

The 2007 Report to the Secretary: Rural Health and Human Service Issues

NACRHHS

**The National Advisory
Committee on Rural Health and
Human Services**

January 2007

Acknowledgements

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The Committee is grateful to many others, too numerous to mention, for their support of the Committee's mission to inform and make recommendations to the Secretary and others on the state of health and human services in rural America.

Sincerely,
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For Committee members' biographies, please visit the National Advisory Committee on Rural Health and Human Services web site at: <http://ruralcommittee.hrsa.gov/>.

Committee membership never exceeds 21. Please note that six new members joined in calendar year 2007; their terms are listed above.

About the Committee

The National Advisory Committee on Rural Health and Human Services (NACRHHS) is a 21-member citizens' panel of nationally recognized rural health and human service experts that provides recommendations on rural issues to the Secretary of the Department of Health and Human Services. The Committee, chaired by former South Carolina Governor David Beasley, was chartered in 1987 to advise the Secretary of Health and Human Services on ways to address health and human service problems in rural America.

The Committee's private and public-sector members reflect wide-ranging, firsthand experience with rural issues in medicine, nursing, administration, finance, law, research, business, public health, aging, welfare and human service issues.

Each year, the Committee highlights key health and human service issues affecting rural communities. Background documents are prepared for the Committee by both staff and contractors to help inform members on the issues. The Committee then produces a report with recommendations on those issues for the Secretary by the end of the year. The Committee also sends letters to the Secretary after each meeting. The letters serve as a vehicle for the Committee to raise other issues with the Secretary separate and apart from the report process.

The Committee meets three times a year. The first meeting is held in early winter in Washington, D.C. The Committee then meets twice in the field (in June and September). The Washington meeting usually coincides with the opening of a Congressional session and serves as a starting point for setting the Committee's agenda for the coming year. The field visits include ongoing work on the yearly topics with some time devoted to site visits and presentations by the host community.

The Committee is staffed by the Office of Rural Health Policy, which is located within the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Additional staff support is provided by the Administration on Children and Families, the Administration on Aging and the Office of the Secretary's Office of Intergovernmental Affairs.

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Common Links

This report confirms the ongoing challenge of delivering specific health and human services in rural areas. One common link is the low volume of patients or clients in rural areas, which creates high fixed costs for any provider. In addition, finding individuals to provide the specific services is also a common challenge. Substance abuse counselors and early childhood education teachers for Head Start are a scarce resource in many rural communities. Medicare Advantage plans face the challenge of arranging a network of rural providers through which to serve their enrollees. The challenges are many and diverse and yet the Committee also witnessed communities in its site visits that have managed to survive and overcome the obstacles, even if that success may be tenuous.

About the Report Format

In this *2007 Report*, the Committee provides the current national context for each chapter's topic in the section, "Why the Committee Chose This Topic."

Then, the discussion moves from the national level onto rural-specific issues in the chapter section, "What Is Known About (the Topic)."

Next, the Committee highlights the work of HHS and other governmental agencies in "Current HHS and Governmental Role."

The Committee then offers a "Conclusion" and its "Recommendations" for the Secretary on how HHS can address some of the obstacles and challenges related to the topic.

Executive Summary

This is the *2007 Annual Report* by the National Advisory Committee on Rural Health and Human Services to the Secretary of Health and Human Services. This year's report examines three key topics in health and human services and their effects in rural areas: Medicare Advantage, Head Start and substance abuse. All are pertinent and timely issues that the Committee chose during its March 2006 meeting.

Medicare Advantage in Rural Areas

Medicare Advantage (MA) is a program that provides health care benefits for elderly Americans through private insurance companies. The program provides comprehensive coverage for Medicare Parts A and B and often Part D. Though overshadowed by the addition of the Part D Prescription Drug Benefit, MA is one of the largest changes to come out of Medicare reform legislation in 2003. The intention of the MA program is to increase the number of Medicare beneficiaries enrolled in private plans and to utilize natural competition between plans to lower costs and improve quality for beneficiaries. In attempting to determine Medicare Advantage's impact on rural America, the Committee looked at available research and received formal testimony from representatives of insurance companies, senior aid organizations and hospital administrators.

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. In addition, rural providers and the beneficiaries they serve often have less experience with managed care. This makes Medicare Advantage a topic of particular importance for rural areas. At the end of its analysis, the Committee remains especially concerned over a number of issues relating to MA. The Committee is concerned about the less stringent oversight of Regional Preferred Provider Organizations (RPPOs) and Private Fee for Service (PFFS) plans than Health Maintenance Organization (HMO) plans. The RPPO and PFFS plans are the most dominant plans in rural areas, so they remain an important consideration to the Committee.

RPPO plans are required to gain a certain density of network providers within their geographic area or provide out-of-network services to beneficiaries at in-network cost-sharing levels. The Committee is unsure of the Centers for Medicare and Medicaid Services' (CMS') approach to compliance with this requirement and has concerns about its implementation. PFFS plans are available in 96 percent of rural counties, and the Committee is concerned whether PFFS plans will honor cost-based reimbursement rates that many rural providers are entitled to under current Medicare regulations. Additionally, the Committee is concerned about the contract

negotiation process between PFFS plans and rural providers, who may have little managed care experience.

Beneficiaries also have had trouble adjusting to Medicare Advantage. The Committee has heard testimony from a number of sources referring to confusion on the part of beneficiaries as to their enrollment in a MA plan, and the plan's terms. Additionally, the Committee is concerned that many senior citizens are enrolling in MA plans that include Part D Prescription Drug coverage when they believe they are only enrolling in a Part D plan. Providers have reported to the Committee that they have seen cases of beneficiaries paying both MA and supplemental insurance premiums, wasting often-scarce resources on a supplemental policy that has no effect.

The issues raised in this report are still unfolding, but the Committee is generally concerned with the effect of Medicare Advantage on rural providers and beneficiaries. CMS and Congress assert that MA plans have the potential to improve the quality of health care for rural beneficiaries. On site visits to Maine and North Dakota, the Committee heard a number of groups describe the confusion surrounding MA for both beneficiaries and providers, and the complexity of issues relating to reimbursement, in- and out-of-network coverage and the confusion of MA with prescription drug coverage. The Committee believes the relationship between beneficiaries, providers, plans and CMS must be well integrated if MA is to improve the health care landscape for rural Americans.

In the Committee's examination of the issues surrounding Medicare Advantage and its impact on beneficiaries and providers, the Committee makes several recommendations to the Secretary, including:

- The Secretary should charge CMS with providing enhanced information that will allow beneficiaries to make well-informed decisions, particularly for rural beneficiaries who have less experience with managed care.
- The Secretary should charge CMS with establishing a web site where providers can

instantly verify beneficiaries' current plan enrollment. Many rural providers have found it difficult to verify beneficiaries' plan enrollments. At times beneficiaries are unsure about their coverage and providers cannot easily access that information. CMS should increase ease of access to its Common Working File via a secure web portal and ensure that its information reflects beneficiaries' current enrollment. This web site would allow all providers ease of access, which would ensure more efficient reimbursement transactions and less administrative work for the providers.

- The Secretary should ensure that CMS provide current enrollment data in a timely manner, so rural enrollment can be tracked. In researching this chapter, the Committee has been extremely frustrated by the delays in the expected release of county-level enrollment data for MA-only plans (i.e., those MA plans that do not include a Part D benefit). Typically, CMS reports the quarterly enrollment data within a few weeks after the end of the quarter. However, 2006 data was not released until September 2006 and was released in a format that prohibits rural-specific analysis. Further county-level data was not released until December 2006. Since health plans are required to report enrollment data on a monthly basis, it is unclear why CMS has been so late in releasing the data to the public. The lack of data hampers efforts by the Committee and others to determine MA's full impact on rural communities.

Head Start in Rural Communities

Head Start is a comprehensive early childhood development program for children aged three to five whose family incomes fall below Federal poverty standards. The goal of Head Start is to provide school readiness skills, health screenings, family involvement and community support for disadvantaged pre-school aged children. It is

administered through the Department of Health and Human Services (HHS), Administration for Children and Families (ACF). Grants are provided from regional ACF offices to local delegate and agency grantees. Since its inception in 1965, Head Start has served over 22 million children, providing a bridge to public education by ensuring children have the skills to succeed when they arrive.

Although data is available to support the success of Head Start generally, little research has been conducted on the effects of Head Start in rural communities. Child poverty in rural America is a serious and pervasive issue, prompting the Committee to analyze how Head Start affects rural children and families. In doing so, it looked at what issues present special challenges to the continuation of the Head Start programs. In site visits, personal interviews and data analysis, the Committee found that the main challenges to rural Head Start programs centered upon transportation, programmatic requirements, access to appropriate health and oral health care, and enrollment fluctuations.

The Committee discovered during its discussions with rural Head Start providers that safety requirements hindered the provision of transportation services. High fuel costs coupled with long driving distances also presented a transportation barrier to the distribution of Head Start services. Some of these concerns have been addressed through a waiver that sites may use to bypass requirements. The Committee believes this new transportation waiver should be promoted in rural areas. Another concern voiced by many of the site leaders was that small changes in a family's income could result in the child being pulled from the program. Local Head Start agencies have the authority to enroll up to 10 percent of participants from families that exceed the Federal poverty requirements, but the Committee recommends research into whether the poverty level requirement should be more flexible to allow more children access to these essential services.

In its discussions with Head Start coordinators and site visits, the Committee discovered widespread satisfaction with the positive effects Head Start has on rural communities. Both the Maine site and the North Dakota site had long

waiting periods for their services. Early Head Start, an educational and parental training program serving children from before birth to age three, is especially sought after in rural communities. In some rural areas Head Start and Early Head Start offer the only source of child care or structured preschool. The success stories of these and other rural sites prompt the Committee to make recommendations strengthening and continuing Head Start in rural communities.

Despite a lack of statistical data, the Committee makes several recommendations to improve the availability of Head Start services in rural areas including the following:

- The Secretary should support research to determine the feasibility and impact of an increase in the percentage of children who can be enrolled in Head Start from families with incomes that exceed the Federal poverty line. This will help preserve small rural programs that may fall short of minimum enrollment requirements.
- The Secretary should support widespread dissemination of information about transportation waivers, especially to rural Head Start sites.
- The Secretary should support grant programs to demonstrate and reinforce collaborative arrangements between Head Start grantees and other public and private programs in the areas of oral health and health care services for Head Start children.

Substance Abuse in Rural Areas

Substance abuse is one of the most serious problems confronting rural Americans today. Regional isolation coupled with a scarcity of treatment facilities can lead to populations with high abuse rates and few avenues for treatment. Many types of substances are abused in rural America, but several stand out to the Committee as particularly noteworthy due to their prevalence and deeply felt

effects in rural areas. The Committee has focused on alcohol, methamphetamine and narcotics addiction for its 2007 report.

Alcohol remains the most widely used and abused substance in the United States. This is particularly true in rural America where high unemployment and poverty rates create an elevated risk for all substance abuse. Underage drinking is an alarming component of the rural alcohol problem. This report highlights research showing that youths living in rural areas are more likely to engage in binge drinking than their urban counterparts. The prevalence of problem drinking among adults 65 and over is also a serious issue for rural America, as rural populations age and face increased risk factors that can lead to alcoholism.

Methamphetamine has quickly spread over the landscape of rural America, and recent publicity has highlighted the damage it causes. Easy to make in rural settings, “meth labs” have sprung up in many different sectors of the United States. Small-time users can shift into large-scale dealers with the aid of just a few commonly found household chemicals and products. Methamphetamine usage rates are higher for rural residents than for urban people, and the differences are even more pronounced among rural young adults ages 18 to 25. Despite increased media attention, the methamphetamine problem seems to only be worsening in rural America, necessitating increased vigilance from all sectors of society.

Similarly, narcotics abuse, and prescription drug or OxyContin abuse in particular, also affects rural areas much differently from urban locales. Young adults in medium to small rural areas use OxyContin at a rate 1.5 times higher than their urban counterparts. The use of these prescription pain medications has been especially pronounced in rural mining communities where long-term physical stress has led thousands to seek medical relief, which then can lead to dependence and addiction. Dealing OxyContin is a tempting way to supplement low rural incomes as those with prescriptions can sell the drug at a significant profit.

Substance abuse is a serious problem in rural areas, and preliminary data shows that young adults there outpace their urban counterparts in the consumption of alcohol, OxyContin and

methamphetamine. However, fewer resources are available to combat addiction in rural areas. Access to services is often hampered by transportation difficulties and associated stigma in seeking treatment in small communities. Federal grant programs have been created to address these shortcomings in service delivery programs, but the Committee believes that more must be done to assure that substance abuse in rural America is effectively prevented and treated.

From an analysis of current research into substance abuse in rural areas, the Committee makes the following recommendations to the Secretary:

- The Secretary should examine the Substance Abuse Prevention and Treatment Block Grant Program formula to determine if the reliance on population size puts rural areas at a disadvantage in qualifying for funding. Findings from this assessment should be shared with the Congress and the governors.
- The Secretary should work with the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand its National Registry of Evidence-Based Programs and Practices to include a section of rural-specific programs and practices.
- The Secretary should require SAMHSA to increase sample sizes in its research activities by over-sampling rural zip codes in survey activities. This would allow sub-state and regional analyses, provide a more robust data sample and ensure adequate representation of rural residents.

Medicare Advantage in Rural Areas

Why the Committee Chose This Topic

Medicare has been a dominant player in rural health care since its inception. The enactment of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 fundamentally changed how most older Americans access health care and, in turn, the future of services available in rural communities. Two of the major changes resulting from the MMA are the addition of the prescription drug benefit to the Medicare program and the redesigning of Medicare+Choice (M+C) into Medicare Advantage (MA). While the addition of the prescription drug benefit plan was much publicized, the greater long-term impact stemming from the MMA changes may be the increased emphasis on the “privatization” of Medicare through MA plans.

As a result of the MMA, M+C, which provided Medicare benefits through private insurance companies, was restructured and renamed Medicare Advantage. The changes were intended to address two public policy goals: 1) substantially increase the number of Medicare beneficiaries enrolled in private health plans, and 2) utilize competition among private plans and between plans and the traditional Fee-for-Service Medicare program to lower cost and improve quality.

The number of plans offered and beneficiaries enrolled under MA is expected to be greater than that experienced under previous Medicare managed care programs. M+C plans were offered primarily in metropolitan areas and appealed to generally healthier and wealthier beneficiaries as a replacement for “Medigap” supplemental insurance plans. One of the goals behind the various changes involved in the transition to MA was higher enrollment for rural populations. These changes include the addition of Regional Preferred Provider

Organization (RPPO) plans, large financial incentives to insurers to encourage the growth of MA plans and more robust risk adjustment.

With the creation of MA and Part D drug plans, legislators tried to utilize the economic leverage large insurers have in the marketplace, which enables the insurers to obtain items and services for Medicare beneficiaries at more competitive rates by taking control of demand. One of the primary ways to accomplish this is to control access to care and demand discounts, often in exchange for promises of increased volumes of patients. In urban settings such behavior can lead to financial instability in the hospital community with pressure for ever-greater discounts. For rural areas, MA may have a similar built-in disadvantage. Plans purchase services from a network of rural providers whose financial well-being is much more fragile than in urban settings and where there is little excess capacity.

