

The Patient Protection and Affordable Care Act of 2010: *Impacts on Rural People, Places, and Providers: A Second Look*

*Prepared by the
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April 2014



Acknowledgements

This work has been funded by the Leona M. and Harry B. Helmsley Charitable Trust, Grant number 2012PG-RHC030. We wish to extend special acknowledgement to Paula Weigel, PhD, who provided considerable assistance in collecting information and writing drafts of text for this document. We also thank Bryant Conkling, MPH, for his research and contributions to the text in this document. Finally, we thank Susan Nardie for her assistance in editing and formatting the document.

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Executive Summary

Implementation of the Patient Protection and Affordable Care Act (ACA) of 2010 contributes to reshaping the health care delivery landscape, particularly in rural areas. Persons living in rural communities have already been impacted through improvements in access to health insurance coverage, reduced exposure to financial loss from medical expenses, and improved access to primary care preventive services and settings. Providers are experiencing improved compensation for primary care services, and investments in rural provider training grants, public health infrastructure, access points, and allied health workforce are promoting improved care delivery and better population health each day in rural communities.

Many of the provisions enacted in the ACA are just beginning to be fully implemented. As yet, their impact remains uncertain for rural communities and the providers that serve them. Shifts in payment from volume to value and a renewed focus on cost containment require reevaluation of system performance measures and examination of how care is organized and delivered to meet the new performance standards. Reductions and modifications in Medicare and Medicaid payments to hospitals and long-term care providers must be monitored to ensure access to care in rural communities is not compromised by further limiting the number of rural providers. Coverage rates in rural areas must improve enough to offset lower payments from Medicare, and lower payments to Medicare Advantage plans must not disadvantage rural residents' access to these plans.

In light of the many ACA provisions yet to be implemented, we foresee substantial opportunities and challenges for rural communities. The health insurance marketplaces and the expansion of Medicaid have tremendous potential to provide access to affordable health insurance and health care in rural areas, yet uneven state-level expansions of Medicaid and variation in enrollment outreach in state exchanges raises concern about rural take-up in many states. The rural health care delivery environment is well positioned to showcase the higher quality and lower costs that result from improved care coordination, yet Medicare program design for the evaluation of pilots and demonstrations must recognize and account for rural differences in patterns of access and transitions. Funding for the expansion of community health centers will improve access points for rural residents, and there is tremendous potential to work together with existing safety net systems in rural areas. The new Prevention and Public Health Fund has the capability to improve and sustain health in rural places, presuming funds allocated through states are used to support rural public health programs, systems, and communities.

We expand on these themes throughout this document. We have organized our comments into six chapters that highlight key areas of the ACA that impact rural communities. We examine the ACA implementation to date, and the challenges and opportunities related to future implementation.

The Panel offers suggestions and recommendations throughout the document that advance rural health interests. They include the following:

In Part 1: Health Insurance Coverage

- Any rural differentials in the impact of Medicaid expansion, including assessment of any unique circumstances due to waivers should be monitored.

- Both internal (e.g., entities within the Department of Health and Human Services, and insurance marketplace entities) and external (e.g., researchers supported by grant funding) analysis should be done of (a) changes in access and use of services by rural residents as a result of affordability of coverage through Medicaid and the marketplaces, (b) assessments of the affordability of the plans offered and chosen by rural residents, (c) participation of rural providers in Medicaid, and (d) inclusion of essential rural providers in networks established by qualified health plans.

In Part 2: Medicare and Medicaid Payment

- Future research should examine whether Medicaid primary care access improves in 2014. If improvements occur, policy makers should consider a permanent change in payment.
- The Medicare Advantage (MA) program should be monitored to ensure that rural access to MA plans has not been compromised (relative to access in urban areas) by payment policies that equalize MA and Medicare fee-for-service payments. In addition, as quality-based incentive payments are implemented, they should be monitored to ensure they are leading to improvements in the quality of MA plans in all areas as intended, including in rural areas.
- Policy should mandate design and implementation of health care delivery and finance innovations appropriate for rural Medicare/Medicaid beneficiaries and providers.
- When and if the Independent Payment Advisory Board becomes active, rural stakeholders should monitor Board action for geographic bias.

In Part 3: Quality and Delivery System Reform

- Federal agencies, especially the Center for Medicare and Medicaid Innovation, should be encouraged to be attentive to rural needs when developing and launching demonstrations and pilots to ensure that the millions of Medicare and Medicaid beneficiaries, as well as other patients and families, in rural areas across the country are receiving care which is aligned with the goals of health reform.
- In the absence of a CMS Critical Access Hospital (CAH) value-based purchasing program, alternative approaches led by state Medicaid agencies and commercial purchasers that shift payment from volume to value are essential in preparing CAHs for a rapidly changing payment and delivery environment, and should be encouraged, supported, and studied.
- Research efforts should include or focus on health care access, delivery, and patient experience issues specific to residents of rural communities.

In Part 4: Public Health

- Rural stakeholders should monitor grant programs that could contribute to improving health in rural areas and encourage participation (i.e., grant applications) by rural communities.
- Rural advocates should use opportunities to secure resources for grant programs that could contribute to improving health in rural areas, and implementation actions by federal partners that facilitate rural participation
- Evaluations of these grant programs should include assessment of impact on rural communities.

- A comprehensive evaluation of the collective impact of statewide public health programs as well as efforts funded by private foundations, on rural communities should be made over time. The results of the evaluation could guide further grant investments, especially as budgets continue to be tight. Programs at the community level include those funded through grants focused on finance and delivery of medical services, such as the Center for Medicare and Medicaid Innovation grants. The interaction of those projects with the goals and activities of traditional public health programs must be understood as having an impact on rural communities.

In Part 5: Health Care Workforce

- The ongoing work in workforce studies, whether or not supported through the relevant sections in the ACA should be monitored. We also recommend consideration of funding for the National Workforce Commission to take full advantage of study results to help shape further policy enhancing the spread of needed health care workers into rural areas.
- Given increased demand from newly insured persons, the Panel recommends vigilance to be sure sufficient personnel inclined to practice in underserved rural areas benefit from programs designed to increase the workforce.

In Part 6: Long-Term Care

- Evidence from states implementing early Money Follows the Person demonstrations suggest challenges unique to rural areas. These include issues relating to transportation (a lack of appropriate options, and the need for fuel assistance), a lack of crucial services (e.g., mobile pharmacies), and shortages of direct service workers.¹ These challenges must be monitored to ensure that home- and community-based services in rural areas are adequately supported.

¹ "Money Follows the Person Demonstration: Overview of State Grantee Progress, July to December 2011." (June 2012). Mathematica Policy Research, Contract Number: HHSM-500-2005-000251 (0002). Submitted to CMS, Division of Community Services Transformation, Disabled and Elderly Health Programs Group.

Part 1: Health Insurance Coverage

Significant Rural Provisions/Highlights

The provisions in the Patient Protection and Affordable Care Act of 2010 (ACA) have had and will continue to have a significant positive impact on rural areas, particularly through their improvements in rural health insurance coverage rates.² ACA provisions expanded coverage to young adults and children eligible for the Children’s Health Insurance Program (CHIP), and implemented insurance reforms. While some of these provisions were implemented between 2010 through 2013, the rest of the provisions were implemented at the start of 2014, including expanded availability of affordable coverage through new insurance marketplaces and expanded Medicaid eligibility at the state level (in those states choosing to expand Medicaid coverage). Some provisions implemented since 2010 have already had a positive impact on coverage rates among rural persons.

Looking Back: ACA Implementation Impact through 2013

A number of key health insurance provisions in the ACA were implemented within the first two years after enactment. Coverage rates (actual enrollment into plans, prior to “open enrollment” in new qualified health plans) among rural persons have increased. Table 1 summarizes the effect of coverage provisions through 2013.

Table 1. Status of Coverage Provisions in the ACA

Provision	Description and Status
Extend coverage by allowing dependents up to age 26 to stay on parent’s plan (Sec. 1001)	The ACA extended health care coverage to young adult children up to the age of 26 under their parent’s individual or employer-based health plan. <ul style="list-style-type: none">• Approximately 3.1 million young adults nationwide gained coverage through December 2011.³• An estimated 600,000 young adults in rural areas are now covered.⁴
Insurance reforms (Sec. 1001)	Restrictions on lifetime caps and the elimination of cost-sharing for certain services have reduced many financial risks associated with underinsurance, a problem more prevalent among rural residents than urban. ⁵ <ul style="list-style-type: none">• The ACA prohibits insurance plans from putting lifetime limits on the dollar amount they spend on benefits, offering financial protection for rural residents with expensive chronic conditions like cancer, heart disease, or HIV/AIDS.• Cost-sharing for recommended preventive services has been eliminated for plans purchased after 2010. This provision has a greater impact on rural residents, whose out-of-pocket spending is higher on average than urban area residents.⁴

² McBride T. (2009). “Impact of the Patient Protection and Affordable Care Act on Covered Persons.” RUPRI Center for Rural Health Policy Analysis and Washington University in St. Louis, MO.

³ “State-Level Estimates of Gains in Insurance Coverage Among Young Adults.” (2012).

<http://www.hhs.gov/healthcare/facts/factsheets/2012/06/young-adults06192012a.html>

⁴ “The Affordable Care Act-What it Means for Rural America.” (2013).

