January 29-31, 2006, Washington, D.C.

Health Resources and Services Administration
Office of Rural Health Policy

Washington, D.C.
January 29-31, 2006

Meeting Summary

The 52nd meeting of the National Advisory Committee on Rural Health and Human Services was held on January 29-31, 2006 in Washington, D.C.

Sunday, January 29, 2006

Governor David Beasley, Chairman of the Committee, convened the meeting on Sunday afternoon. He reviewed the agenda for the meeting and asked the Committee to begin thinking about the annual report for 2007.

The members present were: Susan Birch, RN, MBA; Evan Dillard, FACHE; Joellen Edwards, Ph.D.; Michael Enright, Ph.D.; Bessie Freeman-Watson; Joseph Gallegos; Julia Hayes; Lenard Kaye, D.S.W.; Michael Meit, M.P.H.; Arlene Jackson Montgomery, Ph.D.; Ron Nelson, P.A.; Larry Keith Otis; Patti J. Patterson, M.D.; Heather Reed; Thomas C. Ricketts, Ph.D.; Senator Raymond Rawson, D.D.S.; and Tim Size. Sister Janice Otis was unable to attend. Present from the Office of Rural Health Policy (ORHP) were: Marcia Brand, Ph.D.; Tom Morris, MPA; Jennifer Riggle, J.D.; Karen Stewart, M.P.H.; Phuong Luu; Anjali Garg; Michele Pray-Gibson; Carrie Cochran, MPA; and Emily Cook, M.S.P.H. Dennis Dudley attended representing the Administration on Aging, U.S. Department of Health and Human Services (DHHS). Nikki Bratcher-Bowmen attended representing the Office of Intergovernmental Affairs, DHHS.

Overview of Medicare and Advantage in Rural Communities

Ms. Emily Cook, ORHP

Ms. Cook traced the history of Medicare Advantage and described the basic elements of the program. Some changes from the previous program, known as Medicare + Choice include the addition of Regional Preferred Provider Organizations (RPPOs), Special Needs Plans, financial incentives for certain plans, and the requirement that participating plans include Part D

prescription drug benefits in at least one benefit package. RPPOs encourage plan offerings in rural areas by requiring an entire region to be covered. There are multiple incentives to encourage plans to enter the market. Overall, Medicare Advantage is expected to increase the number of managed care plans available in rural areas, particularly Private Fee-For-Service Plans and PPO plans. Ms. Cook discussed some of the issues that rural providers are facing as the program is implemented. Rural providers are often inexperienced in negotiating contracts with managed care plans and widespread confusion about payment requirements abounds. She spoke about the choices providers must make in dealing with the Medicare Advantage Program and the potential consequences that may follow from signing contracts with different types of plans. She also described the issues that should be considered by rural Medicare beneficiaries as they make their choices of a managed care plan. There can be multiple plans available them, each with different benefits and cost savings that need to be evaluated. In addition, plan provider networks are still being established and can be difficult for beneficiaries to identify. Ms. Cook said that the current environment is confusing and complex, and there is tremendous pressure to make the program work. She provided suggestions on some specific emerging rural issues under Medicare Advantage where the Committee could focus its efforts during the coming year.

Mr. Size commented on the need for the Committee to find a proper balance between patient issues, provider issues, and the issues faced by managed care plans, as the Committee works on its report.

Mr. Nelson commented on inconsistencies in the implementation of the program and conflicting interpretations of the program regulations that are causing problems for both rural beneficiaries and providers.

Mr. Dillard asked whether the Committee could encourage staff at the Center for Medicare and Medicaid Services to meet with various rural constituent groups to discuss the uncertainties and confusions surrounding the program. Governor Beasley replied that the Committee could include that suggestion in its letter to the Secretary on this meeting.

Dr. Ricketts inquired whether the RPPOs were essentially "fixed" or in the process of development. Ms. Cook replied that they are ongoing with respect to the development of provider networks and there are financial incentives in place to help them succeed.