The Committee's concerns, laid out in detail below, focus on a myriad of instances in which the substitution of MA for traditional Medicare may have the effect of stripping from many of the rural providers critical financial supports embedded in traditional Medicare as a result of more than 20 years of efforts by policymakers to create a stable health care environment in rural areas. CMS needs to monitor the impact of these plans on rural providers closely to assure that they continue to exist and provide access to care for Medicare beneficiaries in rural areas.

The Committee is concerned that if MA is implemented in a manner that is not sensitive to the rural context, it could adversely affect the health care delivery system in rural communities. Medicare payments can account for as much as 80 percent of in-patient revenues for small rural hospitals.¹ While the Committee is concerned about

¹ Claude Earl Fox, M.D., Administrator, Health Resources and Services Administration. Testimony before the Senate Subcommittee

MA overall, this chapter will focus on RPO and Private Fee-for-Service (PFFS) plans since these plans are the most prevalent in rural areas.

Though the Committee has significant concerns about MA and how it may affect rural beneficiaries and rural communities, it also recognizes that MA plans, administered correctly, have the potential to improve the quality of health care for rural residents. Many MA plans are designed to coordinate care for beneficiaries and to provide beneficiaries with services that are not offered by traditional Medicare, such as eye exams and annual physical exams.

The Committee also is concerned that beneficiaries rural and urban alike are not adequately prepared for the changes brought about by the MA program. The complexity of the MA program and the accompanying prescription drug benefit has left many beneficiaries confused. Further steps need to be taken to ensure that all beneficiaries sufficiently understand MA plans. The Committee believes CMS should devote considerable effort to simplifying the program, monitoring marketing activities and making sure beneficiaries understand the difference between enrollment in different types of plans as it compares to traditional fee for service.

Moreover, the shift could create undesirable changes in the rural health infrastructure by altering the ways in which beneficiaries, providers, private health insurance plans and the Centers for Medicare and Medicaid Services (CMS)—the government agency that manages the Medicare program and MA plan contracts—relate to one another. When these relationships are altered, issues of adequate access for the beneficiaries and the long-term impact on the rural health care infrastructure must be closely examined.

The MMA includes extensive discussion of quality improvement activities for the MA program. However, the requirements for PPO and PFFS plans, the most common types of plans available in rural areas, are significantly less stringent than for

health maintenance organizations (HMOs), the most common type of plan in urban areas. This is a significant concern for the Committee. While HMOs are required to collect and publicly report data on the quality and outcomes of all services provided to their enrollees, PPO plans are only required to collect and report data on services provided by and outcomes related to contracted providers.

Furthermore, the Committee is apprehensive that the success of MA plans, which historically have enrolled healthier, lower-cost beneficiaries than traditional Medicare,² will have a negative effect on the traditional Medicare program, potentially leaving it with a disproportionate number of sicker and older patients. This may result in traditional Medicare being burdened with higher costs, thereby increasing the pressure to reduce its benefits and provider payments.

Additionally, the Committee is concerned that the MA bidding process creates inequities in the availability of plans with reduced cost sharing or additional benefits in rural areas. CMS sets benchmarks for the cost of providing Medicare benefits in each county. Plans then submit bids for each of the local areas or regions in which they would like to offer an MA plan. If a plan bids below the benchmark amount, then 25 percent of the difference is retained by the Medicare program and the remaining 75 percent is paid to the plan along with the benchmark amount. The additional funds are required to be used for cost sharing, to reduce beneficiary premiums or to provide additional benefits such as dental or vision.

The benchmarks are based on historical Medicare Fee-for-Service payments at the county level, and therefore, there is geographical variation in the benchmark amounts. In general, urban areas with high physician-to-patient ratios have higher rates of utilization and consequently higher benchmark rates. Rural areas with low physician-to-patient ratios have lower utilization and, therefore, lower benchmark rates. Under this

on Labor, Health, and Human Services, Education and Related Agencies on the Potential Crisis Facing Rural Hospitals and the Impact on Rural Communities, July 14, 1999.

² Biles, B., Dallek, G., & Nicholas, L. H. "Medicare Advantage: Déjà vu All Over Again?" *Health Affairs*. (Web exclusive). Posted December 15, 2004. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.586>.

system, plans with aggressive care management and provider contracting that enter areas with high utilization and high benchmark rates can bid well below the benchmark and generate savings for beneficiaries. Because many rural areas have low utilization and low benchmarks, these areas do not have the same opportunities for cost saving through utilization management and lower provider payments. The result is that beneficiaries in rural areas are less likely than those in urban areas to have access to MA plans with low premiums, reduced cost sharing or additional benefits.

The Committee believes that the opportunities for additional savings and benefits should not be based on a system that only rewards areas with excess utilization and does not provide incentives to maintain reasonable utilization in those places where the amount of care provided is already at a minimum.

What Is Known About Medicare Advantage in Rural Areas

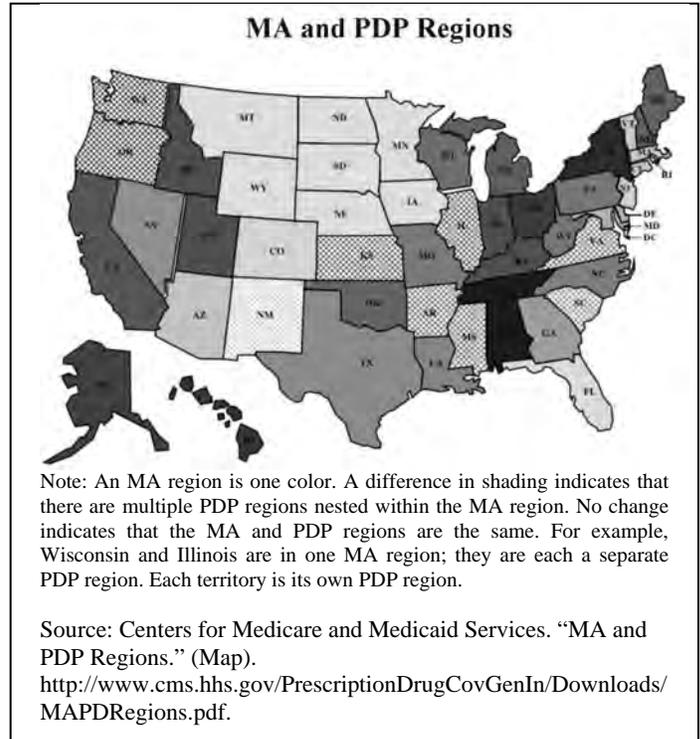
General Information About Medicare Advantage

The MA program was previously known as Medicare+Choice and maintains the same basic structure with a few notable exceptions. The changes particularly relevant to rural communities are the creation of RPPOs and the increased prevalence of PFFS plans in rural areas.

Regional Preferred Provider Organizations (RPPOs)

RPPOs are MA plans that must provide uniform benefit packages and premiums throughout a predetermined region of the country that includes both rural and urban areas.³ (See Figure 1.) They differ from other MA plans in this respect since all

Figure 1



other types of MA plans are able to determine their own service area. As an incentive for the growth of RPPOs, Congress placed a moratorium on the creation of new Medicare local PPO plans. To further encourage plans to join as RPPOs, the MMA created a "stabilization fund" of \$10 billion dollars that CMS can draw from to increase the regional benchmarks (i.e., payments) and make bonus payments to the RPPOs between 2007 and 2013.⁴ With the creation of RPPOs, Congress intended to encourage the growth of private plans in rural areas.

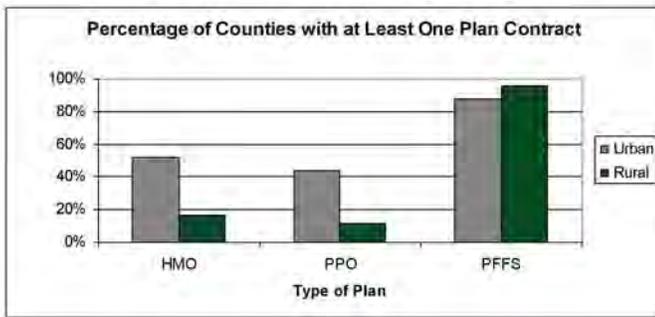
Private Fee-for-Service (PFFS)

Unlike other MA plans, PFFS plans are similar to traditional Medicare in that they do not include a care management component. Presently, PFFS plans are in 96 percent of rural counties and are the most prevalent type of private Medicare plan in rural areas.⁵ (See Figure 2).

⁴ Congressional Budget Office. (October 2004). *CBO's Analysis of Regional Preferred Provider Organizations Under the Medicare Modernization Act*.
<http://www.cbo.gov/showdoc.cfm?index=5997&sequence=0>.

⁵ Scott Harrison and Jennifer Podulka. "Medicare Advantage and

³ Vastag, B. (January 2006). "Payment. M+C Redux?" *Hospitals and Health Networks*.

Figure 2

Source: Unpublished 2005 CMS data.

There are two models of PFFS plans. One PFFS model allows PFFS plans to operate without a contracted network of providers, but the plans must pay all providers at rates that are comparable to traditional Medicare rates.⁶ The other model allows PFFS plans to pay providers at rates lower than traditional Medicare, but requires plans to create formal provider networks that meet community access standards.

Under both models, providers can be “deemed” to be members of the PFFS plan network, meaning they have agreed to accept the plan’s terms and conditions, including the rate of payment. Three conditions must be met in order for a provider to be deemed a member of the PFFS plan network. The provider must know that the patient is a member of a PFFS plan, the provider must be aware of a PFFS plan’s terms and conditions, and the provider must perform a covered service for the patient. Providers are assumed to be aware of the plan’s terms and conditions as long as the plan makes the information available through such means as telephone, mail or the Internet. If all three conditions are met, the provider is deemed to be a contracted member of the PFFS plan’s provider network. As a deemed member of the PFFS plan network, a provider must accept as payment in full whatever rate that particular PFFS plan pays their

other contracted providers. For PFFS plans with formal networks of contracted providers (providers that sign contracts with the plan as opposed to being deemed), this may mean that the providers must accept payments below the traditional Medicare rates, or choose not to treat the patient.

The Committee is concerned that as PFFS plans gain market share, more of the PFFS plans will use the option of formal provider networks and will negotiate rates below the cost of care in rural communities. The network PFFS model is currently being used by only two PFFS plans and only for hospital services; however, it seems likely that more PFFS plans will use the network model in the future.

Supporting Rural Data for Medicare Advantage

In prior years CMS has released data with county-plan enrollment for all Medicare managed care plans (with some privacy constraints regarding small numbers) on a quarterly basis. This data allowed researchers and policy analysts to compare rural and urban enrollment patterns. That enrollment data release process was delayed this year and CMS did not release data until December of 2006. The Committee is pleased that CMS finally released the data. However, it also urges CMS to return to its original policy of releasing this information on a quarterly basis and with enough detail to allow meaningful rural-urban comparisons.

An initial analysis of this data by researchers at the Rural Policy Research Institute (RUPRI) shows that PFFS plans represent 44 percent of prepaid plan enrollment in rural areas, but only 9 percent in urban. This indicates that these types of new MA plans have a much bigger effect in rural areas and on rural providers and Medicare beneficiaries. Regional PPOs represent approximately 2.3 percent of prepaid plan enrollment in rural areas compared to 1.2 percent in urban areas. These numbers are quite low, but not necessarily cause for concern. The regional PPOs are new Medicare options for beneficiaries and it is to be expected that it will take a while for plans to create serviceable networks and educate beneficiaries about the viability of this type of plan.

Special Needs Plans.” Presentation at Medicare Advantage: Availability, Benefits, and Special Needs Plans. Meeting hosted by the Medicare Payment Advisory Commission (MEDPAC), April 19-20, 2006.

⁶ Centers for Medicare and Medicaid Services. (November 15, 2002). *Private Fee-for-Service---Providers Questions and Answers*. MedPAC.

Key Rural Issues

Role of Community Access Standards

The MA program statutes and regulations require that CMS ensure that plan enrollees have reasonable access to covered services,⁷ and CMS has emphasized its commitment to providing that access.⁸ How CMS and MA plans interpret what is “reasonable” access by beneficiaries to local health care is critically important to rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities. The past operational policy of CMS has supported using community access standards when making network adequacy determinations. As made explicit in the *CMS Medicare Managed Care Manual*: “Plans must...ensure that services are geographically accessible and consistent with local community patterns of care.”⁹ This policy did not change with the advent of MA, but the Committee has not been able to determine how or whether CMS is enforcing this provision with PFFS and RPPO plans.

If beneficiaries enrolled in an MA plan are not well informed about their rights to access care locally, they are less likely to exercise that right. This knowledge is particularly important for enrollees in RPPO plans, since they may have the option of obtaining services from non-network providers at in-network rates if their plan’s provider network is inadequate in their area. If CMS does not diligently monitor and enforce plan compliance, plans will have significantly less incentive to contract with a region’s rural providers, undermining the rural health infrastructure in that region’s communities. As long as the current uncertainty and lack of transparency regarding

access and network adequacy persist, rural beneficiaries and the providers that serve them will be less likely to consider MA plans a viable alternative to traditional Medicare.

The Committee is further concerned that lax enforcement of network adequacy will discourage MA plans from contracting with rural providers. Due to their low patient volumes, the fixed costs of operation are high for many rural providers. As a result, rural providers may require payment rates above those offered in urban areas in order to remain in business. Also, there are generally few providers in rural areas. Without the ability to guarantee increased volume in return for lower payment, it can be difficult for plans to negotiate low rates if rural providers are necessary for the plan to meet network adequacy requirements. The Committee believes that this is what contributed to M+C being a largely urban-specific model. If health plans are allowed weak networks of providers in rural areas, plans might steer rural beneficiaries away from their established health care providers. This could force some to commute a greater distance to new providers, in the process disrupting the web of provider linkages that have traditionally treated those beneficiaries and other rural residents.

This dynamic also has the potential to put beneficiaries and the providers that serve them in a difficult situation. The beneficiaries may not know that they are in a private fee-for-service plan and that by receiving care from their local practitioner, they have forced a difficult choice on him or her. If the provider sees any of the beneficiaries, he or she has, in effect, joined the network and accepted its rates with no power to negotiate. If the provider turns the beneficiaries away, there may not be another local provider for the beneficiaries to see. This is more of a potential problem in rural areas given the lower number of health care providers.

Regional Preferred Provider Organizations

In an effort to encourage health insurers to join as RPPOs, CMS established rules that allow it to approve RPPOs that do not have contracted provider networks that meet community access standards. The rules permit RPPOs with inadequate networks to be approved if they demonstrate to

⁷ Social Security Act §1852(d), 42 CFR 422.112 and 42 CFR 422.114.

⁸ Department of Health and Human Services, Centers for Medicare and Medicaid Services. (January 28, 2005). “Medicare Program; Establishment of the Medicare Advantage Program; Final Rule.” *Federal Register*, p. 41.

