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

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Introduction

The enactment of the Patient Protection and Affordable Care Act of 2010 (ACA) began a series of significant changes in access to affordable health insurance, payment for healthcare services, expectations for measurable quality improvement, and how care is organized and delivered. Rural healthcare providers, residents, employers, and public health agencies will all be affected by changes initiated by the legislation. We say *initiated* because the ultimate impact of the changes will be a function of who participates, and how, in making them happen. The purpose of this document is to call attention to elements of the ACA that are likely to affect rural health care within the next three years. The RUPRI Health Panel presents summary statements of particular sections of the ACA related to six issue areas and discusses the implications for access to services and improving the health status of rural residents. Particular attention is given to those elements of the legislation for which consequences are as yet unknown and therefore worthy of close scrutiny and perhaps change during implementation, or reconsideration in future legislation.

We comment in six issue areas, based on major themes in the ACA:

1. Health Insurance Coverage
2. Medicare and Medicaid Payment
3. Quality, Financing, and Delivery System Reform
4. Public Health
5. Healthcare Workforce
6. Long-Term Care

The following pages discuss how the legislation, in each issue area, creates opportunities to improve availability, affordability, and/or quality of care in rural America. The summaries also highlight sections of the ACA that could be improved through the implementation process and/or in subsequent legislation. The written summaries are followed by Table 1, which presents side-by-side provisions from the ACA and Panel recommendations for future activity. A more detailed explication of rural-relevant provisions for all sections of the legislation, along with Panel commentary, can be found in the Appendix.

Part 1: Health Insurance Coverage

Significant Rural Provisions/Highlights

The provisions in the ACA in general will have a significant positive impact on rural areas, through their improvements in rural health insurance coverage rates in the short- and long-run,[1] and through the resulting positive impact on providers. Most of the coverage changes will occur after 2014, but some changes implemented in 2010 will have a positive impact on coverage rates among rural persons, including eligibility for coverage for children as dependents in family plans up to age 26, creation of high-risk pools for persons with pre-existing health conditions, and extension of tax credits and subsidies to small businesses and their employees.

Since rural persons have a higher uninsured rate than urban persons—especially in rural non-adjacent and frontier areas[2]—the impact of these provisions will be disproportionately more important in rural areas than in urban areas in general. In particular, rural persons are more likely to work for small businesses and for low wages. It is worth noting that the impact in rural areas will be the net of positive increases in coverage, balanced by reductions in payment to rural providers, especially through the Medicare program (covered in other areas of this document).

In future years (after 2014), the expansions of coverage through Medicaid and health insurance exchanges, and the use of subsidies and tax credits, will similarly have a disproportionate positive effect on rural areas, relative to urban areas, because of higher uninsured rates in rural areas to start with, and lower incomes of rural persons.[3]

The ultimate impact of expanded affordability will be realized only if individuals and small employers otherwise without health insurance enroll in health plans. Therefore, outreach efforts to ensure that eligible parties in rural places are aware of their health insurance options and know how to exercise their choices will be critical. Implementation activities should ensure that information is easily accessible, including providing web-based protocols for comparing and choosing health plans in places accessible to rural residents.

[1] McBride T. (2009). "Impact of the Patient Protection and Affordable Care Act on Covered Persons." Columbia, MO: Rural Policy Research Institute.

[2] 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.

[3] McBride T. (2009). Op cit.

Part 2: Medicare and Medicaid Payment

Significant Rural Provisions/Highlights

The ACA changes Medicare payment for virtually every rural healthcare provider type, including (but not limited to) physicians, rural hospitals, and Community Health Centers (CHCs). The ACA establishes demonstration projects designed to test new healthcare payment systems. And the ACA tasks new and existing institutions to research and recommend both Medicare payment and cost-saving strategies.

Rural Physicians

Rural primary care physicians will benefit from Geographic Practice Cost Indices (GPCIs) adjustments that will reduce geographic practice expense disparities. Furthermore, in 2011 the practice expense GPCI will be raised to 1.000 (the national mean) for Frontier states, thereby increasing practice expense payments to all physicians practicing in those states. However, changes to the Resource Based Relative Value System in the years following 2011 require monitoring to ensure continued consideration of rural practice realities and to assess the ACA provisions' impact on rural primary care shortages. Primary care physicians will receive a 10% bonus for ACA-defined "primary care services," but only if those "primary care services" represent at least 60% of the practice. The requirement that at least 60% of a practice's furnished services must be particular "primary care services" to receive the ACA primary care bonus may preclude eligibility for those rural primary care practices that tend to offer more procedures (thus proportionally fewer primary care services) than urban/suburban practices. Also, the ACA-defined primary care services currently do not include preventive health services. The percentage of rural practices eligible for the primary care bonus requires monitoring, and preventive healthcare services should be added as "primary care services."