Ms. Cook responded to specific ideas from the Committee on potential topics for the annual report in 2007.

2007 Report Guidelines and Staffing Changes

ORHP Staff

Governor Beasley reviewed guidelines for the 2007 report and the timeline for its completion. Each chapter of the report will be limited to 10 pages and the chapters are to follow the template that was furnished to the Committee. The report needs to be more concise than the report for 2006.

Mr. Morris talked about Committee staff changes for the coming year and related developments in the ORHP.

Dr. Brand, Director of the Office of Rural Health Policy, discussed recent development in the Office, including a new rapid-response mechanism for rural policy research that will be announced in April 2006. She also spoke about the Small Health Care Provider Quality Improvement Program that will fund 10 new grant awards this year. She briefly described the Delta Health Initiative in ORHP and informed the group that the next meeting of the DHHS Rural Task Force would be held on February 8.

Washington Update: National Rural Health Association (NRHA)

Mr. Alan Morgan, National Rural Health Association

Mr. Morgan presented the mission of his organization and noted that membership has been increasing rapidly. He then reviewed the projected FY 2006 budget for rural health programs and talked about the difficult budget outlook for FY 2007. The emphasis in Congress is on program outcomes that can be measured and have a beneficial impact on rural populations. He spoke about the impact of the Medicare Modernization Act on rural Medicare beneficiaries and providers, emphasizing that rural beneficiaries must be able to identify and understand their options and need good information quickly. The Act provides payment adjustments for rural providers that expire over time, and their future is uncertain. Emerging developments in rural health include a possible expansion of the 340B program, which provides discounts for prescription drugs to some rural providers, and legislative initiatives under the Rural Community Hospital Assistance Act proposal, introduced in both the House and Senate. He also said that substance abuse in rural communities is demanding more attention and that NRHA is developing a policy paper on the subject.

Dr. Ricketts commented that some program indicators that have been developed to measure the success of rural health programs may be suitable for urban areas but are unfair in rural settings. He cited some examples related to Title VII programs under the Public Health Service Act. Program evaluation structures need to be created that are appropriate to the unique

conditions in rural areas. Mr. Morgan agreed with the comment and expressed his frustration with the current emphasis on quantification that can discount program benefits in rural communities.

Dr. Brand said that the ORHP is working to better describe outcomes and accomplishments achieved through programs administered by the Office.

Dr. Edwards asked for more information on the NRHA substance abuse initiative. Mr. Morgan responded that methadone abuse has become a major issue in many rural states and the states rural health associations have been pushing this issue.

Dr. Kaye commented that education and training programs are needed to address substance abuse issues and these programs are among the most difficult to quantify in terms of their impact.

Overview of Substance Abuse in Rural Communities

Ms. Ulonda Shamwell, Substance Abuse and Mental Health Services Administration (SAMSHA), DHHS.

Ms. Shamwell spoke about the extent of drug abuse in rural areas and its impact on families, rural economic systems, and rural health care service systems. She described major gaps in substance abuse treatment programs; rural issues related to treatment and prevention; the impact on rural health professionals; the lack of rural workforce in social services; and the scarcity of research on substance abuse in rural areas. Her agency is working to identify treatment and social services models that work in rural areas for inclusion in the SAMSHA web site. She mentioned that telehealth projects supported by the agency are an important tool for expanding access to care. SAMSHA is part of the DHHS workgroup addressing the issue and is supporting prevention programs through block grants to the states. Other support comes from training programs and the Drug Free Communities Program that is funding projects in rural communities. Ms. Shamwell briefly described other SAMSHA initiatives addressing rural substance abuse issues.

Dr. Patterson asked about drug abuse trends in the rural Hispanic population. Ms. Shamwell indicated that there is some correlation between methadone usage and movements of the migrant population.