<http://www.cms.hhs.gov/EmployerRetireeDrugSubsid/Downloads/MMAFinalTitleIIFederalRegister.pdf>.

⁹ Centers for Medicare and Medicaid Services. *Medicare Managed Care Manual*. [Internet-Only Manuals]. “Benefits and Beneficiary Protections” (Chapter 4), p. 57.

<http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

CMS that they have established policies that allow beneficiaries living in the underserved areas to access out-of-network providers at in-network cost-sharing levels. However, it is not clear how CMS is implementing the rules. The Committee is concerned that this ambiguous approach to the network approval process makes it nearly impossible to evaluate the consistency of CMS' enforcement of access standards across plans, markets and time.

Private Fee-for-Service

The deeming process under the PFFS network model bypasses the usual plan-provider contractual negotiations. Rural providers that do not join the PFFS plans initially may be “deemed” when their patients enroll in PFFS plans and return for care. Many rural providers have voiced frustrations that after their patients enroll in a PFFS plan they are compelled to join the plan on a de-facto basis to serve their regular Medicare patients.

Other Beneficiary Issues

The recent changes to MA may dramatically affect the availability of health care in rural communities if beneficiaries are unable to use local services. The Committee has heard multiple testimonies describing confusion among beneficiaries and providers and would like more outreach by CMS.

Private plans often have many different options for benefits and cost sharing. Rural beneficiaries have less experience with managed care than other beneficiaries, creating cause for concern over an increasing reliance on managed care for Medicare services. While many options allow choice, too much variation among plans can be difficult for the elderly, especially rural elderly who do not readily have access to information resources such as the Internet.¹⁰ Furthermore, national advocates for the elderly have indicated that beneficiaries can be confused as to what benefits are covered under the plans. The confusion extends to the type of private plans (HMOs, local PPOs, RPPOs and PFFS) and the relative merits of the different plans in

Beneficiaries' Perspectives on Medicare Advantage Plans

In testimony to the Committee, Deborah Totten, an official working for a senior aid organization in upstate New York, highlighted certain issues regarding beneficiaries' perspectives on MA plans enrollment in her area. Based on MA plan enrollment data collected by her organization, Totten said enrollment in their area has seen only a modest increase since January 2006. One of the factors suspected to be contributing to the low enrollment is the pull-out of managed care in that region in the late 1990s. The region's Medicare beneficiaries are wary of managed care plans and often express concerns that plans will not be available from one year to the next. Ms. Totten observed that, more than choices and savings, Medicare beneficiaries want to be able to rely on and trust their plans. The beneficiaries are not necessarily looking for new options, rather, they are looking for trusted products.

Other MA issues that Ms. Totten raised centered on the confusion by beneficiaries given the many choices. There is a lack of one-on-one, personalized assistance for the beneficiaries. Additionally, there is a lack of materials that would allow beneficiaries to measure and compare the plans and their relative merits. For instance, in Broome County, New York, there are two plans, Excellus Plan II and Excellus Plan III. Both have a co-pay of \$24. Only in close examination would the beneficiaries realize that Excellus Plan II is intended for the medically stable who do not need to access services on a regular basis. In contrast, Excellus Plan III is intended for beneficiaries who need frequent medical attention.

Source: Deborah Totten, Assistant Director, Action for Older Persons, Inc. Presentation to the National Advisory Committee on Rural Health and Human Services. Camden, Maine, June 11, 2006.

¹⁰ Biles, B., Dallek, G., & Nicholas, L. H. “Medicare Advantage.”

The Argument for Future Medicare Health Plan Growth in Rural America

During a site visit to Maine, the Committee met with representatives of Anthem Blue Cross and Blue Shield to discuss their decision-making process for providing a Medicare Advantage (MA) plan in a targeted area. In particular, the Committee wanted to learn why Anthem currently does not offer a plan in the state of Maine despite deep penetration in the Northeast MA market.

Anthem representatives shared that considerable time goes into developing provider networks, particularly in rural areas where private plans have been less active compared to metropolitan areas. They also hypothesized that the great number of resources focused on Medicare Part D implementation in 2005 and early 2006 initially decreased health insurer attention on building MA programs. Anthem representatives stated that many health care insurers utilize the Part D program as a mechanism to initially gain market share in rural areas. After gaining enrollees, those plans attempt to move the beneficiaries into MA plans. The Committee also learned that health insurers often plan to enter certain rural markets with PFFS plans initially and then launch coordinated care plans such as RPPOs, local PPOs or HMOs, depending upon their success and their viability in the particular market. Though Anthem did not previously offer an MA plan in Maine, it will introduce a plan in 2007.

The Anthem representatives cited four dimensions in making its decision to enter an MA

market: economic and demographic factors; health system utilization and provider contracting; the regulatory environment; and Medicare reimbursement, funding and opportunity costs.

Anthem representatives felt that Maine's modest economic and demographic outlook has contributed to slow MA adoption in the region. In addition to MA plans, companies look at the success of their entire health insurance portfolio when entering specific markets. If their success in the commercial market is limited, then the company is less likely to offer an MA plan in that area.

The Anthem representatives asserted that rural markets became significantly more attractive to health plans since CMS began higher risk-adjusted payments for rural areas with the move to MA plans. This new policy helps mitigate barriers MA plans face when moving into an area where beneficiary utilization is higher, and as a result may have higher than average medical expenses. By enacting this risk-adjustment change, Congress intended to incentivize MA plans to provide services to those who have conditions more costly to treat while providing additional opportunities for chronic disease management.

Source: George Siriotis and Laura Schuntermann, Anthem Blue Cross and Blue Shield. Presentation to the National Advisory Committee on Rural Health and Human Services. Camden, Maine, June 12, 2006.

comparison to each other. The MA plan descriptions distributed to beneficiaries do not fully describe the nuances of these plans and the complications that might arise from choosing providers that do not belong to the plans' networks.

Given the greater freedom to interact with providers and beneficiaries that these MA plans have, the Committee is concerned about potential abuse of the system. Recently, the HHS Office of the Inspector General (OIG) announced that the Office is evaluating whether certain health insurers are coercing the beneficiaries to enroll in an MA plan that would include prescription drug benefit (MA-PD) versus a stand-alone Prescription Drug

Plan (PDP). The OIG is in particular examining whether "high-pressure sales tactics" have been used.¹¹

Effects of Medicare Advantage on the Existing Rural Medicare System

The Committee is interested in the effects of MA plans contracting on the existing rural add-on payments for providers. All MA plans, except non-

¹¹ Japsen, B. (February 24, 2006). "Drug Plan Sales Tactics Probed: Seniors Allegedly Steered into HMOs." (Feb 24, 2006). *Chicago Tribune*. Business section, p. 1.

network model PFFS plans, are permitted, but not required, to negotiate payment rates with providers at levels below that of traditional Medicare. This is a process that seems to favor MA plans, particularly in rural areas where providers may have little managed care contracting experience or in rural communities within driving distance of urban-based providers.

Under the traditional Medicare program, many rural providers receive special payment rates intended to reflect the various financial challenges of providing health care in rural areas. When CMS considered the change to MA, these payments were factored into the benchmarking process. The Committee is concerned whether MA plans will recognize these add-on payments for rural providers that have been present in traditional Medicare.

Some MA plans have noted that the short-term bonus payments, such as the stabilization fund and the bonus payments to the RPPOs, do little to influence their decisions to offer plans. In the long term, health insurers are weighing whether the payments will allow the insurers to be profitable against the risk of insuring the Medicare population. If insurers decide that profits cannot be made, then they will likely withdraw their plans, possibly creating a traumatic exiting of managed care like that seen in the late 1990s.¹²

Provider-Related Issues

Although the MA statutes and regulations require plans to pay out-of-network providers at rates comparable to traditional Medicare, providers that care for MA enrollees without a contract with the plan may still lose significant revenue. Even those providers that are “deemed” under the PFFS non-network model may have to accept rates below what they receive from Medicare under the traditional Medicare program. Because their actual Medicare payment rates are not determined until well after services are provided, CMS regulations allow plans to estimate payment rates for providers that are paid under cost-based payment systems. Among these

Providers’ Perspectives on Medicare Advantage

While on a site visit to Devils Lake, North Dakota, the Committee received testimony from Ms. Marlene Krein, President and CEO of Mercy Hospital, on the challenges for beneficiaries and providers regarding the implementation of Medicare Advantage (MA) in their rural community. At this visit, hospital staff described confusion on the part of beneficiaries about enrollment in MA and MA Prescription Drug (MA-PDP) plans, as well as concern about enrollment verification and claims management.

Staff described various instances of beneficiaries not knowing they had left traditional Medicare or thinking they had enrolled in a Part D prescription drug plan when they had actually enrolled in an MA plan. Hospital and clinic staff felt that, in some instances, plans do not sufficiently inform beneficiaries that they are enrolling in a full managed care plan, rather than only the prescription drug component. Several beneficiaries also reported to staff that they retained their Medigap plans because they were not informed that supplemental insurance coverage is not valid under MA plan enrollment.

The Committee learned that enrollment verification is also a challenge for hospital and clinic staff in instances where beneficiaries are not able to tell providers in which plan they are enrolled. Though the hospital has access to the Center for Medicare and Medicaid Services’ Common Working File, they found the information contained in the beneficiaries’ files to be out-of-date. This lack of enrollment verification further complicated the handling of claims, and provided an administrative burden for the providers.

Finally, hospital and clinic staff expressed frustration at beneficiary requests for counsel on MA decision-making—a role they feel is inappropriate as a health care provider. They felt that in their region, local Councils on Aging are ill-equipped to deal with such advanced case management, leaving the beneficiaries with little or no resources to turn to for help.

Source: Staff of Mercy Hospital of Devils Lake and Altru Clinic – Lake Region. Presentation to the National Advisory Committee on Rural Health and Human Services, September 29, 2006.

¹² Siriotis and Schuntermann, Presentation to National Advisory Committee on Rural Health and Human Services.

providers are many types of rural providers including Critical Access Hospitals (CAH) and Rural Health Clinics (RHC). CMS recommends that plans use the providers' interim payment rate, as determined by the Fiscal Intermediary, to set payments for non-contracted providers and does not require the plans and providers to undergo cost settlement. If providers are not aggressive about updating their interim rates on a frequent basis, they may incur losses if their interim rates are below their actual costs.

However, interim rates for Medicare cost-based providers are not available to the plans. As a consequence, plans must contact providers to obtain interim rates, and since rates are subject to change, there cannot be an assumption by the plan that a rate previously obtained from a provider is the current rate or that the rate is relevant for the time period when rendered. This can lead to exchanges of information from providers to plans each time a claim is submitted for payment, creating a cumbersome process for the timely payment of claims. Furthermore, unlike traditional Medicare, plans are not required to reimburse non-contracted providers for unpaid coinsurance and deductibles.

Current HHS and Governmental Role

The Centers for Medicare and Medicaid Services (CMS) is the agency that administers the MA program and oversees the MA plan contracts. CMS receives applications from health insurers and selects the plans that meet the requirements of the program. The approval guidelines for MA plans are provided in the *Medicare Managed Care Manual* and other CMS instructions.

CMS has asserted that MA plans have the capability to improve the quality of health care for rural beneficiaries.¹³ The Committee is concerned about the possible fragmentation in addressing quality, with MA plans addressing quality for one

group of Medicare beneficiaries, while the federally funded Quality Improvement Organizations (QIOs) are working with beneficiaries under traditional Medicare. The Committee believes that MA plans and QIOs must coordinate their quality improvement activities to avoid fragmentation of quality improvement efforts.

Conclusion

The issues being raised in this report on the overarching topic of MA in rural areas are still unfolding. MA's full effect on rural communities is yet to be determined; however, the changes created by the MA program will likely result in a significant transformation of the rural health landscape. It is imperative that, (1) attention be paid to ensuring rural beneficiaries have adequate access to care, (2) payment rates are high enough to sustain a viable rural health system, and that (3) the relationship among beneficiaries, providers, plans and CMS be well integrated. These are significant, long-term issues that need to be addressed.

Recommendations

Centers for Medicare and Medicaid Services (CMS):

The Centers for Medicare and Medicaid Services have an especially important role in the success of rural health care systems, because rural providers are dependent on income from Medicare beneficiaries for their operation. Medicare payments can account for as much as 80 percent of in-patient revenues for small rural hospitals. For this reason, in this chapter the Committee makes several recommendations to the Secretary of Health and Human Services and CMS that are not explicitly related to rural issues, but that discuss issues with a disproportionate impact on rural America.

The Secretary should charge CMS with providing enhanced information that will allow beneficiaries to make well-informed decisions, particularly for rural beneficiaries who have less experience with managed care.

¹³ Rural Assistance Center. "News and Events: More Beneficiaries Participate in Medicare Advantage After Plan Approvals in 2005." Source: CMS Press Release. February 21, 2006. http://www.raconline.org/news/news_details.php?news_id=3926.

Nationwide beneficiaries have voiced frustrations at the complexity and difficulty in understanding MA plans. Navigating the variations in plan coverage, co-payments, out-of-network and in-network stipulations, and other factors has been challenging for many beneficiaries. CMS does provide some information to the beneficiaries, but the educational literature is often long and complex. The Committee recommends that CMS focus on presenting concise, easy-to-understand information that would allow beneficiaries to compare and contrast plans in a manner similar to that provided to beneficiaries comparing prescription drug plans.

The Secretary should strengthen the CMS Regional Offices' roles as sources of definitive MA information.

In the past, CMS granted its regional offices considerable authority in answering questions and making determinations on certain policy issues. With the advent of Medicare Advantage, several Committee members noted that it appears that Medicare information and policy decision determinations are increasingly being centralized. These Committee members believe that location-specific decisions that were previously made in the CMS Regional Offices, such as those related to network adequacy and community standards of care, are increasingly being made in the CMS Central Office or in a single Regional Office. Rural providers can no longer travel reasonable distances to their local Regional Office to meet with CMS staff to ask questions or discuss concerns related to these decisions. The significant changes to Medicare through the MA program and the prescription drug benefit leave many rural providers with questions and a need for information. The Committee is concerned that any potential movement towards information centralization has the potential to leave many rural providers feeling removed from the changes and overwhelmed at the lack of direct assistance. The Committee believes CMS should consider strengthening the role of its Regional Offices to make some determinations on issues related to network adequacy and community standards of care as it relates to Medicare Advantage. Such a change will allow providers to

better understand the market they operate in and respond to important coverage issues that relate to the Medicare Advantage beneficiaries they serve.

The Secretary should mandate that CMS solicit input from rural health care experts in determining and enforcing adequate rural community access standards.

CMS has emphasized that rural community access standards are a priority for the agency. While the Committee is encouraged by that stance, it is concerned that the present rural community access standards applicable to MA plans are not sufficient to meet the health care needs of rural beneficiaries. Thus, the Committee would like CMS to solicit input from rural health care experts in determining the rural community access standards and how best to enforce those standards for MA plans.

The Secretary should ensure that CMS provide current enrollment data in a timely manner, so rural enrollment can be tracked.