Rural Hospitals

As healthcare reform is implemented, the uninsured rate is projected to decline. Thus, hospitals should have less charity care and less bad debt. Because of this the ACA requires CMS to begin to reduce Disproportionate Share Hospital (DSH) payments, which historically have not been a significant source of revenue for most rural hospitals. The phased-in reductions will be offset by increased revenues from the newly insured, at least in the aggregate, but not necessarily in each institution. Without careful monitoring and the willingness to adjust payment policies quickly, safety-net hospitals could be negatively impacted. The ACA also reduces market basket updates to prospective payment system hospitals. Scheduled reductions should be considered in the context of all ACA changes impacting hospital revenue, such as new delivery models, system affiliations, and efficiency improvements. The cumulative impact on revenue may not be negative for rural hospitals. However, monitoring is required to ensure that access to hospital care is maintained for residents in rural communities.

Community Health Centers

The ACA establishes a CHC fund to expand and sustain federal investments in CHCs by appropriating an additional $700 million in FY 2011 that increases to $2.9 billion in FY 2015. The focus on CHCs,

while appropriate, may overlook the needs of rural private practice clinics and Rural Health Clinics, who serve as safety-net providers in many rural communities where there are no CHCs now and little prospect for any in the future. Furthermore, where CHCs are present, additional program emphasis is needed to foster CHC collaboration with other local healthcare providers (e.g., Critical Access Hospitals [CAHs], Rural Health Clinics, and private physician practices) that also may serve a safety-net role in rural communities. For example, regulations could require that CHCs receive letters of support from the local hospital and other primary care practices to be eligible for new capital funding.

New Payment Systems

The ACA establishes several new demonstration projects designed to test new healthcare delivery models, among these Accountable Care Organizations (ACOs) and bundled payment strategies. The ACA mandates consideration of ACOs when awarding Medicare Rural Hospital Flexibility grants, but does not specifically include CAHs in ACO demonstration projects. ACOs are innovative models with potential to improve quality and reduce cost. Although there is risk to rural if ACOs are insensitive to the needs of rural people and providers, there is great opportunity for rural providers to effectively collaborate with other rural providers and/or urban providers. Future legislation should specifically include CAHs in new hospital quality improvement and cost reduction strategies. Based on research suggesting that Medicare Advantage payments have exceeded Medicare fee-for-service payments, the ACA begins to reduce Medicare Advantage payments in 2012 to align the two payments. Insurance industry response to the payment reductions is unpredictable due to complex market conditions. Thus, the provision requires monitoring to ensure that rural disparities in health plan access and benefit plan design do not develop or worsen.

Research and Payment Policy

The ACA establishes the Independent Payment Advisory Board (IPAB), an independent panel of medical experts tasked with devising changes to Medicare's payment system. Beginning in January 2014, each year that Medicare's per capita costs exceed a certain threshold, the IPAB will develop and propose policies for reducing this inflation. The Secretary of the Department of Health and Human Services must institute the policies unless Congress enacts alternative policies leading to equivalent savings. The IPAB requires rural membership representation. Rural stakeholders should monitor board reports for geographic bias. The ACA also tasks the Medicare Payment Advisory Commission to study geographic payment variation, Medicare beneficiary access to services in rural areas, adequacy of payments to providers and suppliers, and rural quality of care. This analysis should be compared to a similar study to be completed by the Institute of Medicine and both used to develop policy. Lastly, 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 and the geographic differences in those rates, use the best available statistical methods and data processing technology to develop such fee schedules and other database tools, and regularly update such fee schedules and other database tools to reflect changes in charges for medical services. Since the data centers will develop fee schedules that reflect geographic differences in market rates, monitoring is required to ensure equitable geographic distribution of medical reimbursements.

Part 3: Quality, Financing, and Delivery System Reform

Significant Rural Provisions/Highlights

National Strategies

The ACA establishes new national strategies and agency responsibilities related to quality, financing, and health system reform. The most common approaches to the development of these strategies are through the formation of new centers (or new responsibilities within existing centers or agencies) and national commissions or other bodies. There are two underlying areas of interest and need from a rural perspective:

1. These centers, committees, and commissions should include meaningful rural representation. Rural perspective and expertise are necessary to ensure that citizens living in rural areas across the country receive the safest and highest quality of care, and that rural providers are assured of policies and programs that support their ability to deliver this high quality care in the most efficient ways possible.
2. The recommendations and actions, taken both individually and in the aggregate, must form a comprehensive and strategic approach to healthcare delivery in ways that account for the needs of rural patients and providers.

Measurement and Transparency

The legislation expands and accelerates the measurement and transparency of the healthcare system in the United States. New measures are called for, across parts of the health delivery system that are already publicly reported as well as many that are not.

From a rural perspective, the continued push for better measures and increased transparency is important and positive. The critical aspect of the expansion of measurement and transparency as the ACA is implemented is that the measures developed and used include measures of rural relevance. 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, or in some instances at all.

Health System Redesign and Care Coordination

Throughout the legislation, health system redesign and improved care coordination emerge as a theme. Numerous pilot and demonstration projects are called for that have the potential to dramatically alter the way care is delivered by reforming systems, workflow, patient engagement, and payment/reimbursement.