<http://www.hhs.gov/healthcare/facts/factsheets/2013/09/rural09202013.html>

⁵ Ziller E, Coburn A, Yousefian A. (2006). “Out-of-Pocket Health Spending and the Rural Underinsured.” Health Affairs, Nov/Dec, 25(6), 1688-1699.

Provision	Description and Status
Pre-existing Condition Insurance Plan (Sec. 1101)	<p>Individuals with pre-existing medical conditions, uninsured for six months or more, can acquire coverage through the temporary Pre-existing Condition Insurance Plan program, until they can enroll in a health plan.</p> <ul style="list-style-type: none"> • As of May 10, 2013, 110,000 people enrolled in the PCIP nationwide, and net outlays for the program were over \$2.4 billion.⁶ • While there are no specific data indicating the proportion of rural- or urban-dwelling enrollees, we believe that many of the newly enrolled are especially vulnerable adults living in rural areas who were previously uninsurable because they had at least one chronic condition and/or they could not afford the high premium cost of offered coverage.
Children’s Health Insurance Program (CHIP) (Sec. 2101)	<p>The ACA extends funding for CHIP through September 2015, and enhances federal matching rates and maintenance of income eligibility standards through September 2019.</p> <ul style="list-style-type: none"> • \$40 billion in funds have been provided to extend CHIP through 2015.⁷ • Beginning in October 2015, states will receive a 23% increase in the CHIP matching rate up to 100%. • The amount available for grants to fund outreach and enrollment activities has increased to \$140 million through FY2015. • These provisions and additional resources should impact rural communities through lowering the rates of uninsured children as well as by measures reflecting improved access to health care providers.
Consumer Operated and Oriented Plan (CO-OP) Program (Sec. 1322)	<p>The CO-OP Program provides low-interest loans to health insurance issuers offering qualified health plans to individuals and the small-group market.</p> <ul style="list-style-type: none"> • Initially funded with \$6 billion, the program has seen the majority of its funding eliminated. • To date, 23 nonprofits have been awarded approximately \$2.1 billion in low-interest loans, creating CO-OP options in 23 states and providing funding for three of the current CO-OPs to expand operations into a neighboring state by 2015. • Experience of the CO-OPs in the new marketplaces is mixed, with some rural states such as Maine, Montana, New Mexico, and Iowa/Nebraska enrolling a high proportion of the newly insured while other states such as Illinois and Michigan seeing less interest.⁸
Small business tax credits (Sec. 1421)	<p>Tax credits of 35% of premium expenses are available to small businesses (<25 employees) that pay for their employees’ health coverage costs.</p> <ul style="list-style-type: none"> • Beginning in 2014, this tax credit increases to 50% of premium expenses. • The impact of this provision should be monitored after the health insurance marketplaces go into effect to determine if an increasing number of small firms in rural areas are offering insurance as the provision intends.

⁶ Redhead S. (May 31, 2013). “Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA).” R41301. Congressional Research Service (CRS). Web. June 2013.

⁷ Ibid.

⁸ Abelson R, Thoms K and McGinty JC. (February 26, 2014). “Health Law’s Small Co-ops Have Mixed Success So Far.” New York Times. Accessed February 25, 2014: <http://nyti.ms/1gDgLrb>.

Looking Ahead: ACA Implementation Issues for Rural Access

Estimates in 2009 indicated that rural persons have higher uninsured rates than urban persons, especially in rural nonadjacent and frontier areas.⁹ Differences in rural coverage rates are largely attributable to the fact that rural persons are more likely to work for small businesses and for low wages, both of which affect the availability and affordability of private employer sponsored health insurance. As a result, provisions of the ACA that aim to increase coverage are likely to have a disproportionately greater impact in rural than urban areas.¹⁰

Two major ACA initiatives currently being implemented will significantly affect the number of uninsured in rural areas: the expansion of Medicaid and the implementation of the state and federal health insurance marketplaces.

Medicaid Expansion

Expanding Medicaid eligibility to all people below 133% (effectively 138% after an income disregard in section 2002) of the federal poverty level (FPL) was a centerpiece of coverage expansion strategies in the ACA, but the Supreme Court's decision in June 2012 makes the Medicaid expansion voluntary for states. As of March 2014, 26 states plus the District of Columbia have committed to expanding Medicaid coverage.¹¹ Given the lower incomes of rural versus urban residents, a larger proportion of rural residents could benefit from state expansion of Medicaid eligibility.¹² However, the states that have chosen not to expand Medicaid have a significantly higher percentage of uninsured Medicaid-eligible rural residents.¹³

States can opt to expand Medicaid at any time and receive the 100% federal match for newly eligible recipients. Two states (Arkansas and Iowa) have been granted waivers from the Centers for Medicare and Medicaid Services (CMS) allowing Medicaid recipients with incomes between 100% and 138% of FPL to purchase health plans through the new marketplaces, using Medicaid payments to cover the costs of premiums. Michigan has been granted a waiver that ties reductions in premiums to wellness incentives.

RUPRI Panel comment: Any rural differentials in the impact of Medicaid expansion, including assessment of any unique circumstances due to waivers should be monitored.

Health Insurance Marketplaces (HIM)

⁹ Lenardson J, Ziller E, Coburn A, Anderson, N. (2009). "Health Insurance Profile Indicates Need for Reform in Rural Areas." (Research & Policy Brief). Portland, ME: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center.

¹⁰ Barker A, Londeree J, McBride T, Kemper L, Mueller K. (2013). "The Uninsured: An Analysis by Income and Geography." (Research Policy Brief). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health, Brief No. 2013-6.

¹¹ "Status of State Action on the Medicaid Expansion Decisions, 2014." The Kaiser Family Foundation. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

¹² Barker A, Londeree J, McBride T, Kemper L, Mueller K. (2013). "The Uninsured: An Analysis by Income and Geography." (Research Policy Brief). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health, Brief No. 2013-6.

¹³ Ibid.

The ACA required health insurance marketplaces be established to offer health plans in both the individual and small group markets. The marketplaces are designed to enable consumers to make apples-to-apples comparisons among different types of health plans. The marketplaces will also administer subsidies for insurance plan purchases for individuals under 400% of the FPL and will administer tax credits available to small employers.

Under the law, states could elect to establish their own marketplace, offer a federal-state partnership marketplace, or default to a federal marketplace. The most recent data show that 16 states plus the District of Columbia are operating a state-based health insurance marketplace (SBM), and 7 states are operating a state-federal partnership marketplace (SFBM). The remaining 27 states have defaulted to a federally run state marketplace (FBM).¹⁴ All exchanges launched open enrollment on October 1, 2013, with coverage beginning January 1, 2014.

The states that defaulted to a FBM have a higher proportion of rural residents than the states that are operating a SBM.¹⁵ Through the end of February 2014, the likelihood of an uninsured person being covered was more than twice as high if they lived in a state with a SBM, as compared to a state with a FBM, and 37% of the previously uninsured have been covered in states running a SBM as compared to only 16% in states running a FBM.¹⁶ Factors that may account for this difference include the following: when the marketplaces were initiated (several states began soon after enactment, the FBMs were not started until the default option was obvious); localized efforts to seek, find, and enroll persons and households; and technical challenges early during the enrollment period. Interestingly, the gap in enrollment success began to narrow slightly in February 2014, since the monthly increase in enrollment was 35% in FBMs compared to 19% in SBMs.¹⁷ These results are preliminary and based on enrollment data in the marketplaces only through the end of February 2014, and subject to change as the final data is released (in April 2014 and beyond).

Preliminary results from the open enrollment period indicate that states that opted to expand Medicaid are reaching a much higher proportion of the previously uninsured, as would be expected. By the end of February 2014, in the states that expanded Medicaid, 41% of those eligible for Medicaid have been determined eligible for Medicaid or CHIP, whereas only 21% of those eligible for Medicaid or CHIP were determined eligible in non-expansion states.¹⁸ States that chose not to expand Medicaid

¹⁴ "State Decisions for Creating Health Insurance Marketplaces, 2014." The Kaiser Family Foundation. <http://kff.org/health-reform/state-indicator/health-insurance-exchanges>.

¹⁵ States using the SBMs had an average population density of 211.7, as compared to states offering FBMs which have a population density of 320.6. (February 6, 2014). See: McBride T. "The Affordable Care Act: Implications for Rural Areas." Presentation at the National Rural Health Association Policy Conference.

¹⁶ McBride T. "Where The Uninsured Live Affects How Likely They Are to Get Covered: Exploring the Implications of State Policy Decisions on Coverage Rates under the Affordable Care Act." (March 2014). Policy Brief. St. Louis, MO: Brown School, Washington University in St. Louis.

¹⁷ ASPE Issue Brief. "Health Insurance Marketplace: March Enrollment Report. For the period October 1, 2013 – March 1, 2014." (March 11, 2014). Department of Health and Human Services: Office of the Assistant Secretary for Planning and Evaluation.

¹⁸ McBride T. "Where The Uninsured Live Affects How Likely They Are to Get Covered: Exploring the Implications of State Policy Decisions on Coverage Rates under the Affordable Care Act." (March 2014). Policy Brief. St. Louis, MO: Brown School, Washington University in St. Louis.

are more likely to have a higher proportion of rural populations: in these states the average population density is 164 per square mile, as compared to 322 per square mile in states that expanded Medicaid.¹⁹

Among those with private health plans, rural people rely more heavily than those in urban areas on the individual and small group insurance markets.²⁰ A key aim of the marketplaces is to offer consumers more meaningful choices among health plans and lower premiums. The success of the marketplaces, as measured by plan availability and choice and premium prices, will therefore be especially important to rural people.