In researching this chapter, the Committee has been extremely frustrated by the delays in the expected release of county-level enrollment data for MA-only plans (i.e., those MA plans that do not include a Part D benefit). Typically, CMS reports the quarterly enrollment data within a few weeks after the end of the quarter. However, 2006 data was not released until September 2006 and was released in a format that prohibits rural-specific analysis. Further county-level data was not released until December 2006. Since health plans are required to report enrollment data on a monthly basis, it is unclear why CMS has been so late in releasing the data to the public. The lack of data hampers efforts by the Committee and others to determine MA's full impact on rural communities.

The Secretary should provide access to MA plan applications through the CMS web site.

The Committee has observed that there is a lack of transparency in how MA plans are approved. The Committee is especially concerned about the composition of plan provider networks and

requirements for rural network adequacy. Thus, the Committee recommends that applications for MA plans be made accessible to the public via the CMS web site, allowing for more transparency and opportunities for rural advocates to comment on the plans.

The Secretary should charge CMS with establishing a web site where providers can instantly verify beneficiaries' current plan enrollment.

Many rural providers have found it difficult to verify beneficiaries' plan enrollment. At times beneficiaries are unsure about their coverage and providers cannot easily access that information. Currently, there are two commercial services (MediFax and Passport Health Communications, Inc.) where Medicare enrollment can be verified. However, there are certain health insurers such as Blue Cross, Humana and United that do not participate in the sites. Though many providers have access to CMS' Common Working File, providers have discovered that information about a beneficiary's status in an MA plan is often not current. The Committee understands that CMS is working to ease access to beneficiaries' MA enrollment status via a secure web portal, and the Committee encourages this. The Committee urges CMS to ensure that the portal is easy to access for providers and provides real-time enrollment data. This web site would allow all providers ease of access and would ensure more efficient reimbursement transactions and less administrative work for the providers.

The Secretary should work with the Congress to develop a payment formula for MA that moves away from prior utilization so as not to rely on a payment mechanism that rewards regions with high utilization at the expense of regions with lower utilization.

§1853(a) of the MMA requires that CMS adjust payments for local and regional MA plans to account for variations in "local payment rates" within each region the plan serves. This provision allows health plans to segregate rural providers within their region and offer them a substantially

lower payment rate. The Committee is concerned that rural beneficiaries, plans and providers will continue to be disadvantaged as the proposed benchmarks for the health plans are significantly affected by some States' historically lower utilization rates. Historically, M+C was criticized for making extra benefits available in regions of the country that had high Medicare utilization, which could not be made available in regions with lower utilization. The Committee would like to prevent similar incidents from happening with the MA program.

The Secretary should assure the efficient administration of PFFS plan payments to non-contracted providers.

Fiscal Intermediaries, at a minimum, should be allowed to release interim rate information directly to PFFS plans without requiring a Freedom of Information request from the plan. Plans should be required to pay the interim rate effective for the dates services were rendered. This is especially crucial for rural providers because PFFS plans are the most prevalent type of MA plan in rural areas. Additionally, plans should be required to pay for bad debt associated with services to their members and documented by the provider within a reasonable timeframe as uncollectible.

Agency on Healthcare Research and Quality (AHRQ):

The Secretary should require the Agency for Health Research and Quality to examine whether non-HMO MA plans provide additional preventive health benefits to those in traditional Medicare who are rural beneficiaries.

CMS has asserted that MA plans have the capacity to improve the quality of health care for Medicare beneficiaries. Additionally, one of the primary Congressional justifications for expanding M+C into Medicare Advantage was to provide more of the benefits of plan choice and the resultant services to rural beneficiaries. This would be a great improvement for rural health care; however, the Committee would like research to corroborate

CMS' assertion and Congress' intentions. Thus, the Committee would recommend that the Secretary work with Congress to ask AHRQ to research the preventative services provided by non-HMO MA plans and to determine whether these services are beyond the level currently provided by traditional Medicare or local HMOs.

Office of Rural Health Policy (ORHP):

The Secretary should work with Congress to give ORHP the authority to provide technical assistance and outreach on ways rural communities can collaborate on examining rural contract reviews of MA plans.

Many rural communities have not historically adapted to the managed care model. Thus, since the MA program will transform rural health care by increasing the prevalence of private plans, rural communities must be educated and informed on how to best collaborate in order to evaluate the rural contract reviews of the MA plans. Rural providers and other existing rural health care leaders need to ensure MA plans provide adequate community access for rural beneficiaries and fairness in payment to rural providers.

Administration on Aging (AoA):

The Secretary should provide the AoA with increased funding to local area agencies on aging to provide increased assistance to beneficiaries enrolling in MA plans.

With the transition to the prescription drug benefit (Part D), the aging network, including the local area agencies on aging, were instrumental in educating the elderly in regards to the Part D changes. The same effort needs to be utilized for MA plans due to their complexity. The Committee would like to see an increase in funding to organizations such as the local area agencies on aging, so that they can effectively inform and educate the elderly about MA plans.

State Insurance Commissioners' Offices:

The Secretary should encourage State insurance commissioners' offices, in a manner consistent with existing Federal oversight of Medicare managed care plans, to act as ombudsmen for rural beneficiaries having difficulties with MA plans.

State insurance commissioners' offices are often knowledgeable about rural concerns, health issues facing their State and the managed care climate in their State. The Committee recommends that the Secretary actively encourage State insurance commissioners' offices to act as ombudsmen for rural beneficiaries. The Secretary should ensure these offices have the regulatory authority necessary to access information on MA plans and report violations of Medicare regulations.

The Secretary should work with Congress to increase funding for the State Health Insurance Assistance Program (SHIP) to further assist seniors in rural areas with the MA program.

States currently receive a grant from CMS to provide advice and counsel to citizens on a number of subjects, including Medicare managed care. Rural beneficiaries have less experience with managed care products, and information about MA is often difficult to obtain and confusing to beneficiaries. The Secretary should work with Congress to increase funding for SHIPs and specifically charge them with helping beneficiaries in rural areas make appropriate choices with regard to MA.

Head Start in Rural Communities

Why the Committee Chose This Topic

Head Start is an early childhood program created in 1964 to meet the developmental needs of disadvantaged preschool-aged children. It is the longest running national school readiness program in the United States and is administered within the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF). As of late 2005, the program has served more than 22 million preschool children throughout the country.

Head Start services are available to children from age three until they enroll in kindergarten or first grade. In the 1994 reauthorization of Head Start, Congress established Early Head Start to serve the needs of low-income pregnant women and their children, prenatal to age three. This comprehensive early childhood program is meant to allow children to transition smoothly into Head Start enrollment, but children are reassessed at age three to ensure their family still qualifies financially for participation. Eligibility for Head Start and Early Head Start participation is based upon whether family incomes fall below the official poverty line as established by the Federal government. In 2006, an income below \$20,000 would qualify a family of four for Head Start services.¹⁴

The Committee chose to focus on Head Start because it is the only early childhood program specifically designed for low-income children and families. Rural communities face higher poverty rates than non-rural, metro areas, and the

Committee wanted to assess how well the Head Start program meets the needs of rural communities. According to the Economic Research Service of the U.S. Department of Agriculture, in the year 2000, “19 percent of non-metro children were poor compared with 15 percent of metro children.”¹⁵ Also, “In 2003, 14.2 percent of the population, or 7.5 million people, living in non-metropolitan (nonmetro) areas were poor.”¹⁶ More current data has not yet become available, but these numbers speak to the importance of Head Start to rural families and children.

While Head Start has existed for more than 40 years, very few researchers or program evaluators have examined Head Start from a rural perspective. Although the program itself has no specific provisions for rural communities, this chapter seeks to identify which aspects of the program are particularly relevant to rural families and communities. It also makes recommendations to address some of the unique program implementation issues facing rural communities.

What We Know About Head Start in Rural Communities

Head Start and Early Head Start serve children and families living at or below the Federal poverty line. The Head Start program is structured so that grants are made directly to local public agencies, non-profit and for-profit organizations, and schools running Head Start programs. The grants are made by the Regional Offices of the ACF. (The Office of Head Start’s American Indian-Alaska Native

¹⁴ Administration for Children and Families. *Head Start Family Income Guidelines for 2006* [Attachment for Information Memorandum]. ACYF-IM-HS-06-02. http://www.headstartinfo.org/publications/im06/im06_02a.htm.

¹⁵ U.S. Department of Agriculture, Economic Research Service. “Rural Income, Poverty, and Welfare: Rural Child Poverty Briefing Room.” <http://www.ers.usda.gov/Briefing/IncomePovertyWelfare/ChildPoverty/>. Updated October 30, 2003.

¹⁶ *Ibid.*

Program Branch and Migrant and Seasonal Program Branch make grants to those specific populations.) The regional ACF offices award Head Start grants to two types of recipients: grantee agencies and delegate agencies. The grantee agency receives money to directly operate Head Start programs (i.e., a school district), while delegate agencies contract out for Head Start services. For fiscal year (FY) 2006, Congress has appropriated \$6.78 billion for Head Start projects and support activities (including training, research and monitoring). This is a slight decrease from the 2005 total of roughly \$6.84 billion; Head Start funding allocations have stayed level at about \$6.7 billion since 2003, up from \$6.2 billion in 2001.¹⁷ The Committee fears that stagnant and slightly decreasing funding levels may not offer appropriate resources for the management of the program.

In 2005, Head Start served a total of 906,993 children across the United States.¹⁸ In addition to fostering the development of learning skills, Head Start programs are designed to promote the overall healthy development of low-income children. In this larger role, Head Start educators focus on such areas as nutrition, mental health, dental health and overall physical health. Classroom activities include reading stories, working with concepts of numbers, visual arts, physical activity, instruction on health and hygiene, science and nature lessons, and many other different activities. Classes are taught by qualified teachers, who often have assistance from parents of students and others who volunteer their services. The program provides classroom staff with in-service training on class management, child assessments, team-teaching, working with parents, supervision of volunteers and other subjects. Home visits by Head Start staff are a significant part of the program, especially in rural areas where the lack of public or private transportation can be a barrier to services for children and families. Head Start programs are designed to foster family involvement in the lives of

the children. During the 2004-2005 Head Start program year, 890,000 parents volunteered with their Head Start program.¹⁹

Head Start has a comprehensive set of program performance standards that grantees and delegate agencies must meet as they operate their programs. Each time Congress reauthorizes Head Start, it also revisits the performance standards. These standards are service requirements that every Head Start program must provide for its enrolled children and their families. The standards are broken down into three main areas: early childhood development and health services; family and community partnerships; and program management and operation.²⁰ Failure to meet performance standards can lead to the termination of a Head Start grant.

Supporting Rural Data

Although Head Start and Early Head Start serve millions of rural children and families, very little research has been done to understand how rural children fare when compared to urban and suburban children. More generally, finding any data about early childhood indicators of progress for rural children is difficult. According to the National Center for Rural Early Childhood Learning Initiatives, “Of 61 key indicators of child well-being, 51 cannot be estimated for rural children using public-use data and a precise definition of rurality.”²¹

The Head Start Family and Child Experiences Survey (FACES) does have a rural variable; however, no researchers have broken down any of the indicators by rurality.

Key Rural Issues

The Committee has learned, through conversations

¹⁹ *Ibid.*

²⁰ National Head Start Association. *Issue Brief: Head Start Program Performance Standards.*

<http://www.nhsa.org/download/advocacy/fact/HSPromo.pdf>.

²¹ National Center for Rural Early Childhood Learning Initiatives, Mississippi State University. (December 2004). “The Rural Early Childhood Information Gap.” *Rural Early Childhood Brief*. No. 1. http://www.ruralec.msstate.edu/briefs/12-04_info-gap_brief.PDF.

¹⁷ Administration for Children and Families, Office of Head Start. *2002 Head Start Fact Sheet.*

http://www.acf.hhs.gov/programs/hsb/research/factsheets/02_hsfhs.htm.

¹⁸ *Ibid.*

with state-level Head Start directors, researchers, and Head Start association representatives, that most Head Start datasets do not include rural variables. Thus, the information described throughout this chapter is based on Committee testimony, site visits, discussions with program leaders and limited research studies that have some bearing on the rural dimensions of Head Start. Based on the information the Committee has obtained, the main challenges facing rural communities in implementing successful Head Start programs fall into the following categories: transportation, workforce requirements, enrollment fluctuation, performance standards, health requirements and financial matching.

Transportation

Some of the greatest challenges facing rural communities in delivering almost any type of health or human service program involve issues of transportation. Especially in smaller and more geographically isolated rural communities, ensuring access for all is impeded by distance and lack of public transportation. In rural or frontier areas, providing the means to bring all of the children to a Head Start facility in a timely and cost-efficient manner can be incredibly difficult. One way that rural communities have overcome this challenge is through a combination of home-based and school-based Head Start programs where children come into a center one or two times per month and Head Start teachers go to the children's homes one or two times per month. Another approach is for the Head Start program to partner with public schools or special education programs to allow Head Start children to ride on their buses or vans and be dropped off at the Head Start facility.

The cost of transportation per child in rural communities is a difficult issue complicated by increases in fuel prices and a lack of economies of scale. Greater distances between homes often necessitate more vehicles than would be required in urban areas, raising the cost per child. These same issues can affect the availability of classroom teachers and volunteers.

A related issue is the more stringent safety requirements for preschool-aged children and

subsequent increased costs of vehicles. Regulations for Head Start transportation require the type of safety restraints and staffing on vehicles that often preclude the use of school buses or allowable alternatives. Provisions within the FY 2006 Head Start Appropriation bill addressed this problem by allowing Head Start grantees to apply for waivers from the safety restraint and bus monitor requirements. As long as rural providers are able to show that meeting these requirements will disrupt the operation of their program, they may have these requirements waived and, in effect, use local transportation to meet the requirement that all Head Start children be transported on school buses or an allowable alternative.²² The rule change took effect in November 2006; the Committee supports the widespread promotion of information about the waiver to help rural sites meet the transportation needs of their children.

Workforce

Head Start regulations require that administrators obtain credentials to demonstrate their competence in early childhood education. The 1996 program guidance required at a minimum that Head Start and Early Head Start educators possess a Child Development Associate (CDA) credential or a State-awarded certificate for preschool teachers that meets or exceeds the requirements of a CDA credential. With each reauthorization of Head Start, Congress may establish new requirements for teacher qualifications. After the most recent 1998 reauthorization, Congress made the following changes:

A mandate in the Head Start Act (October 27, 1998) required that by September 30, 2003, at least half of all Head Start teachers in center-based programs would have an associate, baccalaureate, or advanced degree in Early Childhood Education or a degree in a related field, with preschool teaching experience.²³

²² Administration for Children and Families, Office of Head Start. *2006 Head Start Information Memorandum. Transportation Waivers and Effective Date Extensions*. [Accessed September 9, 2006]. http://www.headstartinfo.org/publications/im06/im06_01.htm.