Rural providers have a great opportunity to successfully lead and participate in these health system redesign efforts to improve care generally, and specifically for those with chronic diseases and at the end-of-life, and those 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 include geographic and service areas with smaller volumes of patients, and measured and evaluated in rigorous yet creative ways to capture accurately the results and learnings, so that the pilots and demonstrations can be replicated in an efficient and effective manner. Of particular concern is that in a number of the pilot projects and demonstrations, eligible hospitals are defined as "Section D" hospitals, which by definition excludes CAHs.

In addition, the legislation addresses current gaps in research and promotes innovation through a number of new programs and policies. The key rural issue in this realm is to assure that when appropriate, research efforts include or focus on rural health care.

Part 4: Public Health

Significant Rural Provisions/Highlights

Title IV of the ACA contains many specific provisions that will facilitate local efforts to improve both individual and community health. A new National Prevention, Health Promotion, and Public Health Council will develop and update a strategy to improve the health of Americans and reduce the incidence of preventable illness and disability. Most agencies of the US government are members of this council, creating a potential for focusing on community health and wellness that includes multiple programs affecting everyone's potential to live healthy lives. An Advisory Group of non-Federal employees is established to work with the National Prevention, Health Promotion, and Public Health Council, with no requirements for particular representation on the group. The group should receive input, directly from members, and/or from others, to understand implications of public health policies and programs for rural communities. A new public health fund is created and sustained to support community-based programs. That 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. Specific elements of a comprehensive approach include a national campaign on health promotion and disease prevention, school-based health centers, community transformation grants, interventions focused on persons between 55 and 64 years of age, small business wellness programs, and research related to the delivery of public health services and disparities.

Part 5: Healthcare Workforce

Significant Rural Provisions/Highlights

Overall, the provisions in the ACA may be used to strengthen the rural healthcare workforce. The final impact will be a function of future appropriations; increased levels and new spending are authorized in the ACA but not specifically appropriated. The ACA creates new support programs and enhances current programs providing loan repayment. Eligibility for loan repayment is extended to allied health and public health professionals. Grants are provided to training programs in family medicine, general internal medicine, general pediatrics, allied health, dental health, geriatric care, mental and behavioral health, and nursing.

A new National Center for Healthcare Workforce Analysis will be a nexus for data collection and analysis supporting future workforce policy. Funding is also authorized for state and regional centers.

Changes to existing programs increase resources devoted to training the types of providers needed in rural areas, and include priority statements favoring rural areas. 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, and that other programs that increase efficiency of practice (such as use of personnel in medical homes) be promoted. Consideration should be given to including general surgery as a specialty eligible for National Health Service Corps support.

Part 6: Long-Term Care

Significant Rural Provisions/Highlights

The ACA contains many provisions that will affect rural long-term care (LTC) facilities, services, and patients. The most significant provision in the legislation is 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 LTC insurance program. Provisions in the law favoring home- and community-based services give states the option of expanding such services with increased federal matching funds, extending the "Money Follows the Person" demonstrations 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. The ACA provides additional funding for Aging and Disability Resource Centers and creates a Federal Coordinated Healthcare Office to improve the coordination of federal and state policies and programs for those who are dually eligible for Medicare and Medicaid services. It authorizes funding for state demonstration projects to support the training of direct care workers, a Hospice Concurrent Care demonstration, and Skilled Nursing Facility Culture Change and Health Information Technology demonstrations.

In addition to these LTC-specific provisions, the law adjusts Medicare payments for several important LTC services: skilled nursing facilities, home health, and hospice care.

With a larger proportion of the population in rural areas (as compared to urban areas) needing long-term support services and LTC, the LTC-related provisions in the ACA are critically important. While passage of the CLASS Act may expand insurance protections for persons needing LTC services later in their life, achieving meaningful take-up rates, especially in rural areas and populations, will require aggressive outreach and education. In addition, lower rural incomes will also be a significant deterrent to enrollment because of the cost of premiums (unless they are scaled to income). Provisions that support the expansion of home- and community-based services and other community support programs have the potential for expanding the availability of these services in rural communities. Unfortunately, however, 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 LTC infrastructure. It will be important to monitor whether the opportunities for LTC support service expansions can overcome those circumstances and actually extend to rural communities. The impact of payment changes for LTC providers will also be important to monitor. Although the law requires the Medicare Payment Advisory Commission to conduct an analysis of the rural impact of home health payment changes, the impact of other changes may not be evaluated.