Mr. Size asked whether the focus should be on treatment or prevention. Dr. Shamwell replied that the needs are so great that you cannot separate one from the other.

Mr. Meit asked about the availability of data on the magnitude of the methadone problem. The speaker answered that federal mental health surveys are conducted each year and some states are good sources for data.

Following the presentations, Governor Beasley called for public comments. There were no comments and the meeting was adjourned until Monday morning.

Monday, January 30, 2006

The meeting was convened at 9:00 a.m. Governor Beasley discussed the agenda for the day and Mr. Morris covered some housekeeping issues.

Overview of Head Start in Rural Communities

Mr. Craig Turner, Administration for Children and Families, DHHS.

Mr. Turner reviewed the history of Head Start since its inception in 1965. The program is was based on the premise that children from disadvantaged families do not start school on an equal footing with other children. The program serves children at ages 3 and 4, and the current budget is $6.8 billion. In addition to education, the program provides health services (screening, dental, immunizations, etc.) and has a strong family service component involving home visits to families. There are currently 20,000 Head Start centers throughout the country. Physical access to the program is a major issue for rural areas. The home-based option is prevalent in rural areas where travel distances make large classrooms impossible. Research suggests that the home-based option is effective. In rural areas experiences in socialization are also made available twice a month. He noted that in rural areas fewer children have access to health care providers and access to dental services is a formidable problem. The program has found that few dentists are willing to see disadvantaged children and each year the situation is getting worse. Research on the program shows that Head Start children do better in school than comparable groups outside the program, but there is no consensus on long-term effects.

Mr. Nelson asked about the home-based component. Mr. Craig said that Head Start must rely on parents since children are in the program for a short time, and that home-based services help parents to understand how their children learn and grow. Mr. Nelson then reported his own experiences with trying to find dental services for children and suggested some strategies for connecting Head Start kids with rural providers.

Mr. Otis asked the speaker to talk about local collaboration between Head Start programs and other resources for children. Mr. Craig said that community collaborations are expected from the Head Start Centers and they are periodically evaluated for their performance in this arena.

Grantees that do not perform well against the performance standards used by the federal regional offices are terminated.

Mr. Craig then spoke at some length about federal oversight of the program.

Ms. Birch expressed concern about the lack of funding in Head Start for community capital expenses. She also asked about the data on immigrant populations served by the program. Mr. Craig replied that Latino children are now the biggest part of Head Start and that finding bilingual staff to serve them has become more of a problem.

Senator Rawson asked about payments for dental services and other health services. Mr. Craig reported that about 4-5 % of the program dollars go to health services.

Ms. Freeman-Watson commented on transportation issues for rural Head Start children and her impression that Head Start is not cooperating with other agencies to address the problem. Mr. Craig said that he could not understand such lack of cooperation and asked her to provide specific information that he could address.

Governor Beasley said that many governors believe that states should have a greater role in the program and asked the speaker for his comments on this issue. Mr. Craig responded that a nine-state pilot experiment was proposed by the president, but not approved by congress. Each state does have a liaison person the in the Governor's Office who is funded by the program.

Governor Beasley asked if someone from Head Start could provide liaison with the Committee as it works on its report. Mr. Craig will respond to this request.

DHHS's Role: Connecting the Three 2007 Topics

Mr. Dennis Williams, Deputy Administrator, HRSA

Mr. Williams thanked the Committee for its work and briefly described some new rural health activities in HRSA. He then introduced Mr. Jack Kalavritinos from the Office of the Secretary, DHHS. Mr. Kalavritinos is in the Department's Office of Intergovernmental Affairs and serves as Co-Chairman of the DHHS Rural Task Force.

Mr. Kalavritinos said that two key issues for the Secretary are implementation of Medicare Part D and planning for the possibility of pandemic flu. He said that the states would be compensated for their expenses in meeting the needs of Medicare dual-eligibles under Part D. He also said that planning meetings on pandemic flu will be held in every state, a major undertaking for the Department. Seven meetings have already taken place. Further, he reported

that substance abuse in rural areas is major focus for the Department and the Committee's selection of this topic is welcome.