²³ Administration for Children and Families. "ACF Questions and

To meet these requirements, the Head Start Bureau allocated \$43 million of its quality improvement funds to ensure additional training for teachers. The Bureau made available \$1,300 grants to Head Start agencies for each teacher without a college degree and \$300 for each with a non-childhood education degree.²⁴ Another training initiative particularly useful to rural providers, the National Head Start Association's HeadsUp! distance learning initiative, has allowed over 2,000 Head Start sites access to a satellite television network of continuing education training and courses for college credit.²⁵

Rural teachers still face greater challenges to meeting the more stringent degree requirements. In rural communities where a higher education facility is not easily available, finding the time and money to obtain the proper degrees can be daunting. A General Accounting Office report in 2003 noted some of the regional challenges facing rural Head Start providers. One Midwestern region reported that "there were few colleges, and some lacked early childhood education programs."²⁶ In one Southern region, "some teachers had to travel two and a half hours to attend class."²⁷ Distance learning through university programs is a popular solution to these geographic challenges, but it also has pros and cons. Another Midwestern region reported the following concerns with distance learning: "(1) it is easy to fall behind, (2) it is more expensive, and (3) most staff need face-to-face interaction with instructors."²⁸ Other concerns with distance learning include "(1) many education programs have a component that requires the student to be on-

campus at scheduled times, (2) courses require a certain level of computer skills."²⁹

During the current Head Start reauthorization debate, both the House and the Senate have called for another increase in the number of teachers who hold at least a bachelor's degree to ensure the quality of the educational program. Each version of the reauthorization bill would require 50 percent of Head Start educators to have at minimum a bachelor's degree. However, no additional funds have yet been stipulated to help Head Start programs meet these new requirements. According to the Center for Law and Social Policy, the House and Senate bills are estimated to cost cumulatively at least \$2.7 billion over the next six years.³⁰ Without financial help, it may be difficult for smaller rural programs to meet the proposed requirements. Some site locations have suggested to the Committee that work experience in the Head Start agency should count towards degree requirements; this would allow experienced providers to more easily meet the new standards. Head Start educators roundly supported more teacher training and education to improve the quality of their programs. They hope that teacher salaries will rise accordingly, so as to remain competitive with the public school system.

In addition to professionally trained staff, the Head Start program is heavily dependent on parents and volunteers to assist in the classroom and help with all other dimensions of the program. In recent years some local program directors have experienced greater difficulty in recruiting volunteers. The relatively new welfare-to-work requirements have made it more difficult for low-income parents to participate as volunteers in the program.

Enrollment Fluctuations

For rural programs serving smaller numbers of children, even minor population shifts or modest changes in family incomes can pose a problem. The

Answers Support: What are the requirements for Head Start staff and teachers?" <http://faq.acf.hhs.gov>. [Accessed March 17, 2006].

²⁴ Administration for Children and Families, Office of Head Start. (1999). *Quality Improvement Funds to Increase the Number of Teachers with College Degrees*. [ACYF-PI-HS-99-03]. http://www.headstartinfo.org/publications/im99/pi99_03.htm.

²⁵ National Head Start Association. "HeadsUp! Network Distance Training for the Early Childhood Community." <http://www.nhsa.org/training/heads%5Fup.htm>.

²⁶ U.S. General Accounting Office. (October 2003). *Head Start: Increased Percentage of Teachers Nationwide Have Required Degrees, But Better Information on Classroom Teachers' Qualifications Needed*. GAO-04-5, p. 26.

<http://www.gao.gov/new.items/d045.pdf>.

²⁷ *Ibid.*

²⁸ GAO, *Head Start*, p. 27.

²⁹ GAO, *Head Start*, p. 28.

³⁰ Ewen, D. *Cost of Meeting House and Senate Proposed Head Start Teacher Qualification Requirements*. Center for Law and Social Policy. July 14, 2005. <http://CLASP.org>.

minimum enrollment for a classroom-based program is 17 children. Within their budget constraints, programs have the flexibility to enroll up to 10 percent of their children from families with incomes slightly above the Federal poverty line. Even with this flexibility, the loss of just a few children can leave programs in a precarious position that may jeopardize their continuation. Program directors fear that the infrastructure they have developed including facilities, staff and other resources may be lost due to the changing status of families under welfare reform and to temporary population shifts that can occur if the birth rate dips or if one or more families leave the area—circumstances that are largely beyond their control. With respect to income status, directors correctly assert that small changes in income do not affect the needs of the children they can serve.

A second issue related to enrollment is that grantees do not have discretion to move funds between regular Head Start and Early Start. The Committee received concerns that this restriction hampered Head Start coordinators' ability to respond to changes in the number of children of different age groups served by the two programs. The inflexibility in the use of funds is seen by some interviewees as an unnecessary impediment to meeting local needs. While this inflexibility may seem inconvenient, the Committee has found that because the programs are administered under two completely separate grants, money cannot be transferred between them.

Delivery Options

The basic delivery options for Head Start are classroom learning, home visits or a combination of the two. Rural grantees are more likely to rely on home visits due to the problems associated with staffing and transportation. Head Start providers in home-visit programs are required to make a minimum of 32 visits per year, or one per week. In addition, there must be a minimum of 16 group socialization activities per year. The Committee found no evidence to suggest that one option has been more successful than the other.

Community Involvement

The Head Start program requires community involvement through its program governance mechanisms and strongly encourages community involvement with all aspects of the program. There is no data available on the extent of community involvement with Head Start in rural areas of the country. However, the Head Start Family and Child Experiences Survey (FACES) funded by HHS does have data showing that parental involvement in the program is about equal between urban and rural areas.³¹ In North Dakota, as in many other site locations, male involvement is recruited to provide positive male role models for the children.

While this information is positive, the Committee believes that transportation issues, geographic isolation, the presence of low-income families with multiple jobs at remote locations and other rural realities detract from community involvement in Head Start programs. Nonetheless, the Committee has learned that in many rural places local churches, civic associations, public school

North Dakota Collaboration

The Committee has met with at least one rural Head Start site that is encouraging collaboration in a powerful way. Students at the Early Explorer Head Start program in Devils Lake, North Dakota, share their facilities with the North Dakota School for the Deaf. In doing so, the program has offered new life to an older building in the town. The School for the Deaf was faced with low enrollment and high costs. After renovating much of the facility, the Head Start children now run and play in halls that were once unused. While the two groups attend separate classes, they eat together in the dining hall, which exposes the Head Start children to American Sign Language and gives an integrative opportunity to the students in the deaf community.

³¹ Administration for Children and Families, Office of Planning, Research and Evaluation. Family and Child Experiences Survey. <http://www.acf.hhs.gov/programs/opre/hs/faces/index.html>.

systems and other groups have coordinated with Head Start to provide meals, transportation, field trips and other activities. There is currently no information on how much of this activity is taking place across the rural landscape.

National Reporting System

As noted, Head Start grantees are required to meet national performance standards. Since 2004, all four-year-olds enrolled in Head Start have been evaluated by the National Reporting System, a standardized assessment that measures pre-math, pre-literacy and language skills. Some Head Start programs raised a concern that the assessments used to measure the performance of Head Start children include questions and concepts that are more appropriate to the experiences and exposures of urban children than for youngsters in rural areas. For example, they cite questions related to animals that would only be seen in a zoo. There are also concerns that many children experience anxiety during testing and that test results may affect the survival of some effective programs. The Committee believes that all assessments should be conducted in a manner that is culturally and geographically sensitive.

Health Requirements

As previously noted, Head Start is designed to educate children and their parents on health issues. The specific health needs of Head Start children are identified and addressed by teachers and volunteers in the classroom, as well as other program officials. Children are required to undergo a health screening within 90 days of Head Start enrollment. After their health needs are identified, Head Start grantees must provide referrals to appropriate health care providers, including primary care, dental care, mental health services, and related services such as legal aid and family violence programs. Head Start Education Coordinators rank health problems at the top of their list of issues that impact the early development of program participants. Further, the most frequent child health problem reported by

Head Start Health Coordinators is the need for dental services.³²

The health-screening requirement can be difficult to meet in areas with chronic shortages of health professionals. Some programs meet the challenge by forging ongoing relationships with local health care providers and health professional schools. In North Dakota, the Head Start programs have partnered with the State Department of Health; their early screenings have led to a remarkable 100 percent immunization rate for Head Start children. If no other sources of funding are available for health care, grantees may use Early Head Start or Head Start funds to provide professional treatment. Program funds have not kept pace with the rapid rise of health care costs, and access to health care providers, especially in the areas of oral and mental health, remains a big challenge.

Oral Health

In 2004 the Committee updated the Secretary on the status of access to dental health in rural areas. Consistent with the findings in this report, Head Start program officials in rural areas report formidable problems in locating dentists to serve Head Start children. This problem is also recognized by the Office of Head Start. In fact, Robin Brocato, Head Start Health Specialist in the Office of Head Start told the American Dental Education Association (ADEA) in June 2006: “Limited access to oral health care is the most pressing health need for Head Start and Early Head Start children,” and she notes the special challenges of rural Head Start agencies where “children must travel over an hour to see a dentist or wait months for an appointment.”³³

Head Start program staff often report that few local dentists are willing to accept children below age three and that many refuse to see Medicaid patients. Also, in rural areas there are a limited number of pediatric dentists to meet the more specialized needs of Head Start children. It is

³² *Ibid.*

³³ American Dental Education Association. “Guest Interview with Robin Brocato,” *ADEA State Issues Update*, Vol. 4, 2, pp. 3-4. <http://www.adea.org/>.

important to note that of the 1,900 Federally Designated Dental Professional Shortage Areas in the country, 1,273 (67 percent) are rural or frontier. North Dakota, “where 44 of the State’s 53 counties have six or fewer practicing dentists,” exemplifies this statistic.³⁴

Dental Hygiene CD-ROM

The Head Start Collaboration Director for Arkansas reported working with the Arkansas Oral Health Coalition and State Office of Oral Health to develop a CD-ROM about dental hygiene that was disseminated to all Arkansas Head Start Centers, dentists and other early childhood programs. The CD has been requested by other states and can be revised for wide applicability.

The National Head Start Oral Health Resource Center has sought to improve access to dental care for Head Start enrollees since its inception in 1996. Working closely with the Office of Head Start Oral Health Initiative, the Resource Center answers questions about Head Start oral health and serves as an information portal for current projects and funding opportunities. In 2006, the Head Start Oral Health Initiative provided 52 four-year grants of \$75,000 to Head Start programs around the country. At least seven of these projects target specifically rural areas, and all of the grantees are required to disseminate their best practices following the implementation of their funded programs.³⁵ The Committee believes that a rural set-aside option or formulaic preference for rural applicants could help address chronic oral health disparities in rural Head Start programs.

In an effort to promote collaboration between dental education programs and Head Start, HRSA’s Maternal and Child Health Bureau (MCHB) along

with ADEA hosted a recent forum on Head Start oral health in June 2006. Collaboration between training programs and Head Start agencies is a win-win situation, offering dental residents valuable experience working with pediatric patients and providing Head Start children access to affordable, available dentistry. While some collaboration is taking place, the amount varies by region and community. The Committee supports the expansion and promotion of collaborative solutions, especially in rural areas.

Financial Matching Requirements

Every local Head Start program is responsible for meeting a Federal matching requirement of 20 percent. The matching requirement can be met through the use of volunteers. Under this approach, a dollar amount is placed on volunteer hours based on prevailing wages in the Head Start program area, and this amount is then used to meet the Federal matching requirement. The Committee has heard from local program leaders that recruiting volunteers is becoming more and more difficult for reasons previously discussed. Without a critical mass of volunteers, it may be impossible for some programs to meet their financial responsibilities.

Current HHS and Governmental Role

Accountability

The Federal role includes efforts to assure program accountability in Head Start. Every Head Start program is required to meet a comprehensive set of national performance standards, encompassing every aspect of the program. Failure to meet the standards can result in termination of the Federal Head Start grant. The standards cover such areas as staffing requirements and qualifications, health-related responsibilities, parental and community involvement, classroom activities, home visits, transportation and other matters. The Committee has found strong support for the standards among rural Head Start personnel. The sites liked being

³⁴ Dwelle, T., Senn, K., & Yineman, K. (July 2006). *Oral Health in North Dakota: Burden of Disease and Plan for the Future*. North Dakota Department of Health.

http://www.ndmch.com/Publications/Oral_Health_State_Plan.pdf.

³⁵ National Head Start Oral Health Resource Center. “Office of Head Start-Funded Projects.”

<http://www.mchoralhealth.org/HeadStart/OHSprojects/index.html>.

held accountable to Federal standards because such oversight gave them an opportunity to showcase their progress and tell their success stories to a receptive audience.

As part of the performance standards, accountability is assured through the program governance requirements. Each program must have a Board of Directors representative of the community and a Policy Council composed of Head Start parents. The Policy Councils have veto power over actions taken by the Board. They provide an opportunity for parents to participate in all local decisions about the program. A significant Council side benefit is the opportunity for Head Start parents to develop leadership ability and vocational skills through their participation. The Committee has heard examples where participation has encouraged some parents to pursue a career in childhood development or has helped them to find other employment opportunities in the community.

Collaboration

Head Start grantees are required to collaborate with other Federal and private programs in providing services to the children. The Committee has learned of some excellent examples of collaboration between Head Start grantees in the areas of health, transportation, use of facilities, etc. One interesting example in the health care area is in Alaska where the Head Start State Collaboration Director is using a Federal grant of \$125,000 for an annual health fair to augment Head Start activities. Head Start children are flown to the fair where they receive health care screening, as well as treatment by physicians and dentists as needed.

The Committee's *2005 Report to the Secretary* included a chapter on collaboration that emphasized its importance in rural areas where resources are scarce. Consistent with the message of this chapter, HHS needs to play a big role in disseminating information about Head Start collaborative models that are working well in rural areas.

Conclusion

The Committee was not surprised to find that the most significant and frequently mentioned issues for Head Start in rural areas relate to health care shortages and transportation difficulties because it has examined these issues for many years in the broader context of access to health care in rural areas and, more recently, with access to human service programs. The other issues that were raised in this chapter concern legislative and/or administrative requirements related to Head Start staffing and workforce development, budgetary restrictions, program eligibility and performance standards. The recommendations found below are intended to address some of these issues.

Recommendations

The Secretary should support research to determine the feasibility and impact of increasing the percentage of children who can be enrolled in Head Start from families with incomes that exceed the Federal poverty line, to help preserve small rural programs that may fall short of minimum enrollment requirements.

The Committee believes that small rural programs should not lose their grants when a small decline in the number of eligible children pushes them below the minimum enrollment standard. It recommends pursuing research into the effects of additional flexibility to enroll children from higher income families to avoid the loss of such programs. The Committee believes that this flexibility could be used with discretion to maintain programs in rural communities where there are few or no childhood education alternatives.

The Secretary should support a long transition period for any increase in the qualification standards for Head Start teachers so that rural educators are able to complete the degree requirements.