As we noted in our first look at the ACA,²¹ three issues are of special concern from a rural perspective.

- First, what latitude will qualified health plans have for defining their market areas? Will, for example, plans be able to exclude rural areas because of higher costs or other considerations?
- Second, how will states define their geographic rating areas and factors? In general, more rating areas in a state will tend to segment risk pools, potentially creating higher premiums for rural versus urban residents.²²
- And finally, what network adequacy standards will marketplaces impose on health plans?

There are multiple rural concerns here. On the one hand, stringent standards might limit the willingness of plans to offer in rural markets where they know they may have difficulty recruiting adequate provider networks. On the other hand, there are concerns that plans might exclude rural providers in favor of more exclusive, urban-based networks.²³

Further, new guidance for 2015 requires qualified health plans in FBMs to include at least one essential community provider (ECP) per county in each of six designated categories where an ECP in that category is available.²⁴ The six designated categories are (1) hospitals (including Critical Access Hospitals), (2) FQHC, (3) Ryan White, (4) Family Planning, (5) Indian Health Services, and (6) other ECP providers that serve low-income, medically underserved individuals including entities like Rural Health Clinics or private physicians' office. Given the importance of Rural Health Clinics and small primary care practices in rural areas it is important that the concept of ECPs include such entities in addition to the types of entities specifically listed in the ACA. The effect of this recent CMS guidance needs to be monitored to determine its impact on rural access and rural providers.

¹⁹ McBride T. (February 6, 2014). "The Affordable Care Act: Implications for Rural Areas." Presentation at the National Rural Health Association Policy Conference.

²⁰ Ziller E, Coburn A. (2009). "Private Health Insurance in Rural Areas: Challenges and Opportunities." (Research & Policy Brief). Portland, ME: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center.

²¹ Coburn A, Lundblad J, MacKinney C, McBride T, Mueller K. (2010). "The Patient Protection and Affordable Care Act of 2010: Impacts on Rural People, Places and Providers: A First Look." Columbia, MO: Rural Policy Research Institute.

²² Ziller E, Coburn A. (2009). "Private Health Insurance in Rural Areas: Challenges and Opportunities." (Research & Policy Brief). Portland, ME: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center.

²³ Talbot J, Coburn A, Croll Z, Ziller E. (2013). "Rural Considerations in Establishing Network Adequacy Standards for Qualified Health Plans in State and Regional Health Insurance Exchanges." *Journal of Rural Health*. doi: 10.1111/jrh.12012.

²⁴ 2015 Letter to Issuers in the Federally-facilitated Marketplaces. Available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>

Both the health insurance marketplaces and the expansion of Medicaid play a critical role in providing access to affordable health insurance and health care in rural areas, and we expect that these new resources could be especially important for rural residents because of the higher prevalence of uninsured individuals and lower incomes of persons in rural areas.²⁵

Market forces unleashed by the ACA may well unfold differently in rural as compared to urban areas. Rural providers face different constraints in their operations due to low volume and may therefore be more reluctant participants in markets predicated on reducing costs per service. Rural residents may face particular challenges finding a health plan that meets their needs, especially if their choices are limited because of living in an unattractive (economically) service area.

RUPRI Panel comment: Both internal (e.g., entities within the Department of Health and Human Services [HHS], SBMs and FBMs) and external (e.g., researchers supported by grant funding) analysis should be done of (a) changes in access to and use of services by rural residents as a result of affordability of coverage through Medicaid and the marketplaces, (b) assessments of the affordability of the plans offered and chosen by rural residents, (c) participation of rural providers in Medicaid, and (d) inclusion of essential rural providers in networks established by qualified health plans.

The ultimate impact of efforts to improve the availability and affordability of health insurance will be realized only if employees of small businesses enroll in health plans. The Administration's decision to delay implementation by one year of certain ACA provisions, such as the Small Business Health Insurance Options Program (SHOP) Marketplace and the employer mandate for businesses with more than 50 full-time employees, will postpone two key activities to encourage small businesses to enroll their employees. Therefore, outreach and "navigation" services tied to the marketplaces should pay even more attention to reaching employees of small businesses in rural places so they develop an understanding of their insurance purchasing options. Outreach to and enrollment of rural individuals already includes web-based protocols for comparing and choosing health plans in places accessible to rural residents, as well as in-person assistance through navigators, in-person assistors, certified application counselors, community health centers (CHCs), and consumer assistance via a 24-hour call center and online chat capabilities. SHOP enrollment for small businesses will occur through agents, brokers, and insurers until the SHOP Marketplaces are available in November 2014.²⁶

²⁵ McBride T. (2009). "Impact of the Patient Protection and Affordable Care Act on Covered Persons." RUPRI Center for Rural Health Policy Analysis and Washington University in St. Louis, MO.

²⁶ "What is the SHOP Marketplace?" (2014). Accessed March 12, 2014. <https://www.healthcare.gov/what-is-the-shop-marketplace/>.

Part 2: Medicare and Medicaid Payment

Significant Rural Provisions/Highlights

Health care financing and payment policy changes embodied in the ACA facilitate a shift from volume to value-based health care purchasing, an emphasis on prevention, and a renewed focus on cost containment. In general, this is a positive change for rural people, places, and health care providers. However, vigilance is necessary to ensure that rural providers, and thus the beneficiaries they serve, are not disadvantaged compared to urban providers. The ACA initiates new demonstration projects designed to test innovative health care payment and delivery models. Unfortunately, it is a continuous challenge to develop appropriate demonstrations and the appropriate rules of engagement to help rural providers develop new approaches consistent with goals of improving health and containing costs. Prospective payment hospitals will experience reduced payment increases, and most acute care hospitals (including Critical Access Hospitals, or CAHs) will receive decreased Disproportionate Share Hospital (DSH) payments due to the ACA. Reduced hospital payments, however, are expected to be offset by increases in private insurance coverage and the expansion of Medicaid that reduce uncompensated care. Expectations about revenue to hospitals (and other providers) may be jeopardized by lower-than-expected enrollment into qualified health plans through the new marketplaces and by states not participating in Medicaid expansion, as described in the previous section.

Looking Back: ACA Implementation Impact through 2013

Several Medicare and Medicaid payment policies and demonstrations have been implemented since 2010. These changes are altering the way health care is practiced and delivered, though much of the impact on costs and quality is not yet known. Table 2 summarizes the rural impact of Medicare and Medicaid policy changes in the ACA.

Table 2. Status of Medicare and Medicaid Payment Provisions in the ACA

Provision	Program and Status
Medicare Physician Fee Schedule update (Sec. 3401)	<p>CMS has updated the work and practice expense portions of the Geographic Practice Cost Indices (GPCIs) used in the calculation of the Medicare Physician Fee Schedule (MPFS).</p> <ul style="list-style-type: none"> Due to GPCI changes legislated by the ACA, physician personal income increases are greater in entire-state Medicare payment localities (which have relatively more rural areas) than in states with multiple Medicare payment localities.²⁷ <p>Payment policy with origins other than the ACA may have more impact on rural physician income. For example, rural physician payment has increased approximately 5% from 2013 to 2014, primarily due to updates in the Conversion Factor (CF) implemented in the Bipartisan Budget Act of 2013.</p>
Primary Care Incentive Payment (PCIP) & HPSA Surgical	<p>From January 2011 through December 2015, primary care providers whose practice revenues from Medicare are 60% or more primary care services are eligible to receive a 10% bonus payment from Medicare. The ACA also provides a 10% bonus to general surgeons performing major operations in primary care health professional shortage areas (HPSAs) under the HPSA Surgical Incentive Payment for the years 2011–2015.</p>

²⁷ MacKinney AC. (2010). "Increases in Primary Care Physician Income due to the Patient Protection and Affordable Care Act of 2010-Continued Tweaking of Physician Payment." (Research Policy Brief). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health, Brief No. 2010-2.

