information collected will be kept completely confidential, and individual providers will not be identified. Data collection for the pilot will continue through March 31, 2005. **If you received a survey notification packet, please complete and submit your survey responses as soon as possible.**

For questions regarding the MCPSS, please contact the MCPSS information line at 1-888-863-3561 or MCPSS@westat.com . For further information and updates, please visit <http://www.cms.hhs.gov/providers/mcpss/default.asp> .

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