As noted in the text of this chapter, both the House and Senate reauthorization bills for Head Start call

for an increase in the percentage of Head Start teachers holding a bachelor's degree. In recognition of the disadvantages that rural communities face in recruiting Head Start educators (lower salaries, fewer educational opportunities, travel distance to educational institutions, etc.) the Committee urges the Secretary to support the longest possible transition period for this requirement. The Committee also believes that work experience in the Head Start program should count towards credit for continuing education requirements.

The Secretary should support widespread dissemination of information about transportation waivers, especially to rural Head Start sites.

Transportation waivers that release rural grantees from some of the most difficult to meet and costly Federal requirements could help solve some of the most pressing concerns regarding transportation for Head Start in rural communities. The Committee believes that rural sites should be as informed about the waivers as possible, so as to provide more transportation options for Head Start children in rural areas.

The Secretary should support grant programs to demonstrate and reinforce collaborative arrangements between Head Start grantees and other public and private programs in the areas of oral health and health care services for Head Start children.

During the past year the Committee learned about collaborative programs involving rural Head Start grantees, public schools, dental schools and other health care providers. The Committee believes that collaborative arrangements are especially important in the areas of oral health and general health care. The Department has begun cross-collaborative discussions to identify areas where they build partnerships. The Committee urges the continuation of these discussions, and requests that the Secretary work to identify best practices among rural Head Start programs and to disseminate that information.

The Secretary should examine what impact current Head Start performance standards, specifically, the

National Reporting System, have on rural Head Start programs.

The Committee found strong support for the Head Start performance standards among the many program officials who spoke with us during the year. However, some concerns were raised about portions of the National Reporting System that may not be appropriate for rural Head Start children. The Committee believes that all assessments should be administered in a culturally and geographically sensitive manner and requests that the Secretary examine this issue, consulting with rural Head Start grantees.

Substance Abuse in Rural America

Why the Committee Chose This Topic

Substance abuse is one of the most difficult challenges facing America.³⁶ This is particularly true in rural areas where a patchwork system of health and human service providers, coupled with geographic isolation, combine to create limited access to needed services. There seems to be no clarity about the most appropriate ratio of substance abuse services to the rural populations they serve, which would make the services both financially and clinically feasible for success. In rural areas an individual is more likely to be referred for substance abuse treatment by the criminal justice system (as opposed to self-referral or referral by the health care system) than in urban locales (47 percent for rural as opposed to 35 percent for urban).³⁷

Members of the Committee have seen firsthand the gaps in providing services to those suffering from substance abuse. These gaps have put added pressure on an already stressed rural health and human service delivery system that is often ill-equipped to deal with the special challenges inherent in serving substance abusers. Complicating the matter further is the fact that different regions of the country are plagued by different substances of abuse. Thus, specific problems associated with these regions must be addressed in different ways.

For the purposes of this chapter, the Committee will focus primarily on this issue of access to services, using alcohol abuse, methamphetamine

abuse and prescription drug abuse for illustrative purposes. This is not to say that these are the only substance abuse issues of concern in rural America. Rather, these were specific ones of concern identified by the Committee members and supported by the data.

What We Know About Substance Abuse in Rural Areas

As one might expect, the 2005 *National Survey on Drug Use and Health* found that abuse of illicit drugs is higher among people living in metropolitan areas than among those living in non-metropolitan areas. The rates were 8.4 percent in large metropolitan counties, 8.4 percent in small metropolitan counties, and 6.9 percent in non-metropolitan counties as a group. The survey breaks down non-metropolitan areas even further and reveals that urbanized counties had a rate of 7.8 percent, less urbanized counties had a rate of 6.5 percent and completely rural counties had a rate of 5.1 percent.³⁸

However, this general study of all-age prevalence is somewhat misleading. When the data are judged by specific drug of abuse, all categories of rural counties have higher overall rates of abuse for methamphetamine and OxyContin. The difference is even more pronounced among rural youth, who far outpace their urban counterparts in abuse of methamphetamine and OxyContin.³⁹

³⁸ Substance Abuse and Mental Health Services Administration. (2006). *Results from the 2005 National Survey on Drug Use and Health: National Findings*. (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.

³⁹ Hartley, D., Gale, J., & Lambert, D. Preliminary Findings of Ongoing Research, National Study of Substance Abuse Prevalence & Treatment Services in Rural Areas. Data from the 2002-2004 SAMHSA *National Survey of Drug Use and Health*. Muskie School of Public Service, University of Southern Maine. http://muskie.usm.maine.edu/m_view_project.jsp?id=2187.

³⁶ The term "substance abuse" includes alcohol and other drugs, unless specified otherwise.

³⁷ Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. (September 30, 2005). "Treatment Admissions in Rural Areas: 2003," *The DASIS Report* (Drug and Alcohol Services Information System). <http://www.oas.samhsa.gov/2k5/rural/rural.cfm>.

Treatment facilities in rural counties reported a total of 115,000 admissions in 2003, with alcohol (52 percent) as the primary substance of abuse. This is compared to a 40 percent admission rate for alcohol abuse in urban settings.⁴⁰ Treatment admission rates, however, give only a sense of the true problem because not all people with a substance abuse problem will seek treatment. Of the estimated 22 million substance-abusing Americans, only about 3.5 million obtained treatment.⁴¹

Rural Substance Abuse Studies and Specifics

Dr. David Hartley and Dr. John Gale of the Maine Rural Health Research Center are leading a national study of substance abuse prevalence and treatment services in rural areas based on the Substance Abuse and Mental Health Services Administration (SAMHSA) 2002-2004 *National Survey of Drug Use and Health*. The Maine study, which is being funded by the Federal Office of Rural Health Policy, analyzes prevalence of substance use and abuse variations along an urban-rural continuum, isolating variables to study age range, rural minorities and regional locations. Substances of interest include alcohol, tobacco (cigarettes), marijuana, methamphetamine, OxyContin and any illicit drug. The researchers contend that substance abuse may be “more pervasive in rural areas given that higher rates of substance abuse are associated with higher levels of poverty and unemployment and lower levels of income.”⁴² [See textbox, this page.] Preliminary findings reveal that alcohol and tobacco are the substances of highest use in rural America. While rural areas have lower usage rates of marijuana and illicit drugs, Hartley and Gale’s

research confirms that methamphetamine and OxyContin are used at higher rates than in metropolitan areas, and the difference is especially pronounced among those aged 18 to 25. These findings are made even more relevant by the fact that it takes a small prevalence rate to achieve a large impact in a rural community.

Explanation of New Data on Substance Abuse Rates

This chapter contains references to new data and research on substance abuse in rural areas that is still in progress, but which may require some additional explanation in terms of validity and sample size.

The data source is the *National Survey on Drug Use and Health* (NSDUH), which researchers from the University of Southern Maine are using to look at distinct subpopulations and substance abuse rates in non-metropolitan statistical areas. The researchers on this project have done more analysis of sub-rural populations than was previously possible with this data source. In any given year, the NSDUH has a sample size of approximately 70,000 individuals.

To address the valid concerns of low prevalence and small sample size, the primary researchers, David Hartley and John Gale, worked with the Substance Abuse and Mental Health Services Administration (SAMHSA) and Research Triangle Institute (RTI) to combine three years of data (2002, 2003 and 2004) to create an overall data sample of approximately 210,000 respondents. Within this framework, RTI also used suppression criteria to remove the reporting of any individual responses with a total number of responses too small to produce a reliable estimate. The preliminary results of this research were presented by Dr. Hartley during testimony to the Committee at its September meeting in Maine. Any further questions about this analysis should be directed to the researchers. Final release of their report is expected in early 2007.

For more information, see the project’s web site: http://muskie.usm.maine.edu/m_view_project.jsp?id=2187, or the main web site for the Center: <http://muskie.usm.maine.edu/ihp/ruralhealth/>.

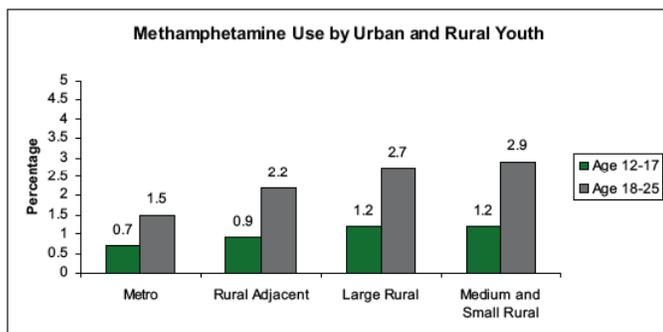
⁴⁰ SAMHSA, Office of Applied Studies. “Treatment Admissions in Rural Areas.”

⁴¹ Mark, T.L., Coffey, R.M., McKusick, D.R., Harwood, H., King, E., Bouchery, E., Genuardi, J., Vandivort, R., Buck, J., & Dilonardo, J. (2005). *National Estimates of Expenditures for Mental Health Services and Substance Abuse Treatment, 1991–2001*. SAMHSA Publication No. SMA 05-3999. Rockville, MD: Substance Abuse and Mental Health Services Administration. <http://www.samhsa.gov/spendingestimates/toc.aspx>.

⁴² Hartley, D., Gale, J., & Lambert, D. Preliminary Findings of Ongoing Research.

Methamphetamine

“Crank” and “ice” are among the names for this artificial psycho-stimulant that is highly addictive and causes psychosis in the user. The drug is made up of accessible and inexpensive household and chemical products and is often produced in “labs” located in remote rural areas to avoid detection. The U.S. Drug Enforcement Administration acknowledges that both rural users of methamphetamine and rural lab settings are increasing. Eighth graders living in small towns are 104 percent more likely to use meth than those who live in large cities.⁴³ For these reasons, the Drug Enforcement Agency considers methamphetamine the number one illegal drug in rural America.⁴⁴ Results for the 2003 *National Survey on Drug Use and Health* show that eight out of every 1,000 rural residents report methamphetamine use, noticeably higher than the five out of every 1,000 urban citizens who report abuse.⁴⁵



Source: Hartley, D., Gale, J., & Lambert, D. *Preliminary Findings of Ongoing Research*.

Aggregate data can often hide large discrepancies among subgroups, camouflaging

widespread substance abuse among certain rural sectors of the population; such aggregation has drawn attention from meth’s prevalence in rural areas. The data Hartley and Gale have examined reveal that young adults (aged 18 to 25) in medium-to-small rural areas use methamphetamine at a rate five times higher than the overall national use rate and twice that of the rate of young adults in metro areas. The prevalence of crystal methamphetamine (a form of methamphetamine that is smoked), especially among rural teens, is overwhelming. The proportion of rural teens who reported ever using crystal methamphetamine (15.5 percent) was almost double the proportion of urban (8.8 percent) and suburban teens (9.5 percent). Crystal methamphetamine was the fourth most commonly used drug among rural teens after alcohol, cigarettes and marijuana, making it more popular among rural teens than chewing tobacco.⁴⁶

State Response to Methamphetamine

The rural methamphetamine experience is exemplified in Illinois. Over the past five years, methamphetamine abuse has been the reason for the largest increase in social services there of any single primary drug. The total number of people who were served increased from just 1,528 in FY 2001 to 5,252 in FY 2005. This is an increase of more than 243 percent. Patients from rural counties in central and southern Illinois received 77 percent of these services.¹ However, caution must be used in drawing conclusions about the methamphetamine problem because it is a relatively new area of focus.

¹ Oversight Hearing: Evaluating the Synthetic Drug Control Strategy: Hearing Before the House Subcommittee on Criminal Justice, Drug Policy, and Human Resources of the House Committee on Government Reform, 109th Congress. (June 16, 2006). (Testimony of Lewis E. Gallant, Ph.D., Executive Director, National Association of State Alcohol and Drug Abuse Directors).

⁴³ The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (January 2000). *No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America, A CASA White Paper*. (Commissioned by the U.S. Conference of Mayors), p. 5. http://www.casacolumbia.org/absolutenm/articlefiles/379-no_place_to_hide_01-28-00.pdf.

⁴⁴ U.S. Drug Enforcement Administration. “Fact Sheet: Fast Facts About Meth.”

<http://www.usdoj.gov/dea/pubs/pressrel/methfact03.html>.

⁴⁵ Substance Abuse and Mental Health Services Administration. (2004). *Results from the 2003 National Survey on Drug Use and Health: National Findings*. (Office of Applied Studies, NSDUH Series H-25, DHHS Publication No. SMA 04-3964). Rockville, MD. <http://www.oas.samhsa.gov/NHSDA/2k3NSDUH/2k3Results.htm>.

⁴⁶ Mink, M.D., Moore, C.G., Johnson, A.O., Probst, J.C., & Martin, A.B. (March 2005). *Violence and Rural Teens: Teen Violence, Drug Use, and School-Based Prevention Services in Rural America: Executive Summary*. South Carolina Rural Health Research Center.

Alcohol

Despite the media coverage of the methamphetamine and OxyContin epidemics, these are found to be only one one-hundredth as common as alcohol abuse. Alcohol is “universally, the substance of choice” among youth and adults alike, in both urban and rural areas.⁴⁷ In fact, 20 percent

of rural young adults (aged 18 to 25) met criteria for alcohol or drug abuse in 2003, compared to 10 percent of youth (aged 12 to 17) and about 6 percent of adults.⁴⁸ The data reviewed by Hartley and Gale reveal that alcohol is used more by rural youth of high school age than by urban youth. Binge drinking, consuming five or more drinks on the same occasion (whether at the same time or within hours of each other) on at least one day in the past 30 days, also occurs most often among youth in rural and frontier areas of the U.S.⁴⁹ According to the latest SAMHSA Office of Applied Studies report, the predominantly rural states of North Dakota, South Dakota and Wisconsin accounted for the majority of the areas with the highest rates of underage binge drinking.⁵⁰

Studies over the past 30 years have established the link between teenage alcohol and a plethora of health concerns and other problems such as motor vehicle crashes, drowning, suicide, homicide, falls, fires, cigarette smoking, illicit drug use, early sexual activity, sexually transmitted diseases, rape, unwanted pregnancies, academic failure, school truancy and dropout, job difficulties, fighting, property destruction and delinquency.⁵¹ Both alcohol and drug use are known to be related to suicide.⁵² The Committee urges the Secretary and other policymakers to keep in mind that alcohol abuse continues to be a concern that requires consistent focus, regardless of new or emerging substance abuse threats.

Safe Schools/Healthy Students

The **Safe Schools/Healthy Students Initiative** is a unique Federal grant-making program designed to prevent violence and substance abuse among our nation's youth, schools and communities. The SS/HS Initiative is supported by three Federal agencies—the departments of Education, Health and Human Services and Justice. The initiative seeks to develop real-world knowledge about what works best to promote safe and healthy environments in which America's children can learn and develop. Since 1999, more than 220 urban, rural, suburban and tribal school districts (in collaboration with local mental health and juvenile justice providers) have received grants using a single application process. The program has broad goals, but includes projects that focus on addressing issues related to abuse of alcohol and drugs in school settings. Over the course of this initiative, a number of grants have been made to rural communities. Due to some budget reductions, there was not a competition for this program in FY 2006.

There has been a great deal of interest in this program by local school systems, but due to funding restrictions less than 5 percent of applicants are funded.