Provision	Program and Status
Incentive Payment (HSIP) (Sec. 5501)	<ul style="list-style-type: none"> • In 2011, over \$560 million in bonus payments were distributed to primary care providers, of which more than \$76 million went to rural providers.²⁸ • Approximately 80% of family practice physicians and 65% of general internists practicing in rural locales qualified for the 10% Medicare bonus.²⁹ • Mean bonus amounts for rural providers were approximately \$8,000 for primary care physicians and \$3,000 for nurse practitioners, physician assistants, and clinical nurse specialists.³⁰ • CMS pays these new incentives, in addition to HPSA physician bonus incentive payments. Although not specifically targeted to rural physicians, the programs may improve recruitment and retention of rural primary care physicians and general surgeons, but they sunset in 2015.
Medicaid and Medicare payment parity (Sec.1202)	<p>Medicaid payments to primary care physicians match Medicare payment rates in 2013–2014. Initial CMS estimates suggest that over \$11 billion in new revenues support Medicaid primary care.</p> <ul style="list-style-type: none"> • Since a higher proportion of the rural population is insured through Medicaid, including those among the newly eligible, this program should be especially beneficial for rural people and providers.
Payment for preventive services (Sec. 4106)	<p>Beginning January 2013, states that offer Medicaid coverage with zero cost sharing for certain preventive services receive a 1% increase in federal matching payments.</p> <ul style="list-style-type: none"> • The elimination of cost sharing encourages providers to deliver preventive services and removes a financial barrier to accessing preventive services.
Community Health Centers (Sec. 5601)	<p>The ACA authorizes \$11 billion for the Community Health Center Fund (CHCF) over five years to operate, expand, and construct CHCs. The majority of those funds (\$9.5 billion) supports ongoing health center operations, creates new sites in medically underserved areas, and expands preventive and primary services at existing sites. A separate \$1.5 billion is committed to major construction and renovation projects of CHCs nationwide.³¹</p> <ul style="list-style-type: none"> • Nearly one-half of all CHCs are located in rural areas and serve 10 million rural residents.³² • Funds from this authorization have also supported CHC-based enrollment activities
Hospital Payment (Title III. Subtitle B. Part 1.)	<p>Rural protections were extended to several hospital payment provisions, including outpatient hold harmless, reasonable costs for certain diagnostic lab tests, rural hospital demonstration, Medicare-dependent hospital classification, and inpatient hospital payment adjustment for low volume hospitals.</p> <ul style="list-style-type: none"> • These extensions were only for approximately one year. These payment programs are helping sustain rural providers during a time of transition to other

²⁸ Centers for Medicare and Medicaid Services. “Primary Care Incentive Payment Program.” <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PCIP-2011-Payments.pdf>.

²⁹ *Ibid.*

³⁰ Shane D, MacKinney AC, Ullrich F, Mueller KJ, Weigel P. (2013). “Assessing the Impact of Rural Provider Service Mix on the Primary Care Incentive Payment Program.” (Research Policy Brief). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health. Brief No. 2013-16.

³¹ Bureau of Primary Health Care, Health Resources and Services Administration. “The Affordable Care Act and Health Centers.” <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>

³² National Association of Community Health Centers. Removing Barriers to Care: Community Health Centers in Rural Areas. Fact Sheet. November 2011.

Provision	Program and Status
	<p>value-based payment systems.</p> <p>The Medicare Rural Hospital Flexibility Program was reauthorized, with authority for grant funding extended through FY 2012. Purposes for funding are to help prepare CAHs for value-based purchasing (VBP) and participating in delivery system reforms. Funding has been: FY 2011, \$41 million; FY 2012, \$41 million, and FY 2013, \$38 million.</p> <p>Acute care hospital and skilled nursing facility market basket updates have been adjusted by an annual economy-wide private nonfarm business multifactor productivity.</p> <ul style="list-style-type: none"> • This may result in a payment rate decrease from prior years. Payments were further reduced by 0.25% in years 2010 and 2012. • Since CAHs are paid on a cost-based reimbursement system, this provision does not impact CAHs.
<p>New Payment Systems (Sec. 3022)</p>	<p>The Medicare Shared Savings Program establishes a new type of Medicare provider entity (an Accountable Care Organization, or ACO) that agrees to be accountable for improving clinical quality and patient satisfaction while controlling cost. If costs are less than expected, CMS shares savings with the ACO.</p> <ul style="list-style-type: none"> • Some 365 Medicare ACOs have been established. <p>The Medicare VBP program provides financial incentives for high quality and patient satisfaction (and eventually efficiency). To fund VBP, DRG payments to hospitals are reduced 1.0% in 2013 and 1.25% in 2014.</p> <ul style="list-style-type: none"> • CAHs are currently exempt from VBP. <p>Bundled payment demonstrations evaluate a single payment for an episode of care, including post-acute services. The demonstration continues from 2012 through 2016.</p> <ul style="list-style-type: none"> • These programs are too new to evaluate their effectiveness in improving quality and/or lowering cost or their impact on providers and patients. Although there is some rural provider participation in these innovations, it is unclear if the current innovations will be scalable for broad rural participation.
<p>Medicare Advantage (Sec. 3201)</p>	<p>The ACA reduces Medicare Advantage (MA) payments to be more aligned with the average cost of Medicare fee-for-service.</p> <ul style="list-style-type: none"> • Overall beneficiary enrollment in MA plans continues to grow, from 11.9 million beneficiaries in 2011 to 13.1 million in 2012, to 14.6 million in 2013.^{33,34}
<p>Center for Medicare and Medicaid Innovation (CMMI) (Sec. 3021)</p>	<p>CMMI funds multiple Medicare and Medicaid payment innovation demonstrations, including accountable care, bundled payments for care improvement, primary care transformation, initiatives focused on the Medicaid and CHIP populations, initiatives to accelerate the development and testing of new payment and service delivery models, and initiatives to speed the adoption of best practices.³⁵</p> <ul style="list-style-type: none"> • These programs are in various stages of implementation and operation. • Rural sites are included in a limited number of CMMI demonstration projects. Evaluations of effectiveness and impact have not been completed, however.

³³ Carey M. (2014). "Obama Administration Proposes 1.9% Cut in Medicare Advantage Payments." Kaiser Health News. Accessed March 13, 2014. <http://www.kaiserhealthnews.org/stories/2014/february/21/medicare-advantage-plans-federal-payment.aspx>.

³⁴ Medicare Advantage Fact Sheet, November 2011. The Kaiser Family Foundation. <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.

³⁵ Center for Medicare and Medicaid Innovation. Accessed February 24, 2014. <http://innovation.cms.gov/initiatives/index.html#views=models>.

Provision	Program and Status
	Information is available at: http://cph.uiowa.edu/ruralhealthvalue/innovations/InnovationQ.php .
Payment Research (Sec. 3127)	The Medicare Payment Advisory Commission (MedPAC) will study geographic payment variation, Medicare beneficiary access to services in rural areas, adequacy of payments to providers and suppliers, and rural quality of care. <ul style="list-style-type: none"> • Among several recommendations in its report, MedPAC suggests replacing the current GPCI for provider work with an adjuster and allowing the GPCI floor to expire at the end of 2013.³⁶ • The floor expiration would result in a payment loss to health care providers in localities with below average work GPICs. The work floor was temporarily reinstated in December 2013 through March 2014,³⁷ and extended again through March 2015.³⁸ Without an adjuster that recognizes workforce need in shortage areas, this expiration will widen geographic disparities in provider pay.

Looking Ahead: ACA Implementation Issues for Rural Providers and Beneficiaries

Physicians

It is unclear whether the temporary payment increase in 2013-2014 to primary care providers in Medicaid will significantly increase provider participation in Medicaid.

RUPRI Panel comment: Future research should examine if Medicaid primary care access improves in 2013-2014 and try to determine what, if any, impact this temporary adjustment had to inform whether policy makers should consider a permanent change in payment.

The ACA expands VBP to physicians by including a Medicare value-based modifier (VBM) that adjusts physician payment based on quality-of-care measures and cost comparison to physicians in similar specialties and locations. Implementation of the VBM begins in 2015, with all physicians involved in 2017. The physician VBM will apply to all physicians billing Medicare. However, physician practices that have measured and actively improved quality will more likely benefit from the program. Small, independent, rural practices with less quality improvement capacity may be at a disadvantage.

Although not part of the ACA, a proposal jointly authored by the Senate Finance Committee and the House Ways and Means Committee would have replaced the Sustainable Growth Rate methodology and the Medicare VBM with a more comprehensive measure of physician performance—the Merit-Based Incentive Program (MBIP). The MBIP includes both payment bonuses and penalties for physician clinical quality, patient satisfaction, and efficiency performance. The bill also provided bonuses for participation in alternative payment models (e.g., ACOs) and Patient-Centered Medical Homes. As with the VBM, physician practices with robust quality improvement processes are likely to be more successful under the MBIP.

³⁶ Medicare Payment Advisory Commission. (June 2013). "Report to the Congress: Medicare and the Health Care Delivery System; Chapter 8, Mandated Report: Geographic Adjustment of Payments for the Work of Physicians and other Health Professional." http://www.medpac.gov/chapters/Jun13_Ch08.pdf.

³⁷ Bipartisan Budget Act of 2013. Accessed March 13, 2014. www.gpo.gov.

³⁸ The Protecting Access to Medicare Act. Signed into law April 1, 2014.

Community Health Centers

In 2014, reimbursement to CHCs will change to a prospective payment system set at 103% of previous expenditures. The payment rate will increase each year at the Medicare Economic Index rate. Furthermore, nearly \$1 billion of additional funding to expand the program is to be available in years 2014 and 2015.

The expansion of new rural CHC access points, while positive, should be coordinated with existing safety-net providers such as Rural Health Clinics and rural private practices. Additionally, in places where CHCs already exist, additional program emphasis is needed to foster collaboration with other local health care providers that also serve as safety-net providers. Innovations in state Medicaid programs in Oregon, Colorado, and elsewhere create opportunities for collaboration under the rubric of ACOs, as does the Medicare program.