Table 1: Suggestions for Improvement to Certain Sections of the ACA

Section	Summary of Section	Suggestions For Improvement/Monitoring
1101	A temporary high risk pool program will be established for persons with pre-existing conditions precluding access to insurance coverage. Existing state programs must maintain current levels of support.	This provision is beneficial to rural persons—although the number of rural people affected is small, it is very important to them. Consideration should be given to making sure plans are affordable to rural persons.
1311	A grant program will be created to help states establish exchanges. The minimum criteria to be certified as a health plan include network adequacy, the inclusion of essential community providers, and accreditation with respect to local performance on clinical quality measures. This section allows for regional or other interstate exchanges.	In general, health insurance exchanges (HIEs) have the potential to expand the availability of coverage to rural persons. However, it will be crucial to monitor several aspects of HIE. In particular, the following should be monitored: outreach activities, how risk rating and selection is handled, whether there is an adequate number of affordable choices of plans available for rural persons across the whole region, how subsidies are coordinated with the HIE, whether network adequacy standards incorporate usual patterns of care, and how governance is handled in the HIE (that is, does it include rural representation).
1421	Small businesses will receive tax credits equal to 50% (35% for tax-exempt eligible small employers) of the lesser of (1) non-elective contributions for premiums or (2) the aggregate amount of contributions that the employer would have made if each employee had enrolled. Eligible employers are those with no more than 25 full-time equivalent employees with average annual incomes of less than $50,000.	This provision is critical for rural employers and employees, since a disproportionate share of rural persons are employed in small businesses with lower wage rates. It will be very important to monitor the outreach of the tax credits, and whether small employers become aware of the availability of this program, and take it up.
2001	Medicaid eligibility will be expanded to include all persons under age 65 in low income households who are not enrolled in Medicare. *As amended by Reconciliation:* The federal government will fund 100% of the cost of newly eligible persons from 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter. States can initiate this provision sooner, if desired.	This expansion of coverage will have a significant positive impact on rural persons because of the disproportionately higher percentage of rural persons with low incomes. It will be important to monitor whether outreach is done to rural areas to enroll eligible persons.
2701	The Secretary shall publish a recommended a core set of adult health quality measures for Medicaid eligible adults, with an initial set reported by January 1, 2012.	Core measures should include rural-relevant measures based on the scope and type of services appropriately delivered in rural communities.

Section	Summary of Section	Suggestions For Improvement/Monitoring
3011	A national strategy will be established for improving the delivery of healthcare services, patient health outcomes, and population health.	The national strategy should be comprehensive and coordinated, and include a strong rural component that recognizes the unique needs and opportunities of rural communities, patients, and providers.
3013	The Secretary shall lead a national quality measurement development effort focused on health outcomes, care transitions, health information technology, efficiency, equity, and patient experience.	These measures should apply to all rural providers. Therefore, they need to be sensitive to the rural context.
3021	A Center for Medicare and Medicaid Innovation will be established in the Centers for Medicare and Medicaid Services to test a list of 12 specified payment and service delivery models, including such approaches as patient-centered medical homes, geriatric assessments and comprehensive care plans, care coordination for chronically ill, medication therapy management services, community-based health teams, patient decision-support tools, and electronic monitoring by specialists.	The new Center for Medicare and Medicaid Innovation payment and delivery models tested should include an emphasis on models relevant to rural providers and patients, and a sufficient number of demonstration sites to adequately test those models.
3022	The ACA mandates consideration of Accountable Care Organizations (ACOs) and value-based purchasing when awarding Medicare Rural Hospital Flexibility grants. However, Critical Access Hospitals (CAHs) are not specifically included in the ACO and bundled payment demonstration projects.	Future legislation should specifically include CAHs in new hospital quality improvement and cost reduction strategies.
3127	The Medicare Payment Advisory Commission 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.	This analysis should be compared to a similar study to be completed by the Institute of Medicine and both used to develop policy.
3403	The ACA establishes the Independent Payment Advisory Board (IPAB), an independent panel of medical experts tasked with devising changes to Medicare's payment system. Beginning in January 2014, each year that Medicare's per capita costs exceed a certain threshold, the IPAB will develop and propose policies for reducing this inflation. The Secretary must institute the policies unless Congress enacts alternative policies leading to equivalent savings.	The IPAB requires rural membership representation. Rural stakeholders should monitor board reports for geographic bias.

Section	Summary of Section	Suggestions For Improvement/Monitoring
3504	Regionalized systems for emergency care: At least 4 multi-year contracts or grants will be made to support pilot projects to design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. Priority will be given to an entity that serves a population in a medically underserved area.	Implement at least one of the 4 grants in a predominantly rural region.
4003	The Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention will convene task forces to review clinical services and community-based preventive health interventions. The task forces' deliberations will include consideration of social, economic, and physical environments that can affect health and disease.	Consideration of factors other than healthcare delivery should include uniquely rural considerations, such as impacts of extraction industry activities and how sparsely populated areas develop and sustain public health activities. Assurance of such consideration could be accomplished by including input from the Office of Rural Health Policy.
5208	Additional funding is available to create and support nurse-managed health clinics that provide primary care or wellness services to underserved or vulnerable populations.	Develop the eligibility in such a way that there are incentives to develop rural nurse-managed clinics as a mechanism to address physician shortages in rural areas.
5302	The ACA authorizes funds to support training direct care workers in long-term care settings and training of health workers that function similar to extension service workers, providing support to community residents interacting with exchanges and other new elements of the healthcare system. Funding is also provided to Area Health Education Centers, making all of them eligible for infrastructure development and effectiveness grants.	Programs functioning outside of training institutions but which contribute to the likelihood of attracting and retaining health professionals in rural and underserved areas are supported by the ACA. These programs should be monitored to be sure that to the greatest extent possible, rural needs are addressed.
5405	A primary care extension program will be 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.	Emphasize 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, and coordinate the two programs when possible.
5501	Primary care providers will be paid an additional 10% for primary care services (defined by certain CPT codes) if primary care represents 60% or greater of the practice. This payment will be in addition to the 10% Health Professional Shortage Area bonus.	Because rural physicians often provide more procedures, many may not meet the primary care percentage threshold and thus would not be eligible for the primary care bonus. Thus, further study is required to determine if revisions might be needed to benefit rural primary care physicians.