For more information, and for a map showing local initiative sites in each State, see:
<http://www.sshs.samhsa.gov/initiative/currentinit.aspx>.

⁴⁸ Van Gundy, K. (2006). *Substance Abuse in Rural and Small Town America*. The Carsey Institute, Reports on Rural America, Volume 1, Number 2, p. 17.

⁴⁹ (Binge drinking definition) SAMHSA Office of Applied Studies. “2005 National Survey on Drug Use and Health: National Results.” <http://www.oas.samhsa.gov/NSDUH/2k5NSDUH/2k5results.htm#Ch3>. [Accessed October 2006].

⁵⁰ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *2002-2004 SubState Report on Substance Use and & Serious Psychological Distress*. Rockville, MD. <http://oas.samhsa.gov/substate2k6/toc.cfm>. [Accessed August 2006].

⁵¹ Robertson, E.B. (Ed.), et al. *Rural Substance Abuse*. (NIDA Research Monograph 168). “The Prevention of Alcohol Use by Rural Youth.” Carol N. D’Onofrio, p. 17.

⁵² Pirkola, S. (1999). *Alcohol and Other Substance Misuse in Suicide*. Department on Mental Health and Alcohol Research, National Public Health Institute, Helsinki, Finland, pp. 28, 32.

⁴⁷ Robertson, E.B. (Ed.), et al. *Rural Substance Abuse: State of Knowledge and Issues. Proceedings of a Meeting, April 26-27, 1994*. NIDA Research Monograph 168. (Printed in 1997). U.S. Department of Health and Human Services, National Institutes of Health, p. 1.

Older Adults and Alcohol Abuse

A study currently underway at the University of Maine Center on Aging, funded by the Maine Department of Health and Human Services' Office of Substance Abuse, is assessing the alcohol abuse-related needs and resources of adults 65 and older in Maine. Alcohol abuse is often a hidden problem for older adults given the emphasis of alcohol prevention efforts on teens and young adults. Yet, binge and chronic heavy drinking can heavily impact the health of older people when combined with the increased prevalence of chronic illness, use of prescription medications, and multiple physical, social and economic losses that many older adults experience. As rural America becomes more heavily populated by elderly residents, these issues are of increasing relevance. Older adults might be particularly vulnerable to chronic or heavy alcohol use due to the following risk factors: 1) the use of alcohol in pain management or "self-medication," 2) isolation from family, friends and the community in general, 3) the link between economic hardship and the possibility of substituting alcohol for more costly prescription drugs, 4) emotional factors such as loss of a spouse or loved ones, and 5) difficulties associated with the transitions of aging, such as stress and loneliness.

Study findings have implications for raising awareness of the health complications, social impact

and community readiness for addressing alcohol abuse in older adults. One in four community professionals surveyed reported contact with an older adult whom they believe to be abusing alcohol.

Key barriers to prevention and treatment of alcohol-related problems in older adults centered around program funding constraints, lack of community awareness of the severity of the problem, lack of transportation to services and psychological barriers. Financial barriers consisted of a lack of reimbursement streams for providers, limited funding for substance abuse programs and the overall cost of treatment for older adults.

Key recommendations rising from the research include: 1) challenging health care providers (doctors, nurses, social workers, home health professionals and direct care workers) to advocate for expanding treatment and prevention programs and to involve older adults in conversations about alcohol use and abuse, and 2) encouraging communities, older adults, family members, caregivers, concerned citizens and municipal officials to support initiatives that will raise awareness of the extent of the problem of elder alcohol abuse and to pursue strategic initiatives to increase prevention efforts within the community.

For more information, see:
<http://www.umaine.edu/mainecenteronaging/>.

Narcotics

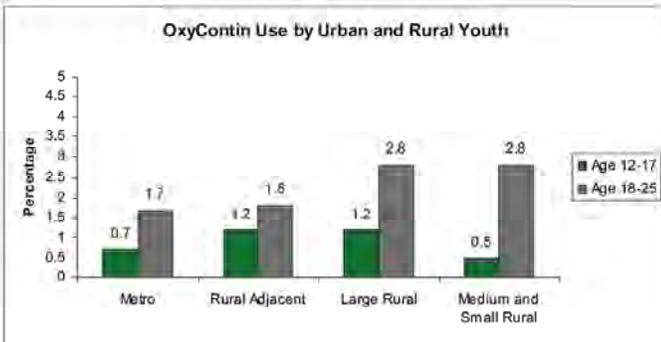
Narcotics are drugs that alleviate physical pain, suppress coughing, alleviate diarrhea and anesthetize. The opium poppy is the natural source of narcotics, and synthesized drugs such as thebaine, morphine and codeine can also act like opium. Prescription synthetic narcotic pain-relievers such as OxyContin (oxycodone) and Vicodin (hydrocodone) are often obtained and taken for unintended purposes.

Reports of OxyContin abuse in rural areas, which are often economically depressed, include the selling of prescriptions by patients with genuine prescriptions, forging prescriptions and robbing

pharmacies.⁵³ The illegal sale of OxyContin is attractive due to the great profits that can be realized. A 40-milligram pill costs approximately \$4 by prescription, yet it may sell for \$20 to \$40 on the street. Nationwide, treatment admission rates for narcotic painkillers increased by 155 percent between 1992 and 2002; for rural areas the increase was 269 percent.⁵⁴

⁵³ Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (CSAT). (April 2001). *CSAT Advisory: Breaking News for the Treatment Field*, Volume 1, Issue 1. "OxyContin: Prescription Drug Abuse." DHHS Publication No. (SMA)02-3636 NCADI Publication No. MS726.
<http://www.ncadi.samhsa.gov/govpubs/ms726/>.

⁵⁴ Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. "The Treatment Episode Data Set (TEDS)."
<http://www.oas.samhsa.gov/2k2/TEDS/TEDS.cfm>.



Source: Hartley, D., Gale, J., & Lambert, D. Preliminary Findings of Ongoing Research.

As with alcohol, Hartley and Gale have found that OxyContin has a higher use rate among young adults than among teens or adults, and that this is especially true in rural areas. The prevalence rate for OxyContin among 18-to-25 year-olds is 2.8 percent in rural areas as opposed to 1.7 percent among the same age group in urban locales.⁵⁵ OxyContin, found in drugs like Percodan and Tylox, comes in tablet form, which is then easily chewed, crushed and snorted, or dissolved and injected. These methods cause a faster and more dangerous release of medication. Rural eastern areas of the United States, particularly Maine, Virginia and Kentucky, brought significant OxyContin abuse to the public eye in 1998. During the next two years OxyContin abuse increased and spread to other depressed areas of the country, especially in Maryland, West Virginia and Florida, as well as to urban areas in Pennsylvania and Massachusetts.⁵⁶

Supporting Rural Demographics

Access to substance abuse prevention, treatment or recovery services of any kind in rural areas is a problem because there are simply so few resources dedicated to the problem there and few providers who are knowledgeable about rural culture. The economic impact of the 1980s on rural areas forced

Substance Abuse in Bucksport, Maine

Folks in Bucksport, Maine suspected that they had some substance abuse problems, like so many small towns do. But when they saw the numbers, the town leaders knew they needed to do something. That was when things really got difficult.

In some ways, the recognition of the problem was the easy part. According to the 2004 “Maine Youth Drug and Alcohol Use Survey,” residents of Hancock County were abusing alcohol, prescription drugs and other illegal drugs at rates that often exceeded the statewide averages. Of most concern was what was going on in the schools, where kids were abusing substances such as alcohol, marijuana and other drugs at alarming numbers.

Fighting substance abuse would prove to be a challenge. Over the past few years, the town had lost both its school-based substance abuse counselor and another substance abuse counselor at the local paper plant. The Bucksport Bay Healthy Communities Coalition tried a number of different approaches to hire a local counselor, usually through grants and pilot projects, but had trouble sustaining the effort. Local officials felt the Federal and State funding streams weren’t designed to meet the needs of small towns, which made it difficult to design a sustainable program. Over a two-year period, there were four counselors who came from other nearby places to offer services, but they only came in a few days a week.

“In the 10 years plus [that] we’ve been working on this, [it] is absolutely a core issue,” said Mary Jane Bush, the executive director of the Bucksport Bay Healthy Communities Coalition, expressing her frustration with the funding silos preventing an integrated approach. “With the different Federal agencies and the State departments, with their own policies and requirements, we’ve been working hard, but you see the disconnect.”

The challenges faced by Bucksport aren’t unique to this community. Developing sustainable substance abuse treatment and counseling services is difficult with low population volumes and limited reimbursement. Collaborative solutions seem to be the most viable option for treatment services, but funding silos make coordinating efforts difficult.

For more information on the survey, see <http://www.maine.gov/dhhs/osa/data/mydaus/index.htm>.

⁵⁵ Hartley, D., Gale, J., & Lambert, D. Preliminary Findings of Ongoing Research.

⁵⁶ Department of Justice, Office of Inspector General. (September 2002). Evaluation and Inspection Report I-2002-010. Review of the Drug Enforcement Administration’s (DEA) Control of the Diversion of Controlled Pharmaceuticals Report Number I-2002-010.

some of the rural workforce to move to urban areas, taking with them much of the resource base and personnel that supported the delivery of health, mental health, and drug and alcohol abuse prevention and treatment services.⁵⁷ Rural residents have to travel farther for “local” treatment: often between 13 and 30 miles to get to a substance abuse treatment facility, and the average distance in a frontier area may be dramatically longer. Whereas 49 percent of metro residents live within one mile from a treatment facility, only 9 percent of rural residents have such an opportunity for care.⁵⁸ However, distance to access presents a paradox for rural substance abuse treatment. Because of the stigma associated with seeking drug abuse treatment, many rural residents prefer to travel outside of their home community to seek in-patient or outpatient care. Thus, nearness of facilities may not be an especially attractive factor for rural residents seeking treatment.

This Committee has championed the notion of integrating behavioral health care services in its past work, including integrating substance abuse treatment with primary care services in rural areas, for a number of reasons, one of which is the reduced stigma associated with seeking substance abuse treatment if it is being provided in a primary care facility.⁵⁹ Because of this stigma and because of inequitable coverage and reimbursement policies, which force health care professionals to use procedure codes for treating the symptoms of substance abuse (e.g., fatigue, irritability, weight loss) rather than the addiction itself in order to get reimbursed,⁶⁰ the true extent of a substance abuse

Cando, North Dakota

In an isolated patch of northeastern North Dakota, a small town’s health care leaders are enjoying success in taking on a problem that many big cities struggle with mightily—providing effective substance abuse treatment.

The Center for Solutions is a residential drug treatment center that has become an important part of the small, integrated health care delivery system in Cando (pronounced “Can Do”). The Center takes care of up to 24 clients recovering from any number of substance abuse addiction challenges—from alcohol and methamphetamine to prescription drug abuse. As such, it’s one of the few services of its kind located in such a small place (population 1,172).

The center is the brainchild of Glenda Spencer, now the director of Addiction Services at the center, and a veteran in the field of substance abuse treatment. Spencer had spent most of her career watching traditional hospital-based treatment centers struggle with—and often fail—to break the habit for those suffering from addiction. She felt there had to be a better and more holistic way to do things, and she convinced the Towner County Medical Center Board to let her try.

Housed in a converted old farmhouse, the Center for Solutions treatment center utilizes a patient-centered treatment model Spencer first developed at a nearby hospital. Under Spencer’s direction, the Center draws patients, age 14 and older, from across the upper Midwest, as far as 250 miles away. It has a standing waiting list, despite relying almost completely on the basis of word-of-mouth advertising.

The revenues generated by the Center have also helped improve the financial status of the Towner County Medical Center by bringing in needed revenue to a cash-strapped, locally owned and operated health care system. The Center takes third-party insurance, but staff members note that many of the patients pay out-of-pocket for its services. In that way, the Center finds itself facing the same challenges as many of its urban counterparts, where access to these services is limited, even if one has health insurance.

⁵⁷ Robertson, E.B. (Ed.), et al. *Rural Substance Abuse*. (NIDA Research Monograph 168), p. 1-2.

⁵⁸ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2001). *Summary of Findings from the 2000 National Household Survey on Drug Abuse*. Series H-13, DHHS Publication No. (SMA) 01-3549. Rockville, MD, 2001.

⁵⁹ National Advisory Committee on Rural Health and Human Services. (April 2004). *The 2004 Report to the Secretary: Rural Health and Human Service Issues*. “Integrating Behavioral Health and Primary Care Services in Rural Areas,” p. 11.

⁶⁰ American Academy of Pediatrics, Committee on Child Health Financing and Committee on Substance Abuse. (October 2001). “Improving Substance Abuse Prevention, Assessment, and Treatment Financing for Children and Adolescents.” *Pediatrics*. 108,4, pp. 1025-1029.

problem in a community may remain hidden. The Committee has learned through testimony and site visits that reimbursement vagaries also inhibit access to treatment. For example, in Wisconsin substance abuse day treatment providers are reimbursed at the provider’s usual and customary charge or the maximum allowable fee established by the Department of Health and Family Services, whichever is less. In general, individuals with private insurance, with its visit limitations and caps, are not eligible for State-funded services. Uninsured individuals have to pay out-of-pocket for substance abuse services or rely on publicly funded services. Medicaid’s benefits, especially for children and adolescents, are comprehensive, but because the reimbursement rates are so low, few qualified providers are willing to offer care to these beneficiaries.⁶¹

different modes of substance abuse treatment and recovery services are a necessity. Telemedicine and other technologies have been the hope for almost a decade as the key to solving the substance abuse treatment access problems in rural areas.

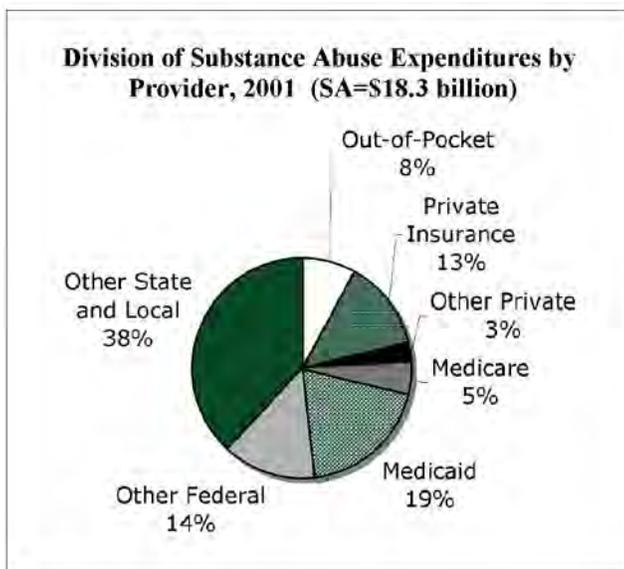
For school-age children with substance abuse problems, the rural school setting is often of little help. Rural schools are ill-equipped to handle the substance abuse problems of their students. Even though rural teens are at significantly greater risk of using certain drugs than both suburban and urban teens, mental health and health education staff from rural schools were less likely than their counterparts in urban schools to receive training for such teen services as suicide prevention, family counseling, peer counseling, self help and tobacco use prevention.⁶² Moreover, rural schools have fewer policies and security practices that prevent violence and drug use than do urban schools.⁶³

The United States spent approximately \$18 billion on substance abuse treatment in 2001. This represents an estimated 17.6 percent of the combined total mental health expenditure for that year and only 1.3 percent of all health care spending. Substance abusers rely predominantly on public funding for treatment. Some 76 percent of substance abuse expenditures came from public sources, compared to 45 percent for all health care spending by public sources. State and local governments, along with Medicaid, constitute more than half of all funding.