Hospitals

Disproportionate Share Payments (DSH) – Medicare

Based on the premise that greater insurance coverage will result in less uncompensated care to hospitals, Medicare and Medicaid DSH payments will be reduced starting in fiscal year 2014 (approximately 5% of DSH payments go to rural hospitals).³⁹ CMS will reduce Medicare DSH payments to hospitals to 25% of current DSH payments, but then adjust by an additional payment to Prospective Payment hospitals to lessen the impact of the DSH reduction. The additional payment considers three factors: the change in the hospital's DSH payment under the ACA, the percentage decrease in the number of uninsured, and the amount of uncompensated care that the DSH hospital provides as compared to all DSH hospitals.^{40,41} The Medicare DSH reduction may be in excess of increased revenue from the newly insured if the number of uninsured remains relatively higher in rural areas and/or the amount of uncompensated care persists despite ACA implementation. The financial impact of DSH payment loss not offset by increased insurance payments will be more profound among rural hospitals with low or negative operating margins.

Disproportionate Share Payments (DSH) – Medicaid

The CMS final rule on a two-year DSH Health Reform Methodology considers five factors to determine a state's Medicaid DSH reduction:

- Impose a smaller percentage reduction on low DSH states;
- Impose larger percentage reductions on states that have the lowest percentages of uninsured individuals during the most recent year for which such data are available;
- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients;

³⁹ Association of American Medical Colleges. "Medicare Disproportionate Share Payments." https://www.aamc.org/advocacy/teachhosp/97342/teachhosp_hosp0003.html

⁴⁰ National Association of State Mental Health Program Directors. "The Dish on DSH." http://www.nasmhpd.org/docs/Policy/Medicare_Financing_Disproportionate%20Share%20for%20Hospitals%20%28DSH%29.pdf.

⁴¹ Davis C. National Health Law Program. "Q&A: Disproportionate Share Hospital Payments and the Medicaid Expansion." http://www.apha.org/NR/rdonlyres/328D24F3-9C75-4CC5-9494-7F1532EE828A/0/NHELP_DSH_QA_final.pdf.

- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care; and
- Take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.⁴²

Since the ACA did not originally consider that states might opt out of Medicaid expansion, CMS has yet to decide how to reduce DSH payments to nonparticipating states. The Bipartisan Budget Act of 2013 delays Medicaid DSH cuts until Oct. 1, 2015. This delay in DSH cuts means in 2016, with no further legislative changes, hospitals will face double the DSH reductions, or \$1.2 billion cumulatively. Rural hospitals that rely on DSH funds and hospitals located in states that do not expand coverage to low income adults will be vulnerable to financial losses. Furthermore, new Medicaid payments may not offset reduced DSH payments to rural hospitals that serve a disproportionate number of low-income individuals. Without careful monitoring and the willingness to adjust payment policies quickly, safety-net hospitals could be negatively impacted.

Hospital Value-Based Purchasing (VBP)

VBP for PPS hospitals continues with larger DRG payment reductions of 1.5% in 2015, 1.75% in 2016, and 2.0% in 2017 and subsequent years.

Market Basket Update Reductions

The ACA reduces market basket updates to the hospital prospective payment system through productivity adjustments, which represents another implicit tradeoff between insurance and covered lives. Although the market basket update change represents a reduction in anticipated Medicare rate increases, hospital financial impact may be ameliorated by other ACA-initiated changes and non-ACA health care reform. This issue is covered in Part 3 of this paper, under Quality and Delivery System Reform.

Volume Reduction Strategies

The ACA mandates clinically focused Medicare payment changes. Medicare will not pay hospitals for inappropriate readmissions and will penalize hospitals up to 1% of annual Medicare reimbursement for hospital-acquired conditions in 2015. Medicaid has also implemented a provision prohibiting payments to states for services related to certain hospital-acquired infections.

Skilled Nursing Facilities and Home Health

The ACA required that the Secretary report to Congress by October 1, 2011, a plan to implement a Medicare skilled nursing facility VBP program.⁴³ That plan outlines three alternatives for payment: attainment-based incentives, achievement-based incentives, and a hybrid model. The Home Health

⁴² Federal Register. "State Disproportionate Share Hospital Allotment Reductions, proposed rule." <https://www.federalregister.gov/articles/2013/05/15/2013-11550/medicaid-program-state-disproportionate-share-hospital-allotment-reductions#h-19>.

⁴³ U.S. Department of Health and Human Services Report to Congress: Plan to Implement a Medicare Skilled Nursing Facility Value-Based Purchasing Program. Accessed February 28, 2014. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf>.

report outlined similar payment alternatives.⁴⁴ The ACA did not mandate an implementation date for these VBP programs.

The ACA also requires revision of the home health prospective payment system payment rates and wage index for 2014. Adjustments are rebased to the national, standardized 60-day episode payment rates, the national per-visit rates, and the Non-Routine Supply conversion factor.⁴⁵ The rule for adjustment is to be phased in over four years. The impact of these changes on rural home health services is unknown.

Medicare Advantage

RUPRI Panel comment: The MA program should be monitored to ensure that rural access to MA plans has not been compromised (relative to access in urban areas) by payment policies that equalize MA and Medicare fee-for-service payments. In addition, as quality-based incentive payments are implemented, they should be monitored to ensure they are leading to improvements in the quality of MA plans in all areas as intended, including in rural areas.

New Payment Systems

A few Medicare ACOs are rural based, and a significant number include rural areas. CMS has recently reported shared savings payments to ACOs from 2012. The data are yet to be analyzed from a geographic perspective. It will be important to learn if ACO rurality tends to be associated with likelihood of shared savings. Although the ACA mandates development of a VBP program for CAHs, there has been no planning activity to date. Thus, the impact of new payment systems on clinical quality and care cost is not yet known, especially in rural areas, where participation is low. Furthermore, CMMI is testing multiple new health care delivery and payment options. Due to the required scale of many of the CMMI demonstrations, participation includes few rural providers compared to urban providers. There is risk that rural providers will increasingly be left out of innovation opportunities and CMS will not have the chance to learn from the rural experience.

RUPRI Panel comment: Policy should mandate design and implementation of health care delivery and finance innovations appropriate for rural Medicare/Medicaid beneficiaries and providers.

Research and Payment Policy

The ACA established the Independent Payment Advisory Board (IPAB), an independent panel of medical experts (including rural representation) tasked with developing proposals to reduce Medicare cost growth. Beginning in January 2014, for each year that Medicare's per capita costs exceed a certain threshold, the IPAB is to develop and propose policies for reducing this inflation. The HHS Secretary must institute the policies unless Congress enacts alternative policies leading to equivalent savings. As of March 2014, however, IPAB members have yet to be appointed. Furthermore, since Medicare cost

⁴⁴ U.S. Department of Health and Human Services Report to Congress: Plan to Implement a Medicare Home Health Agency Value-Based Purchasing Program. Accessed February 28, 2014. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPFS/Downloads/SNF-VBP-RTC.pdf>.

⁴⁵ Centers for Medicare and Medicaid Services, Home Health Agency Center. Accessed March 13, 2014. <http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html>.

growth has been less than the target cost growth that triggers Board action, there is no savings target or need for IPAB cost-control proposals in 2014.⁴⁶

RUPRI Panel comment: When and if the IPAB becomes active, rural stakeholders should monitor Board action for geographic bias.

As part of the provision to review health plan premium increases and improve transparency of health care pricing to purchasers of health care, the ACA establishes medical reimbursement data centers to develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services. From May through July 2013, grants to states totaling \$87 million were awarded to approximately 57 recipients in support of data center development.⁴⁷ Since the data centers may develop fee schedules that reflect geographical differences in market rates, it will be important to monitor how fee schedules in rural areas differ from those in urban, and monitor how new fee schedules affect rural access to health care. However, funds to award the grants have not yet been appropriated.

⁴⁶ Spatalnic P. "2013 IPAB Determination." <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/IPAB-2013-04-30.pdf>.

⁴⁷ Center for Consumer Information and Insurance Oversight. "The Health Insurance Rate Review Grant Program." <https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=17918>.

Part 3: Quality and Delivery System Reform

Significant Rural Provisions/Highlights

The ACA called for significant changes in how quality of care is assessed and paid for, and how the health care delivery system is organized and operates. A small but growing number of rural providers and communities have found ways to participate in the ACA demonstrations and pilots. CMS' Center for Medicare and Medicaid Innovation (CMMI) efforts to date have frequently been relevant to rural in terms of topic and focus, but are not designed to be amenable to rural participation. Rural challenges to participation often include measuring quality in a low-volume environment, patient attribution methodology, and limited technology and staffing infrastructure. In addition, very few ACA programs to date have been designed specifically to test new quality and delivery system changes for rural providers and communities.

RUPRI Panel comment: Federal agencies, especially the CMMI, should be encouraged to be attentive to rural needs when developing and launching demonstrations and pilots to ensure that the millions of Medicare and Medicaid beneficiaries, as well as other patients and families, in rural areas across the country are receiving care that is aligned with the goals of health reform.

Looking Back: ACA Implementation Impact through 2013

Many programs and commissions designed to address quality and delivery system reform have been initiated since 2013. These efforts are promoting new targeted approaches that will ultimately enhance quality and achieve the goals of improved health and lower costs. Table 3 summarizes the activities to date and the impact of such efforts on rural areas.