Section	Summary of Section	Suggestions For Improvement/Monitoring
5602	A negotiated rulemaking process will be created to develop a methodology and criteria for designating Medically Underserved Populations and Health Professional Shortage Areas.	Rural participants in this process, and those providing insight and analysis to the negotiators, will need to consider strengths and weaknesses of data used, processes for de-designation without jeopardizing continuous access because payment bonuses are negated, and differential impacts on types of rural providers.
8002	Implementation of national voluntary long-term care insurance will require, among other provisions, the establishment of a CLASS Independence Advisory Council and a Personal Care Attendants Workforce Advisory Panel, and the development of "advice and assistance counseling services."	Rural representation on the CLASS Advisory Council and the Personal Care Attendants Workforce Advisory Panel should be ensured. Consideration of rural implementation concerns with "advice and counseling" will be vital. Rural outreach and enrollment strategies may be needed.
10303	The Secretary shall develop and periodically update (at least every 3 years) provider-level outcome measures for hospitals and physicians, as well as other providers as determined appropriate by the Secretary.	These measures should apply to all rural providers. Therefore they need to be sensitive to the rural context.
10331	By January 1, 2019, provide financial incentives to beneficiaries served by high quality physicians. A patient navigator program is supported with grants that shall not exceed 4 years.	Ensure that the measures to determine "high quality physicians" include measures of services and care relevant to rural practice.
10408	A grant program is established for small businesses to provide comprehensive wellness programs.	Rural applicants should be encouraged, perhaps with technical assistance in grant writing.

Appendix: Detailed Tables with Commentary on Rural Relevant Provisions from the ACA

Section	Rural Implementation/Impact
Health Insurance Coverage	
1001-2711*:* A group plan and health insurance issuer of group and individual plans may not establish lifetime limits on the dollar value of benefits.	Rural people are more likely to be in plans with limits on benefits, so the change will be especially important. Standardization may be needed to create fairness between and across urban and rural areas.
1001 – 2714: Persons up to age 26 can stay in parent's plan.	This provision is beneficial to rural dependents, since in rural areas adults age 18-26 are more likely not to be enrolled full time in an educational system that would have them in dependent status.
1002-2793: Grants will be made to States or Exchanges in States for consumer assistance programs, including assistance with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance.	A set aside or directive to address rural circumstances may be needed.
1101: A temporary high-risk pool program will be established for persons with pre-existing conditions precluding access to insurance coverage. Existing state programs must maintain current levels of support.	This provision is beneficial to rural persons—although the number of rural people affected is small, it is very important to them. Consideration should be given to making sure plans are affordable to rural persons.
1102: Re-insurance for early retirees	This provision is particularly beneficial to early retirees in rural areas.
1103: An Internet portal will be established to provide information on coverage options. A direct appropriation of $250 million for state grants to create information for consumers.	While this is important and crucial for the functioning of health insurance exchanges (HIEs), consideration should be given to make sure the portal is accessible to rural residents since rural persons are less likely to have access to Internet services. The accessibility of information should be monitored for its impact in rural areas with respect to availability of affordable health plans.
1311: A grant program will be created to help states establish exchanges. The minimum criteria to be certified as a health plan include network adequacy, the inclusion of essential community providers, and accreditation with respect to local performance on clinical quality measures. This section allows for regional or other interstate exchanges.	In general, HIEs have the potential to expand the availability of coverage to rural persons. However, it will be crucial to monitor several aspects of HIE. In particular, the following should be monitored: outreach activities, how risk rating and selection is handled, whether there is an adequate number of affordable choices of plans available for rural persons across the whole region, how subsidies are coordinated with the HIE, whether network adequacy standards include usual patterns of care, and how governance is handled in the HIE (that is, does it include rural representation).