Current HHS and Governmental Role

SAMHSA and NIH

The Department of Health and Human Services supports three agencies designed to address substance abuse, comprised of the Substance Abuse and Mental Health Services Administration (SAMHSA) and two National Institutes of Health (NIH) research institutes, the National Institute on



Source: Mark, T.L. et al. (2005). *National Estimates of Expenditures for Mental Health Services and Substance Abuse Treatment, 1991–2001*. SAMHSA Publication No. SMA 05-3999. Rockville, MD. <http://www.samhsa.gov/spendingestimates/toc.aspx>.

A community might like to provide counseling, prevention and recovery services for substance abuse, but salaries are often lower in rural areas, making recruitment and retention of qualified providers and staff difficult. Because of the extreme rural geographic distances and isolation,

⁶¹ *Ibid.*

⁶² Mink, Michael D. et al. *Violence and Rural Teens*.

⁶³ *Ibid.*

Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

There are three centers within SAMHSA, two of which focus on substance abuse: the Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse Treatment (CSAT). CSAP is the primary source of funding for substance abuse prevention programs through its discretionary grant programs and its administration of the 20 percent prevention portion of the Substance Abuse Prevention and Treatment Block Grant program to States, territories and the Red Lake Nation. The Center for Substance Abuse Treatment (CSAT) is responsible for improving community-based substance abuse treatment services also, through its discretionary grant programs and its administration of the Substance Abuse Prevention and Treatment Block Grant program (SAPT). The SAPT Block Grant provides funding to States, territories and the Red Lake Nation according to a formula. These funds are used to plan, carry out and evaluate activities to prevent and treat substance abuse.

In 2006, SAMHSA announced its intention to update the National Registry of Evidence-Based Practices and Programs (NREPP). This registry is used to identify successful substance abuse and mental health interventions. This “decision support tool” is meant to help States, territories and other key stakeholders collaborate on best practices and innovative approaches.⁶⁴ A web site is scheduled to be unveiled in late 2006 to distribute substance abuse treatment success stories to the public.

CSAT - Access to Recovery

In early 2003, President Bush announced a \$600 million program to increase the national capacity of substance abuse treatment and related services, including faith-based entities. The Access to Recovery initiative, administered by SAMHSA/CSAT, supports State efforts to assist

individuals addicted to drugs and alcohol by providing funds for substance abuse service providers. Some \$25 million is targeted to methamphetamine treatment for FY 2007. One interesting aspect of the program for rural areas is a voucher component in which individuals can select any treatment provider they choose, even in another town. Anonymity is often difficult to maintain in rural communities; help for a substance abuse problem may be more attractive if offered in a place away from one’s home town.

CSAP: Prevention of Methamphetamine Abuse Grants

In September 2006, SAMHSA’s Center for Substance Abuse Prevention announced the award of 10 grants, totaling over \$10.1 million over three years, to help local communities expand evidence-based substance abuse prevention programs and systems to stop abuse of methamphetamine. The Prevention of Methamphetamine Abuse Grants will be used in a number of ways, such as implementing evidence-based community prevention programs that target populations at greatest risk for methamphetamine abuse; training and education of professionals, educators, law enforcement personnel, families and others about the signs of methamphetamine abuse and prevention options; and testing and evaluating pilot programs focused on drug-endangered children. The annual award is expected to be from \$300,000 to \$350,000 per year for up to three years.

In August of 2006, SAMHSA announced the distribution of seven grants totaling \$10 million to treat methamphetamine in rural areas. The rural-specific focus of the grants reflects SAMHSA’s urge to target those areas “hardest hit by methamphetamine abuse over the past decade, enabling rural communities to provide more comprehensive, integrated care for adults using methamphetamines or other emerging drugs of abuse.”⁶⁵ The grants are designed to meet the needs

⁶⁴ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (June 30, 2006). Notice Regarding Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-Based Programs and Practices: Priorities for NREPP Reviews. *Federal Register*. Vol. 71, No. 126, pp. 37590-37591.

⁶⁵ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, News Release. “\$10 Million Awarded to Fight Methamphetamine in Rural America.” August 2006.

of an increasing number of people seeking care for addiction, especially in non-metro areas.

NIDA

The National Institute of Drug Abuse (NIDA), within the National Institutes of Health (NIH), conducts and supports research on drug abuse and addiction. NIDA supports over 85 percent of the world's research on the health aspects of drug abuse and addiction. In 1994 NIDA, in collaboration with the United States Department of Agriculture and the National Institute on Alcohol Abuse and Alcoholism, coordinated a conference to assess substance abuse in rural communities with the goal of initiating a research program designed to gain a better understanding of substance abuse in rural America. This conference reviewed what was known to date about drug and alcohol abuse in rural settings, identified gaps in the knowledge base and suggested areas for further study. A monograph based on the papers from the conference was produced, entitled *Rural Substance Abuse: State of Knowledge and Issues*, and was published in 1997. The Committee unanimously agrees that this monograph should be updated.

NIAAA

The National Institute of Alcohol Abuse and Alcoholism, within NIH, is the lead U.S. research institution on the effects of alcohol use and alcoholism. In its mission to reduce U.S. alcohol abuse rates, NIAAA conducts research studies in numerous areas including genetics, neuroscience and epidemiology, and also looks at the health risks of alcohol consumption, and alcohol abuse prevention and treatment. In 1998 the Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP) initiated the Enforcing Underage Drinking Laws (EUDL) Discretionary Grant Program; the NIAAA helped to provide a rural focus to the program in 2004 when a Rural Communities Initiative was created to address the challenges of deterring underage drinking in rural areas. To date NIAAA-funded researchers are

evaluating EUDL programs within rural areas of 15 states.⁶⁶

What are the Shortcomings of the Current Response?

The lack of research data has consistently been the biggest downfall for policymakers attempting to quantify and address the rural substance abuse problem. Funding for substance abuse services depends on data and information about the target population. Current substance abuse surveys and studies do not allow for or recognize the differences, or similarities for that matter, between urban and rural substance abuse trends. Based only on numbers of clients, rural areas lose out on funding for programs. Lack of programs means lack of access to prevention, treatment and recovery services. Because of the data problems, we are unsure if a successful treatment modality from an urban setting will be effective with a rural population. Despite the fact that the formula is mandated by the Public Health Service Act, the Office of Management and Budget has criticized the distribution formula for the SAPT Block Grant funds because it does not correspond with the prevalence of substance abuse; thus, Block Grant-funded services vary by State.⁶⁷ As it stands now, most funding from Federal and State sources appears weighted toward the urban experience, given reliance on population numbers for allocation of funding.

The Committee learned from rural substance abuse experts in its site visits that the primary rural challenges with the SAPT Block Grant is that the funding level is not sufficient to ensure resources for both urban and rural areas. These individuals were also concerned that the available funding tended to be fairly restrictive in how it could be allocated and targeted in a way that, given low-

⁶⁶ Office of Juvenile Justice and Delinquency Prevention. "Program Summary: Enforcing Underage Drinking Laws." <http://ojjdp.ncjrs.org/Programs/ProgSummary.asp?pi=17>.

⁶⁷ ExpectMore.gov. "Substance Abuse Prevention and Treatment Block Grant."

<http://whitehouse.gov/omb/expectmore/summary.10001066.2005.html>.

patient volumes, did not work well for small communities.

Data are not collected at a level that allows for sub-state analysis. This is unfortunate because the availability of that kind of specific data might help States and regions target scarce resources. Some of the rural/urban data gap is beginning to close, however. SAMHSA administers three national data collection efforts, each of which recognizes, to some extent, the differences in substance abusing populations across the country. The National Survey on Drug Use & Health (NSDUH) provides yearly national- and State-level estimates of alcohol, tobacco, illicit drug and non-medical prescription drug use. This information is separated into rural and urban categories. The Drug Abuse Warning Network (DAWN) is a national public health surveillance system that collects data and reports information on adverse health consequences associated with drug misuse and abuse. DAWN captures data on drug-related emergency room visits from a national probability sample of hospitals with over-sampling in selected metropolitan areas. The final national data collection effort is the Drug and Alcohol Services Information System (DASIS). The DASIS collects national data on drug treatment services, including location, types of services offered and rates of utilization. Its demographic information on admissions to treatment facilities includes a rural analysis.

Conclusions

The main hurdle facing the Department in addressing rural substance abuse is the diffusion of resources, especially to small communities. Larger communities and urban areas can point to dramatic figures that warrant more spending. In smaller, rural areas, where substance abuse can be more damaging to the social networks in such close-knit communities, the spending on prevention, treatment and recovery services is minimal. As pointed out by the Hartley and Gale analysis, it takes a small prevalence rate to achieve a large impact in a rural community. A consistent concern to the Committee is that marketing and media messages are failing with respect to the dangers of substance abuse.

Usage of alcohol, cigarettes and drugs are often implicitly condoned when attractive celebrities portray characters that use and abuse these substances.

Recommendations

The Secretary should examine the Substance Abuse Prevention and Treatment Block Grant program formula to determine if the reliance on population size puts rural areas at a disadvantage in qualifying for funding. Findings from this assessment should be shared with the Congress and the governors.

Recognizing its limited understanding of the formula by which funding decisions are made through the SAPT Block Grant, the Committee would like to see research conducted that examines the equity of the formula. The typical “rural/urban” split of data is not as helpful to smaller communities and frontier areas because funding decision-making usually emphasizes population size, rather than the incidence of the problem. To provide answers to the problems of substance abuse in these communities more weight should be given to the prevalence of the substance abuse problem in a given geographic area. The cost to provide any type of health or human service is greater in rural areas because of the geographic distances and low volumes of clients. These factors do not minimize the need for services. Ideally, the Secretary could commission a comprehensive look at program authorities and regulations that deal with substance abuse programs to examine whether services are limited by the formula’s guidelines.

The Secretary should ensure that NIDA Research Monograph 168, Rural Substance Abuse: State of Knowledge and Issues be updated as the findings are now a decade old.

The Committee specifically supports the following research priorities outlined in NIDA Research Monograph 168, *Rural Substance Abuse: State of Knowledge and Issues*:

- a. Study of the varying use and abuse patterns for

different cultural, ethnic, gender, generational, and occupational subgroups (e.g., farming, fishing, mining, lumbering, blue- and white-collar manufacturing, and service providers) within rural populations.

b. Evaluation of existing prevention/treatment services being delivered to rural populations, including studies of special subpopulations such as those living in economically depressed communities and mobile communities such as migrant farm workers.

c. Assessment of outreach strategies to expand prevention and/or treatment services to underserved populations in rural areas.

The Secretary should work with SAMHSA to expand its National Registry of Evidence-Based Programs and Practices (NREPP) to include a section of rural-specific programs and practices.

The Committee believes this registry is an important tool for States, communities and practitioners to identify and replicate best practices in substance abuse prevention and treatment. It commends SAMHSA and HHS for its creation. The Committee also believes that collecting some information on rural-specific interventions and projects would provide even greater assistance to rural communities who struggle with unique funding, volume, resource and workforce challenges due to their isolation and distance from the standard substance abuse treatment and prevention infrastructure available in urban and suburban communities.

The Secretary should initiate pilot programs to explore creative models for substance abuse prevention, treatment and recovery programs in rural school systems through a rural-focused expansion of the Safe Schools/Healthy Students initiative.

Such an initiative represents a unique partnership of Federal agencies and provides a necessary focus on preventing drug addiction among children and adolescents. In 2004 the Committee toured a Safe

Schools/Healthy Students grantee site in Nebraska and was impressed by the scope of this collaborative initiative. The rural-focused projects funded by this grant program are numerous, and its mechanisms have been proven to work well for rural communities.

The Secretary should conduct research and evaluation into the use of technology for meeting the needs of substance abuse treatment.

The Committee notes that mental health providers have achieved some level of success using telehealth technology to deliver needed services in rural communities. In the course of its work over the past year, the Committee believes that this technology may also hold great potential for providing substance abuse treatment. In addition, the use of this technology may also help decrease the stigmatization of substance abuse treatment in small rural communities since it may afford greater anonymity.

The Secretary should require SAMHSA to increase sample sizes in its research activities by over-sampling rural zip codes in survey activities. This would allow sub-state and regional analyses, provide a more robust data sample and ensure adequate representation of rural residents.

HHS and SAMHSA spend considerable time and money conducting needed research on substance abuse and treatment. This research has provided an important base of information through which to inform policy and program decisions. However, due to sample-size limitations, there are often problems conducting sub-State and/or sub-regional analysis. This limits the ability of States and communities to use this important data in targeting scarce resources. Further, nationally representative survey samples are often not generalizable to rural communities when population data are collected proportionally. By increasing overall sample sizes and including an over-sample of rural residents, HHS can greatly increase the utility of this data to draw conclusions on rural populations and for specific rural communities.

Acronyms Used

ACF – Administration for Children and Families
AoA – Administration on Aging
ADEA – American Dental Education Association
AHRQ – Agency on Healthcare Research and Quality
CSAP – Center for Substance Abuse Prevention
CSAT – Center for Substance Abuse Treatment
CAH – Critical Access Hospital
CASA – National Center on Addiction and Substance Abuse
CDA – Child Development Associate
CMS – Centers for Medicare and Medicaid Services
DASIS – Drug and Alcohol Services Information System
DAWN – Drug Abuse Warning Network
DEA – Drug Enforcement Administration
EUDL – Enforcing Underage Drinking Laws Grant Program
FACES – Head Start Family and Child Experiences Survey
FY – fiscal year
HMO – Health Maintenance Organization
HRSA – Health Resources and Services Administration
HHS – U.S. Department of Health and Human Services
MA – Medicare Advantage
MA-PD – Medicare Advantage with a Prescription Drug Benefit
M + C – Medicare + Choice
MCHB – Maternal and Child Health Bureau

MMA – Medicare Prescription Drug Improvement and Modernization Act
NIAAA – National Institute on Alcohol Abuse and Alcoholism
NIDA – National Institute on Drug Abuse
NIH – National Institutes of Health
NREPP – National Registry of Evidence-Based Programs and Practices
NSDUH – National Survey on Drug Use & Health
OIG – Office of the Inspector General
OJJDP – Office of Juvenile Justice and Delinquency Prevention
ORHP – Office of Rural Health Policy
PDP – Prescription Drug Program
PFFS – Private Fee for Service
QIO – Quality Improvement Organizations
RPPO – Regional Preferred Provider Organizations
RUPRI – Rural Policy Research Institute
SAMHSA – Substance Abuse and Mental Health Administration
SAPT – Substance Abuse Prevention and Treatment Block grant program
SHIP – State Health Insurance Assistance Program