Table 3. Status of ACA Quality and Delivery System Reform Programs and Commissions

Program/ Commission	Status
National Prevention Council (NPC) (Sec. 4001)	The NPC released the National Prevention Strategy in June 2011, targeting improvement in population health, and the National Prevention Council Action Plan in June 2012. The Council reports annually on progress.
Medicaid and CHIP Payment and Access Commission (MACPAC) (Sec. 2801)	MACPAC reviews and assesses payment policies under Medicaid and CHIP. MACPAC also examines how factors affecting expenditures and payment methodologies enable beneficiaries to access services, affect provider supply, and affect providers serving a disproportionate share of low-income and vulnerable populations. <ul style="list-style-type: none"> • \$11 million has been obligated through 2012.
Center for Medicare and Medicaid Innovation (CMMI)^{48,49}	CMMI develops and tests innovative health care payment and service delivery models. Programs and demonstrations include the following: <ul style="list-style-type: none"> • <i>Medicaid Incentives for the Prevention of Chronic Disease</i>. \$30 million in grants to 10 states has been awarded for the purpose of providing incentives to Medicaid

⁴⁸ Centers for Medicare and Medicaid Services, Innovation Models. <http://innovation.cms.gov/initiatives>. Accessed March 13, 2014.

Program/ Commission	Status
(Sec. 3021)	<p>beneficiaries to participate in healthy lifestyle programs to prevent or help manage chronic disease.</p> <ul style="list-style-type: none"> • <i>Childhood Obesity Demonstration Program.</i> \$12 million of \$25 million has been obligated to conduct a demonstration project to identify effective childhood obesity prevention strategies. • <i>Independence at Home Demonstration Project.</i> The project tests a payment incentive and service delivery model over three years that uses primary care teams to provide home-based services to patients with multiple chronic conditions. Fifteen independent practices and three consortia are participating in the demonstration. • <i>Community-Based Care Transitions Program.</i> This five-year program provides funds to hospitals and community-based organizations to test models for improving care transitions from the hospitals to other settings. There are 102 organizations participating in this program. Approximately \$200 million of the initial \$500 million appropriation has been rescinded. • <i>Bundled Payments for Care Improvement.</i> This initiative evaluates four different models of bundled payments to incentivize care redesign. There are 105 organizations participating across the four models of bundled payments. • <i>Federally Qualified Health Center Advanced Primary Care Practice Demonstration.</i> This program tests the efficiency of patient-centered medical homes among Federally Qualified Health Centers. There are 485 participants. • <i>Pioneer Accountable Care Organization Model.</i> There are 23 organizations participating in this population-based payment model (there were 32, but 9 withdrew from the program in July 2013). • <i>Advanced Payment Accountable Care Organization Model.</i> There are 35 organizations participating in this Medicare Shared Savings Program.
Federal Coordinated Health Care Office, CMS (Sec. 2602)	<p>Section 2602 of the ACA established the Federal Coordinated Health Care Office to ensure more effective integration of benefits under Medicare and Medicaid for individuals eligible for both programs, and to improve coordination between the federal government and states in the delivery of benefits for such individuals. Its primary functions are to:</p> <ul style="list-style-type: none"> • Monitor and report on annual total expenditures, health outcomes, and access to benefits for all dual-eligible individuals, including subsets of the population. • Facilitate the testing of various delivery system, payment, service and/or technology models to improve care coordination, reduce costs, and improve the beneficiary experience for individuals dually eligible for Medicare and Medicaid. • Perform policy and program analysis of Federal and State statutes, policies, rules, and regulations impacting the dual eligible population.
Section 3014 called for a multi-stakeholder group to provide input into the selection of quality measures at	<p>In 2011, the Measures Applications Partnership (MAP) was established, and it submitted its first annual review of performance for use in federal rulemaking in February 2012. MAP is a multistakeholder, consensus-based group of 60 organizations representing the full range of private- and public-sector health care stakeholders.</p> <ul style="list-style-type: none"> • On the MAP committees—one Coordinating Committee and four workgroups, with collectively 24 members—there are two rural members.

⁴⁹ Redhead S. (May 31, 2013). "Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)." R41301. Congressional Research Service (CRS). Web.

Program/ Commission	Status
the National Quality Forum.	
National Strategy for Quality Improvement in Health Care (the National Quality Strategy [NQS]) (Sec. 3011)	<p>The first iteration of the NQS was submitted to Congress in March 2011. The NQS pursues three broad aims: better care, healthy people/healthy communities, and affordable care.</p> <ul style="list-style-type: none"> • 2012 and 2013 updates have been submitted to Congress, and now also include agency-specific quality plans in support of the NQS.
Patient Centered Outcomes Research Institute (PCORI) (Sec. 6301)	<p>PCORI awards comparative effectiveness research grants that ultimately help people make informed health care decisions, based in part on patient populations' input and preferences. To date, PCORI has approved 279 awards, totaling \$464.6 million.</p>

Looking Ahead: ACA Implementation Issues for Quality and Delivery System Reform in Rural Areas

The ACA established new national strategies and agency responsibilities related to quality and delivery system reform. The most common approaches to developing these strategies have been to form new centers, create new responsibilities within existing centers or agencies, and form national commissions or other bodies. While the national strategies and commissions that have emerged as a result of the ACA have generally been relevant and useful in the rural health environment, there is a noticeable lack of rural representation and expertise, which may have adverse implications as the strategies evolve into programs, policies, and implementation. Rural advocates should make a concerted effort to encourage agencies and commissions to strike an appropriate balance of rural representation in federal agency strategy and planning, and to fully utilize the current rural positions as a channel for input.

Quality Measurement and Value-Based Purchasing

The legislation expands and accelerates the measurement and transparency of health care system performance in the United States. New measures are called for across parts of the health care delivery system, some of which are already publicly reported as well as many that are not. For example, the National Quality Forum has been tasked with providing input on national priorities for health care quality improvement, and also provides input on the selection of quality measures for use in public reporting of performance information.⁵⁰ The HHS Secretary has also published a core set of quality measures for Medicaid-eligible children and adults for voluntary use by state Medicaid programs.⁵¹ CMS has not yet (and may not) issued regulations or launched a pilot project for VBP for CAHs.

RUPRI Panel comment: In the absence of a CMS CAH VBP program, alternative approaches led by state Medicaid agencies and commercial purchasers that shift payment from volume to

⁵⁰ "National Impact Assessment of Medicare Quality Measures". (March 2012). Centers for Medicare and Medicaid Services. <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures>.

⁵¹ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-1-4-2012.pdf>.

value are essential in preparing CAHs for a rapidly changing payment and delivery environment. Such programs should be encouraged, supported, and studied.

From a rural perspective, the continued push for better measures and increased transparency is important and positive. However, the measures developed and used must be relevant to rural areas. Measures are used for internal improvement, external reporting and accountability, and increasingly, for incentive and payment decisions. Rural-relevant measures should assess performance based on the scope and type of services appropriately delivered in rural communities; benchmarks and performance standards should be rigorous, and expectations should be for high quality of care within the scope of services provided. Rural providers should not be disadvantaged by measurement systems (and associated incentive or payment systems) that by their specifications (e.g., clinical service, numerator/denominator size, inclusions/exclusions) make it impossible for a rural provider to perform well.

Health System Redesign and Care Coordination

As illustrated by the national strategies and initiatives in Table 3, health system redesign and improved care coordination are a theme in the ACA. Numerous pilot and demonstration projects are underway that have the potential to dramatically alter how care is delivered by reforming health care systems, improving care coordination across settings and within communities, engaging patients and the public more actively, and modifying payment systems to reward quality.

Rural providers could successfully lead and participate in these health system redesign efforts to improve care, especially those that target chronic diseases or end-of-life care and populations in the most complex socioeconomic situations. However, to realize the potential in rural communities, the pilot projects and demonstrations must be designed and implemented to allow geographic and service areas with smaller volumes of patients to participate. Furthermore, their effectiveness should be measured and evaluated in rigorous yet creative ways to accurately capture results and knowledge, so that the pilots and demonstrations can be replicated in rural areas efficiently and effectively. Of particular concern is that eligible hospitals in a number of the pilot projects and demonstrations are defined as “Section D” hospitals, which by definition excludes CAHs.

PCORI research emphasizes comparative effectiveness, and incorporates patient-centered perspectives by, for example, requiring patient representation on grant applications. This provides a new opportunity for rural residents to have their voice heard on rural health issues. Significant funding is available, and the work is patient-centered.

RUPRI Panel comment: Research efforts should include or focus on health care access, delivery, and patient experience issues specific to residents of rural communities.

There is great opportunity for rural providers to effectively collaborate with other rural providers and/or their urban counterparts in initiatives such as forming ACOs. Conversely, ACOs operating in the market areas of rural providers but not including those providers in the ACO’s organization could be a threat to sustaining patient volume for rural providers.

Many of the demonstration and pilot projects that have emerged as a result of the ACA emphasize effective care transitions and care coordination, including Patient-Centered Medical Homes, the Medicare Coordinated Care Demonstration, and the Community-Based Care Transitions Program. When accompanied by new payment models that reward effective care transitions and care coordination—such as ACOs and bundled payments—these programs are rapidly testing new approaches to improve quality and health, and lower costs. The rural health care delivery environment is especially well positioned to coordinate the care of its patient population, typically organized around a primary care emphasis with a small network of referral hospitals, skilled nursing facilities (SNFs), home health agencies, and the ability to know not only patients but their families and the social and human service supports available locally. Again, program design that accounts for lower volume, as well as rural patterns of access and transition, are necessary to realize the potential of these types of care delivery and payment reforms in the rural environment.