Section	Rural Implementation/Impact
1421: Small businesses will receive tax credits equal to 50% (35% for tax-exempt eligible small employers) of the lesser of (1) non-elective contributions for premiums or (2) the aggregate amount of contributions that the employer would have made if each employee had enrolled. Eligible employers are those with no more than 25 full-time equivalent employees with average annual incomes of less than $50,000.	This provision is critical for rural employers and employees, since a disproportionate share of rural persons are employed in small businesses with lower wage rates. It will be very important to monitor the outreach of the tax credits, and whether small employers become aware of the availability of this program, and take it up.
2001: Medicaid eligibility will be expanded to include all persons under age 65 in low income households who are not enrolled in Medicare. *As amended by Reconciliation:* The federal government will fund 100% of the cost of newly eligible persons from 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter. States can initiate this provision sooner, if desired.	This expansion of coverage will have a significant positive impact on rural persons because of the disproportionately higher percentage of rural persons with low incomes. It will be important to monitor whether outreach is done to rural areas to enroll eligible persons.
9022: Eligible employers are those with an average of 100 or fewer employees during either of the 2 preceding years. Employers are required to contribute. Employees are required to have at least 1,000 hours of service for the preceding year.	Given the disproportionately higher percentage of rural persons in small businesses, this provision will have an important impact on rural persons. It is not clear how many rural employers will be able to afford to implement these plans, however.
10105 and 1416 (GAO Study): The objective of this study is to recommend new applications of the federal poverty rate, adjusted for geographic differences. Collection of the data will be extremely difficult, casting doubt on the validity of measure for small places (pending definition of "region").	This study could have important implications for rural areas, so it will be important to monitor this work. The definition of region and geographic area will be important, as this definition has variable impact on programs across geography.
10203 Funding for the Children's Health Insurance Program is extended through the end of 2015.	This is an important provision for rural persons given the higher coverage rates for the Children's Health Insurance Program in rural areas.
10329: The Secretary must develop methodology to measure health plan value that takes into consideration, where applicable, (a) overall cost to enrollees under the plan, (b) quality of the care provided for under the plan, (c) relative risk of the plan's enrollees as compared to other plans, (d) actuarial value or other comparative measure of the benefits covered under the plan, and (e) other factors as determined by the Secretary.	The impact of risk selection may be particularly important in rural areas, where populations are small, and rural persons are known to have a higher risk profile. Therefore, how health plans handle risk selection, and how the regulations are set to monitor this can be crucial for rural persons, affordability, and the accessibility of plans.
Medicare and Medicaid Payment	
2503: The upper payment limit for pharmaceuticals will be calculated as no less than 175% of the weighted average of the most recently reported monthly average manufacturer prices for purchases from retail pharmacies.	Although this provision improves upon those of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, reimbursement to rural pharmacies remains problematic and may require special safety-net provider payment provisions.

Section	Rural Implementation/Impact
2551: Medicaid Disproportionate Share Hospital (DSH) allotments will be reduced as insured rates increase. Yearly aggregate reductions will equal $500 million in FY 2014 and up to $4.0 billion in FY 2020. To implement these reductions, the Secretary will impose the largest reductions on those states with the lowest percentage of uninsured or those that do not prioritize hospitals with high Medicaid volumes or high uncompensated care volumes, impose smaller reductions on low DSH states, and consider the extent to which a state's DSH allotment was included in budget neutrality calculations for coverage expansion approved July 31, 2009.	It is unclear if DSH payment reductions will be offset by revenue increases from the newly insured. Most rural hospitals have not received significant revenues through DSH payments. Without careful monitoring and the willingness to adjust payment policies quickly, safety-net hospitals could be negatively impacted.
2702: The Secretary will incorporate into Medicaid regulations certain state practices that prohibit payment for healthcare acquired conditions.	Critical Access Hospitals (CAHs) should not be excluded from this quality improvement requirement.
3022: The ACA mandates consideration of Accountable Care Organizations (ACOs) and value-based purchasing when awarding Medicare Rural Hospital Flexibility grants. However, CAHs are not specifically included in the ACO and bundled payment demonstration projects.	Future legislation should specifically include CAHs in new hospital quality improvement and cost reduction strategies.
3102: The Geographic Practice Cost Index (GPCI) for practice expense is adjusted to reduce payment differences across Medicare localities in 2010 and 2011. Additionally, the GPCI for practice expense will be raised to 1.000 for Frontier states.	Changes to the Resource Based Relative Value System in the years following 2011 require monitoring to ensure continued consideration of rural practice realities, including physician shortages.
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.	This analysis should be compared to a similar study to be completed by the Institute of Medicine and both used to develop policy.
3131: The Secretary will rebase home health payments per episode to include changes in the number of visits per episode, intensity level, average cost and other factors. These changes will be phased in over 4 years. MedPAC will analyze the impacts of payment adjustments on access to care, outcome quality, and the number of home health agencies (including numbers of rural/urban and for-profit/nonprofit agencies). Additionally, the Secretary will evaluate cost and quality of care among efficient providers compared to less efficient providers.	The rural impact of the rebasing requires monitoring to ensure that rural access to home health services is not compromised. Rural realities such as distance to clients, lower volumes, and consequent inefficiencies should be considered in the MedPAC and Secretary reports.