Mr. Size observed that Medicare Part D is creating unique problems for nursing homes that must learn to cope with many different contracts under Part D. He said that these issues should be recognized in the Department.

Dr. Ricketts expressed concern about reduced funding for health workforce programs in the Department. He said that we are losing a central source of support and data to address the problem. Mr. Williams responded that while funding was reduced, there are still ways of tracking national trends.

Mr. Meit encouraged the Department not to neglect local level planning for pandemic flu emergencies. There is no source of support for this in rural communities. Dr. Ricketts reinforced the need for local planning efforts.

Research on Substance Abuse in Rural Communities: Panel Discussion

Ms. Peggy Halpern and Ms. Ann McCormick, Office of the Assistant Secretary for Planning and Evaluation (ASPE), DHHS

The two panel members provided information on a Departmental project to strengthen rural data for research and evaluation in human services. Information has been scarce due to the lack of empirical research, special challenges in collecting rural data, and other factors. The purpose of the project is to establish a solid foundation for research and to inform research and policy makers about human service needs of rural communities. The goals are to summarize current conditions and trends, select service conditions for in-depth research, and compile information of data sources suitable for research. The speakers described the complex geographic, social, and economic factors that influence human services delivery in rural areas. They went on to describe the factors that were considered in selecting priority research topics for the project. Ultimately, three topics were selected from a list of twenty potential human service issues confronting rural areas. The topics selected were work supports for low-income families, substance abuse, and child welfare. Focusing on substance abuse, the speakers talked about the dimensions of the problem in rural areas and their findings from the existing literature. They identified methodological limitations on studies of rural substance abuse and gaps in our research knowledge. They described how data sources were identified and compiled to provide a comprehensive resource for future research. A list of selected federal and non-federal substance abuse data sources was presented. The speakers suggested how the data might be

used to address substance abuse research gaps and offered considerations for future studies of rural substance abuse.

Mr. Size expressed interest in human services collaboration issue and noted that we keep creating "silos" in which the different programs operate. Ms. McCormick said that some work on the "silo" problem has been done, but this is an interesting gap in research at the federal level.

Dr. Edwards asked the speakers for advice on how the Committee could narrow the substance abuse topic. Ms. Halpern responded that a focus on methadone use and/or alcohol abuse is warranted.

Mr. Morris commented on the lack of data in rural substance abuse and asked about the best data that is available. Ms. McCormick said that the data is most extensive on the problem of alcohol abuse.

Research on Head Start in Rural Communities: Panel Discussion

Ms. Maria Woolverton, Office of Planning Research and Evaluation, Administration on Children and Families
Dr. Nicholas Zil, Westat Corporation

Ms. Woolverton described the major national studies of Head Start, including the Head Start Family and Child Experiences Survey (FACES), the Head Start Impact Study, and the Early Head Start Research and Evaluation Project. FACES and the Impact Study are longitudinal studies of Head Start quality and impact. Early findings from the Head Start Impact Study show modest but statistically significant effects of Head Start on some cognitive domains and health and parental practices and perceptions. The Early Head Start Research and Evaluation Project shows positive impacts on multiple domains of children's development and parenting. A related project will gather information about program management practices and services. In addition, there are special population projects involving American Indian children and migrant populations. The program is collecting an inventory of applied research to evaluate the evidence for Head Start quality improvement. The program has established consortia of research and research support organizations and a Head Start data archive has been created.