Evaluations of the many health system redesign and care coordination initiatives and demonstrations are underway and will begin to yield results in the next several years, providing valuable insight into their effectiveness, particularly how they translate to rural areas. In the current environment of experimentation and change, it is critical that there is a thorough and comprehensive cataloging and analysis of what is working in rural communities and health systems so that future policies and programs can be maximally efficient and effective, whether at the federal or state level, and in both the public and private sector. The success and value of new programs, models, and initiatives in the rural context can be assessed using the principles outlined in the RUPRI Health Panel’s 2011 paper, *The Rural High Performance Health Care System of the Future*, in which the Panel outlined a vision for a rural health system based on a set of five principles: Affordability, Accessibility, Community Health, High Quality Care, and Patient Centeredness.

Part 4: Public Health

Significant Rural Provisions/Highlights

The ACA has implications for public health in at least three major ways. First, changes to insurance coverage for the many newly covered persons, including specifying essential benefits, create affordable access and remove financial barriers to seeking preventive and routine (primary care) services. Second, Medicare and Medicaid payment policy changes described in Part 2 create incentives for health systems to keep populations healthy, thereby increasing shared savings and lowering the risk of incurring non-reimbursable expenses (e.g., exceeding bundled payment amounts or not receiving a payment for hospital readmissions). Third, Title IV of the ACA includes new initiatives in public health such as the National Prevention Council, reauthorized funding for existing programs, and new programs with authorized funding, including the Prevention and Public Health Fund (PPHF). This fund has been created with ongoing, sustaining funds to support community-based programs. The fund was initially appropriated with \$500 million in 2010; subsequent appropriations were reduced from the levels specified in the ACA. This fund and other authorized grant programs could improve and sustain health in rural places, presuming funds allocated through states are used to support rural public health programs and systems.

Looking Back: ACA Implementation Impact through 2013

A comprehensive public health program requires a national campaign on health promotion and disease prevention that includes prevention research, health screenings, and research related to the delivery of public health services and disparities; school-based health centers (for which \$142 million has already been granted to fund construction and renovation of school-based health centers); community transformation grants that fund community-based prevention and wellness program efforts; interventions focused on persons between 55 and 64 years of age; and small business wellness programs. These programs and their status are summarized in Table 4.

Table 4. Status of Public Health Provisions

Provision	Program and Status
Prevention and Public Health Fund (Section 4002)	Funds have been appropriated and allocated to new and existing programs, although not at the levels provided in the ACA. <ul style="list-style-type: none"> The original \$15 billion (over 10 years) fund was cut by \$6.25 billion by the Middle Class Tax Relief and Job Creation Act of 2012 (the “fiscal cliff” legislation). Appropriations: \$500 million in FY 2010; \$750 million in FY 2011; \$1 billion in FY 2012; and \$949 million in FY 2013.
National Prevention, Health Promotion and Public Health Council (Section 4001)	The Council has issued reports in each year 2010-2013, and received recommendations from the Prevention Advisory Group each year 2011-2013.
Coverage of Preventive Health Services (Section 2713)	An interim final rule was released in July 2010. Regulations were effective beginning September 17, 2013. <ul style="list-style-type: none"> A report from the Assistant Secretary for Planning and Evaluation in March 2013 reported 71 million persons received expanded preventive services coverage.

Provision	Program and Status
Clinical and Community Preventive Services (Section 4003)	This section incorporates work of task forces staffed by the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention. <ul style="list-style-type: none"> • Three annual reports have been released. • Funded in part from the PPHF.
School-based Health Centers (Section 4101)	\$50 million was appropriated in each fiscal year FY 2010–FY 2013 for the Capital Program for schools. Grantees from 2011 are listed at: http://wayback.archive-it.org/3926/20140108162337/http://www.hhs.gov/news/press/2011pres/12/20111208a_grantees.html .
Oral Health Activities (Section 4102)	Grants were awarded to states in fiscal years 2010, 2011, and 2012.
Medicare Coverage of Annual Wellness Visit and expanded Medicare coverage of preventive services (Sections 4103 - 4106)	A report from HHS showed that more than 25 million beneficiaries used one or more free preventive services in 2011.
Community Transformation Grants (Section 4202)	Competitive grants are available for evidence-based community preventive health activities. <ul style="list-style-type: none"> • Grants are available for communities and states, and state grants have been used to benefit rural communities. • Funded from the PPHF in FY 2011–FY 2014.
Health Disparities Data Collection (Section 4302)	In October 2011, HHS issued data collection standards for race, ethnicity, sex, primary language, and disability status. <ul style="list-style-type: none"> • They did not include standards related to geographic location or socioeconomic status.
Public Health Services and Systems Research (Section 4301)	Research is to focus on strategies for services and systems, including identifying strategies for state and local systems. <ul style="list-style-type: none"> • Funds (\$20 million) were appropriated in FY 2011 from the PPHF.
Small Business Wellness Program (Section 10408)	This is a new program of grants to employers with fewer than 100 employees to provide access to comprehensive workplace wellness programs. <ul style="list-style-type: none"> • The program was funded in FY 2011 (\$10 million) and FY 2012 (\$10 million) from the PPHF.

Looking Ahead: ACA Implementation Issues for Rural Inclusion in Public Health Demonstrations and Initiatives

The most important impact of the ACA on prevention and public health could be through the provisions expanding insurance coverage, which also expands access to preventive health (including mental health), but analyzing the impact of the ACA on public health will likely not be possible for many years. However, full funding for public health programs remains the paramount concern as implementation of the ACA approaches year five. Authorization levels for programs in Title IV of the ACA have not been reached during annual appropriations, affecting the prospects for rural initiatives as well urban. The most dramatic change has been the \$6.5 billion reduction in the PPHF from the original authorization of \$15 billion. Several specific programs in Title IV have not received appropriations to

the levels authorized (in some cases zero), and the PPHF has been used to support some of those programs (e.g., public health services and systems research, Community Transformation Grants). In a context of reduced funding and continued pressure to constrain spending, a natural tendency is to demand the highest level of return for the scarce dollars being spent. Therefore, maintaining a balance of investment between urban (high, concentrated population) and rural (low, scattered population) places will be challenging. Nevertheless, gains in population health and the ability to achieve objectives that include cost savings from reduced use of expensive acute care services are equally important in all settings. Hence, the argument for public health investments in rural places can and should continue to resonate with policy makers and program administrators.

RUPRI Panel comment: The grant programs summarized above could contribute to improving health in rural areas, and we therefore recommend:

- ***Rural stakeholders monitor those programs and encourage participation (i.e., grant applications) by rural communities***
- ***Rural advocates use opportunities to secure resources for the programs and implementation actions by federal partners that facilitate rural participation***
- ***Evaluations of these programs include assessment of impact on rural communities***

The greatest potential to benefit rural places could come from statewide programs that receive funds authorized by the ACA. For example, with the Community Transformation Grant program, grants to states have been used to implement the program in rural communities.

RUPRI Panel comment: A comprehensive evaluation of the collective impact of statewide public health programs, as well as efforts funded by private foundations, on rural communities should be made over time. The results of the evaluation could guide further grant investments, especially as budgets continue to be tight. Programs at the community level include those funded through grants focused on finance and delivery of medical services, such as the CMMI grants. The interaction of those projects with the goals and activities of traditional public health programs must be understood as having an impact on rural communities.

Multiple studies have documented underuse of preventive services among rural residents. The ACA removes financial barriers to preventive services in private insurance plans and expands access to preventive health benefits in the Medicare program. While these improvements do not have a uniquely rural impact, they are important to efforts to meet objectives of improving the health of rural populations. However, it is not known whether removal of financial barriers will create pathways by which rural residents actually access preventive and health maintenance services. The interplay of financing and availability of providers will determine the outcome of efforts to promote improved personal health, and more research is needed to understand the interplay of those factors (e.g., does greater likelihood of payment increase the availability of the service) and the resulting behavior of individuals and households (i.e., will they obtain the services).

Part 5: Health Care Workforce

Significant Rural Provisions/Highlights

Several provisions in the ACA have the potential to strengthen the rural health care workforce, including primary care provider training grants, expanded graduate medical education sites, enhanced compensation to rural primary care providers, and increased funding levels for the National Health Services Corp.

Looking Back: ACA Implementation Impact through 2013

While several programs were funded starting in FY 2011, several have not been funded to the full amounts authorized by the ACA. Investments in workforce have been made, often using discretionary funding within the HHS budget and using sources obligated by the ACA, such as the PPHF and the CHCF.

Table 5. Status of Healthcare Workforce Initiatives

Initiative	Program and Status
Rural Physician Training Grants (Section 101501)	Up to \$4 million per year through FY 2013 has been authorized for medical schools to recruit students based on likelihood to practice in underserved rural communities, and to maintain a curriculum and training experience designed to enhance preparation to practice in rural underserved areas. <ul style="list-style-type: none"> Funds were not appropriated.
Teaching Health Centers Graduate Medical Education Program (Section 5203)	This program supports an increased number of primary care medical and dental residents trained in community-based settings across the country. Eligible Teaching Health Centers include Federally Qualified Health Centers, Community Mental Health Centers, and Rural Health Clinics; health centers operated by the Indian Health Service, an Indian tribe, or a tribal organization; and entities receiving funds under Title X of the Public Health Service Act. <ul style="list-style-type: none"> \$30 million has been awarded. Of 22 funded Centers, 15 serve rural communities.⁵²
Primary Care Training and Enhancement Program (Section 5301)	Grants are available to training programs to increase the number of residents training in primary care specialties. <ul style="list-style-type: none"> Grants were funded in FY 2011 from the PPHF at \$167 million, plus \$39 million from general funds. Funding has been at levels of \$39 million and \$37 million since 2011. No data is available as to location of residents once in practice.
Reauthorized funding for Title VIII nursing workforce programs (Section 5312)	Funding for Advanced Nursing Education included 26 schools of nursing in FY 2011. <ul style="list-style-type: none"> \$31 million was appropriated from the PPHF in FY 2011. The program has been funded at levels of more than \$60 million per year, FY 2011–FY 2013. Data are not yet available on the ultimate placement of graduates.
Primary Care Extension Program (PCEP) (Section 5405)	A primary care extension program is established to support and assist primary care providers in services related to preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques, through grants to states.