Section	Rural Implementation/Impact
3201: Medicare Advantage payment reductions begin in 2012 to align Medicare Advantage payments with Medicare fee-for-service payments.	Insurance industry response to the payment reductions is unpredictable due to complex market conditions. The provision requires monitoring to ensure that rural disparities in health plan access and benefit plan design do not develop or worsen.
3401: A productivity adjustment to market basket updates for prospective payment system hospitals will be equal to a 10-year average of changes in economy-wide private nonfarm business. This adjustment may result in a lower payment than the previous year. The Secretary will reduce any increases by 0.25% in FYs 2010 and 2011 and reduce any increases by 0.2% in FYs 2012 through 2019. However, the reduction will be 0.0% if the percentage of the non-elderly insured population for the preceding fiscal year is at least 5% less than projected.	Scheduled reductions listed in the section should be considered in the context of all ACA changes impacting hospital revenue, such as new delivery models, system affiliations, and efficiency improvements. The cumulative impact on revenue may not be negative for rural hospitals. However, monitoring will be required to ensure rural access to hospital care is maintained.
3403: The ACA establishes the Independent Payment Advisory Board (IPAB), an independent panel of medical experts tasked with devising changes to Medicare's payment system. Beginning in January 2014, each year that Medicare's per capita costs exceed a certain threshold, the IPAB will develop and propose policies for reducing this inflation. The Secretary must institute the policies unless Congress enacts alternative policies leading to equivalent savings.	The IPAB requires rural membership representation. Rural stakeholders should monitor board reports for geographic bias.
5501: Primary care providers will be paid an additional 10% for primary care services (defined by certain CPT codes) if primary care represents 60% or greater of the practice. This payment will be in addition to the 10% Health Professional Shortage Area bonus.	Because rural physicians often provide more procedures, many may not meet the primary care percentage threshold and thus would not be eligible for the primary care bonus. Thus, further study is required to determine if this provision will benefit primary care practices in rural areas.
10101: Medical reimbursement data centers shall develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates, use the best available statistical methods and data processing technology to develop such fee schedules and other database tools, and regularly update such fee schedules and other database tools to reflect changes in charges for medical services.	Since the data centers will develop fee schedules that reflect geographic differences in market rates, monitoring is required to ensure equitable geographic distribution of medical reimbursements.
10503: A Community Health Center (CHC) fund is established to expand and sustain federal investments in CHCs by appropriating an additional $700 million in FY 2011 that increases to $2.9 billion in FY 2015.	CHCs are not the only rural safety-net provider. This significant CHC funding influx should be balanced with the needs of rural private practice clinics and rural health clinics.

Section	Rural Implementation/Impact
1109 (Reconciliation Bill): $400 million is made available for prospective payment system hospitals located in the lowest Medicare-expenditure counties.	Rural impact will depend on county characteristics, not on being a rural or underserved location. Rural hospitals should not be penalized with program ineligibility for economic and other factors beyond their control.
Quality, Financing, and Delivery System Reform	
2602: A Federal Coordinated Healthcare Office will be established to improve coordination between the federal government and states for dually eligible individuals to simplify the process to access services, improve the quality of health care and long-term services, improve care continuity, and improve the quality of performance of providers of services and suppliers under Medicare and Medicaid programs.	Rural expertise is necessary in the new Federal Coordinated Healthcare Office to assure rural dually enrolled needs are met and improvement opportunities realized.
3011: A national strategy will be established for improving the delivery of healthcare services, patient health outcomes, and population health.	The national strategy should be comprehensive and coordinated and include a strong rural component that recognizes the unique needs and opportunities of rural communities, patients, and providers.
3014: A multi-stakeholder group will provide input into the selection of quality measures to the National Quality Forum and then to the Secretary.	The multi-stakeholder group should include meaningful rural representation.
3501: The Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality will have new responsibilities to conduct healthcare delivery system research and quality improvement technical assistance.	The Agency for Healthcare Research and Quality Center for Quality Improvement and Patient Safety efforts should explicitly include rural research and quality improvement technical assistance.
Cost Measures	For the cost and quality measures listed here, the measures developed and publicly reported should include measures of rural relevance. Rural relevant measures should assess performance based on the scope and type of services appropriately delivered in rural communities. 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, or in some instances at all.
1001–2719a: Healthcare cost information will be made available to the public through an Internet website that allows consumers to understand the amounts that healthcare providers in their area charge for particular medical services.	
1001-2718: Hospitals must make public a list of standard charges, including for diagnosis-related groups.	
1001-2718: Insurers must report the percentage of premiums used for clinical services, quality improvement, and all other non-claims costs.	
6005: A health plan that provides pharmacy benefits management services on behalf of a health benefits plan in an exchange or through Medicare must report four new measures.	

Section	Rural Implementation/Impact
Quality Measures	
2701: The Secretary shall publish a recommended core set of adult health quality measures for Medicaid eligible adults, with an initial set reported by January 1, 2012.	
3013: The Secretary shall lead a national quality measurement development effort focused on health outcomes, care transitions, health information technology, efficiency, equity, and patient experience.	
3015: The Secretary shall collect and aggregate data on quality and resource use measures from information systems used to support healthcare delivery and may award grants for this purpose.	
10303: The Secretary shall develop and periodically update (at least every 3 years) provider-level outcome measures for hospitals and physicians, as well as other providers as determined appropriate by the Secretary.	
10331: By January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians and other professionals who participate in the Physician Quality Reporting Initiative, and implement a plan to make information on physician performance public through Physician Compare.	
Delivery System Reform	
2703: State planning grants will be available to provide medical assistance to individuals with chronic conditions who designate a provider or a team of professionals as their health home; hospital readmission and savings data will be measured.	Ensure that the readmissions and savings data required by the legislation for evaluation purposes do not bias against the participation of rural providers.
2705: A 5-state demonstration project will be established under which payments to “large” safety net hospital systems or networks are adjusted from a fee-for-service structure to a global capitated payment model.	At least one of the sites in each of the 5 state demonstrations should include a rural network to test the efficacy of a global capitated payment model in rural communities. CAHs should be included as part of eligible networks.
3021: The Center for Medicare and Medicaid Innovation will be established in the Centers for Medicare and Medicaid Services to test a list of 12 specified payment and service delivery models, including such approaches as patient-centered medical homes, geriatric assessments and comprehensive care plans, care coordination for chronically ill, medication therapy management services, community-based health teams, patient decision-support tools, and electronic monitoring by specialists.	Ensure that the new Center for Medicare and Medicaid Innovation payment and delivery models tested include an emphasis on models relevant to rural providers and patients.