Dr. Zil presented the methodology of FACES and the multiple sources of data obtained by the survey. The survey assesses children at the beginning and end of a year and includes interviews with parents, classroom observations, interviews with center directors, and interviews with coordinators and teachers. The survey is a mechanism for generating findings on program performance. The FACES has successfully assessed more than 5,000 children in 83 Head Start programs around the country. The survey has enjoyed high response rates from parents,

children, and teachers, and FACES measures show high reliability and validity across cohorts. FACES 2000 will sample 2,800 children in 43 programs and follow them until the end of kindergarten. Dr. Zil presented the characteristic of Head Start parents; the family structures of Head Start children; child characteristics; child care arrangements in Head Start families; and information on the health status of families. He also provided information on home and neighborhood characteristics of Head Start families and data obtained from the survey's use of depression measurement scales. He discussed child assessment measures and measures of classroom quality used in the survey. He gave examples of analytical comparisons (regional comparisons, urbanicity, family types, etc) that can be made with FACES data. Finally, Dr Zil spoke about the Data User's Guides for FACES that are available to researchers and policy makers.

Governor Beasley asked Dr. Zil about findings from the data that most stick in his mind. Dr. Zil said that changes in Head Start racial and ethnic composition are dramatic. The program now has a high concentration of Hispanic children. He also mentioned the finding that 40% of Head Start children have two working parents.

Dr. Ricketts asked about the rural sample size for the survey. Dr. Zil replied that it is about 40% and that rural areas were over sampled.

Dr. Kaye asked if there were any data related to program collaboration. Dr. Zil said that the survey did not cover program collaboration, but there may be some insights that could be derived from the data.

In response to a question from Dr. Ricketts, Dr. Zil stated that many of the poorest, most disorganized families do not enroll their children in Head Start. Some are families in which there is abuse and neglect. Ms. Woolverton added that this might be seen more in the South and the problems merit further study.

Dr. Zil responded to other questions related to program collaboration and noted that the positive impacts of Head Start appear to degrade as children grow older.

Medicare Advantage in Rural Communities: The Research Perspective

Dr. Keith Mueller, Rural Policy Research Institute

Dr. Mueller first presented the most current enrollment data for Medicare Advantage, predicting that enrollment would increase rapidly over the coming months. The most rapid enrollment growth in rural areas is in Private Fee-For-Service Plans. He made some general observations

about the impacts of the program, noting that the main thrust is to gain affordability for beneficiaries and increase the number of enrollees. He then spoke about the impact of the program on rural providers and the choices that have to make with respect to signing and negotiating contracts with the plans. He highlighted the different issues and concerns for hospitals, physicians and pharmacists in rural areas. The issues for hospitals are perhaps more complex because traditional Medicare payments for hospitals are more complicated and the impacts can be quite different for different classes of rural hospitals under Medicare. Dr. Mueller talked about the potential problems with Private Fee-For-Service Plans in rural areas and the complexities surrounding the provider "deeming" policy. He talked about access standards for Preferred Provider Organizations and other issues related to these plans. He described key issues and considerations for Critical Access Hospitals as they review and negotiate contracts offered by Medicare Advantage plans.

Dr. Mueller lead a discussion with the Committee on a wide variety of issue related to the implementation of Medicare Advantage in rural areas and provided suggestion on how the Committee might focus it efforts on the rural issues.

Tuesday, January 31, 2006

Most of the morning was devoted to separate meetings of the sub-committees on substance abuse, Medicare Advantage, and the Head Start Program. The sub-committees met to plan their activities for the coming year and develop preliminary ideas for the content of chapters to be included in the annual report to the Secretary for 2007.

Following the sub-committee meetings there was a brief discussion of plans for the June meeting of the Committee in Camden, Maine. Also, it was announced that the September meeting will be held in Grand Forks, North Dakota.

Mr. Morris asked for comments on the letter to the Secretary that is sent following each meeting of the Committee. The Committee agreed that the letter should include the Committees' thoughts and concerns about several issues related to the Medicare Advantage Program and the need for more guidance from the Department. Language will be developed by ORHP staff and circulated for comment.

There were no public comments and the meeting was adjourned.