⁵² Morris T. (May 23, 2013). Testimony before the Committee on Homeland Security and Governmental Affairs Subcommittee on the Efficiency and Effectiveness of Federal Programs and the Federal Workforce. U.S. Senate.

Initiative	Program and Status
	<ul style="list-style-type: none"> Beginning 2011, the PCEP has emphasized small and rural primary care providers when targeting technical assistance, much as the new Health Information Technology Regional Extension Center program has done for electronic health record technical assistance.
National Health Service Corps (Section 5207)	Funding levels increased each year FY 2010–2015 (\$320 million to \$1.155 billion) for operations, scholarships, and loan repayments. <ul style="list-style-type: none"> Actual funding has ranged from \$315 million in FY 2011 to \$385 million in FY 2013, nearly all of which has been from the CHCF.

Looking Ahead: ACA Implementation Issues for Health Care Workforce Priorities

To evaluate and provide recommendations on national health care workforce priorities, goals, and policies and to review health care workforce supply and demand trends, the ACA established a new 15-member National Health Care Workforce Commission. While Commission members were named, funding for their work was not appropriated. The National Center for Health Workforce Analysis, a Center to support the Commission as a nexus for data collection and analysis supporting future workforce policy, has received funding of approximately \$2.8 million per year since 2010. Funding via grants was authorized but not appropriated for state and regional centers to support workforce development strategies. The Health Resources and Services Administration recently funded three centers for workforce analysis, whose programs of study include rural-relevant projects. The center at the University of North Carolina at Chapel Hill focuses on flexible use of workers to improve care delivery and efficiency. Its initial set of projects include one that analyzes the scope and balance of services provided by primary care physicians in rural and rural shortage areas. The center at George Washington University focuses on flexible use of workers, with an emphasis on CHCs. The center at the University of California at San Francisco focuses on long-term care.

RUPRI Panel comment: The ongoing work in workforce studies, whether or not supported through the relevant sections in the ACA should be monitored. We also recommend consideration of funding for the National Health Care Workforce Commission to take full advantage of study results to help shape further policy enhancing the spread of needed health care workers into rural areas.

Changes to existing programs increase resources devoted to training the types of providers needed in rural areas, and include priority statements favoring rural areas.

RUPRI Panel comment: However, given increased demand from newly insured persons, the Panel recommends vigilance to be sure sufficient personnel inclined to practice in underserved rural areas benefit from these programs.

Policies in the ACA could contribute to stabilizing rural practices. The payment incentive for primary care is targeted to those who are submitting Medicare Part B claims, and may continue beyond the dates set in the ACA, which we recommend. Incentives to recruit and retain primary care workforce in rural areas are essential to care management and primary care in payment reform initiatives such as the Medicare Shared Savings Program.

Part 6: Long-Term Care

Significant Rural Provisions/Highlights

Access to a full continuum of long-term services and supports (LTSS) remains a significant problem in rural areas. Title VIII (Sections 8002-3, amending Title XXXII of the Public Health Service Act), the *Community Living Assistance Services and Support Act* (CLASS Act), a national, voluntary long-term care insurance program, was the most significant provision in this section of the ACA. The CLASS Act, however, was repealed in a provision of the American Taxpayer Relief Act of 2012. Other ACA LTSS provisions include enhanced federal matching for home- and community-based services and supports, increased funding for Aging and Disability Resource Centers, and adjusted Medicare payments for long-term care services.

Looking Back: ACA Implementation Impact through 2013

While the CLASS Act was a centerpiece of the ACA's LTSS provisions, it was formally repealed in January 2013. A 15-member Commission on Long-Term Care was created with the purpose of developing a plan for better financing and delivery of long-term care services. In September 2013, the commission released a report including 28 proposals for legislative and administrative action, though the commission failed to come to a consensus regarding the financing of long-term care services—the most critical aspect of making long-term care accessible and affordable to those in need of it, particularly to those in rural communities.

The ACA contains provisions giving states the option to expand home- and community-based services with increased federal matching funds. Examples include extending the Money Follows the Person demonstration to help Medicaid beneficiaries transition from institutional to community care settings, and expanding protections against spousal impoverishment for Medicaid beneficiaries receiving home- and community-based services. To date, over \$340 million has been awarded to states expanding their Money Follows the Person demonstration programs.

RUPRI Panel comment: Evidence from states implementing early Money Follows the Person demonstrations suggest challenges unique to rural areas. These include issues relating to transportation (a lack of appropriate options, and the need for fuel assistance), a lack of crucial services (e.g., mobile pharmacies), and shortages of direct service workers.⁵³ These challenges must be monitored to ensure that home- and community-based services in rural areas are adequately supported.

The ACA provides additional funding for Aging and Disability Resource Centers that serve as a coordination resource for LTSS information and resources. Of \$50 million appropriated over a five-year period, \$15 million has been spent.

The ACA also created a Federal Coordinated Health Care Office to improve the coordination of federal and state policies and programs for those who are dually eligible for Medicare and Medicaid services. New initiatives and coordination at the state level should streamline care and improve quality across

⁵³ "Money Follows the Person Demonstration: Overview of State Grantee Progress, July to December 2011". (June 2012). Mathematica Policy Research, Contract Number: HHSM-500-2005-000251 (0002). Submitted to CMS, Division of Community Services Transformation, Disabled and Elderly Health Programs Group.

programs, and reduce expenditures by enhancing current service delivery programs. In many rural counties, more than half the Medicaid population is dually enrolled in Medicare, so efforts to improve coordination for these dual eligibles should have a positive impact on their health and quality of life.⁵⁴

Funding has also been awarded for state demonstration projects to support the training of direct care workers (described in Part 5, above), a Hospice Concurrent Care demonstration, and Skilled Nursing Facility Culture Change and Health Information Technology demonstrations.

Looking Ahead: ACA Implementation Issues for Long-Term Care in Rural Areas

With a larger proportion of the population in rural areas (relative to urban areas) needing LTSS, the provisions in the ACA are critical. While passage of the CLASS Act had the potential to expand insurance protections for persons needing LTSS later in life, achieving meaningful take-up rates, especially in rural areas and populations, would have required aggressive outreach and education. In addition, lower rural incomes would have been a significant deterrent to enrollment because of the cost of premiums (unless they were scaled to income).

Provisions supporting the expansion of home- and community-based services and other community support programs have the potential to expand the availability of these services in rural communities. Unfortunately, many rural areas lack the capacity to apply for grant funding and are often overlooked for the expansion of support service programs (e.g., home- and community-based services) because of the more limited LTSS infrastructure. It will be important to monitor whether the opportunities for LTSS expansions can overcome those circumstances and actually extend to rural communities.

The impact of payment changes for long-term care providers will also be important to monitor. A new Medicare hospice payment system is set to begin after FY 2014. A review of the impact of the payment changes to hospice providers suggests rural hospices may be more adversely affected than urban hospices by the proposed payment policy. One report estimates that hospices serving mostly rural patients would see their median margin decrease by a range of 0% in 2008 to -16% in 2019.⁵⁵ The changes in hospice payment policy could have an adverse impact on access to these services in rural areas. Scheduled Medicare payment reductions have already gone into effect for home health agencies, putting pressure on providers to reduce costs while also improve their reporting of quality measures.⁵⁶ This, too, could have unintended consequences for the provision of home health services in rural areas if payments do not cover the cost of providing care, and must be monitored for their effect on access to these services among rural Medicare beneficiaries. ACA-legislated reform of the prospective payment system for SNFs includes reductions in the market basket update by a productivity adjustment factor that assumes increasing productivity of SNF providers (such as new technology and fewer inputs).⁵⁷ Since productivity increases may be more difficult to attain in rural nursing facilities, the effect of this provision on the financial health of rural SNFs should be monitored.

⁵⁴ "Quick Take: Geographic Variation in Dual Eligible Enrollment." (May 23, 2012). The Kaiser Family Foundation. Accessed April 1, 2014. <http://kff.org/health-reform/fact-sheet/quick-take-geographic-variation-in-dual-eligible/>.

⁵⁵ "The Medicare Hospice Benefit & Recent Changes Impacting the Hospice Community." National Hospice and Palliative Care Organization.

⁵⁶ "Medicare finalizes home health payments for 2014." (November 22, 2013). Accessed April 1, 2014. <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2013-Press-releases-items/2013-11-22-2.html>.

⁵⁷ "Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Legislative History." (July 2013). Accessed April 1, 2014. www.cms.gov/Medicare/.../Legislative_History_07302013.pdf.

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