Section	Rural Implementation/Impact
3022: ACOs will become a permanent part of the Medicare program, and become models based on shared savings.	In implementation, the governance and payment mechanisms for ACOs should not preclude rural participation.
3023: A national pilot program will be established on payment bundling specific to 8 conditions.	Include conditions and sites relevant to rural.
3026: A community-based care transitions program will be established that provides funding for improved care transition services to high-risk Medicare beneficiaries by working across the continuum of care through arrangements with hospitals.	Include CAHs in the program.
3126: This section improves the demonstration project on community health integration models in certain rural counties.	A requirement that CAHs must provide rural health clinic services is removed, allowing for more CAH participation.
3140: The Medicare Hospice Concurrent Care demonstration program shall be conducted for 3 years in not more than 15 hospice programs, including urban and rural programs.	This may create a greater probability of developing and sustaining rural healthcare services.
3501: A Quality Improvement Network Research Program may be established to test, scale, and disseminate interventions to improve quality and efficiency in health care. Quality improvement technical assistance grants or contracts will be available to support institutions that deliver health care and to healthcare providers, including rural and urban providers.	Technical assistance grants could be beneficial to small rural physician practices and hospitals, and to small networks.
3502: Community health teams will be established to support patient-centered medical homes in primary care practices within hospital service areas served by them.	Include rural primary care practices in CAH service areas.
3503: A new Patient Safety Research Center provides grants or contracts to entities to implement medication management services provided by licensed pharmacists.	Include a representative proportion of rural pharmacy sites in the medication management program.
3504: At least 4 multi-year contracts or grants will be made to support pilot projects to design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. Priority will be given to an entity that serves a population in a medically underserved area.	Implement at least one of the 4 grants in a predominantly rural region.
3505: Grants will be made to trauma centers to further core missions, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, and coordination with local and regional trauma systems.	In implementation, support rural access to and participation in trauma services and systems.

Section	Rural Implementation/Impact
5208: Additional funding will be available to create and support nurse-managed health clinics that provide primary care or wellness services to underserved or vulnerable populations.	Develop the eligibility in such as way that there are incentives to develop rural nurse-managed clinics as a mechanism to address physician shortages in rural areas.
5405: A primary care extension program is established to support and assist primary care providers about 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.	Emphasize 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, and coordinate the two programs when possible.
10331: By January 1, 2019, "provide financial incentives to beneficiaries served by high quality physicians."	Ensure that the measures to determine "high quality physicians" include measures of services and care relevant to rural practice.
10333: A Community-based Collaborative Care Network Program will be established to support community-based collaborative care networks for low-income populations. A network is a consortium of healthcare providers with joint governance structure (including providers within a single entity) that provides comprehensive and integrated healthcare services for low-income populations.	Create the network and governance criteria in such a way to include CAHs, and rural networks that include home care, hospice, and skilled nursing facilities.
Public Health	
4001: The National Prevention, Health Promotion and Public Health Council includes secretaries of federal agencies (e.g., HHS, Agriculture, Education, Labor) and develops strategies improve health status. An Advisory Group of non-Federal members is established.	The Advisory Group should include rural representation (not required by statute). Annual reports should include discussion of rural-specific recommendations, particularly for small, remote rural communities.
4002: A national investment in prevention and public health is supported with a fund that will grow to $2 billion; available in FY 2015 and annually thereafter.	Reports of use of the fund for specific programs should include uses in rural areas and how successes can be replicated.
4003: The Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention, will convene task forces to review clinical services and community-based preventive health interventions. Their deliberations will include consideration of social, economic, and physical environments that can affect health and disease.	Consideration of factors other than healthcare delivery should include uniquely rural considerations, such as impacts of extraction industry activities and how sparsely populated areas develop and sustain public health activities. Assurance of such consideration could be accomplished by including input from the Office of Rural Health Policy.
4004: A national media campaign on health promotion and disease prevention, executed through competitively bid contracts, will be evaluated every two years.	Evaluation should include analysis of how projects use design elements to reach rural populations and communities.

Section	Rural Implementation/Impact
4101: Funds are *directly appropriated* for each fiscal year 2010 through 2013 for school-based health centers.	Preference is given to communities with evidence of barriers to primary health care and mental health and substance use disorder prevention, which creates a competitive advantage for many rural areas to receive funding.
4102: This provision establishes a 5-year national public education campaign and grants to demonstrate the effectiveness of research-based dental caries disease management activities.	The grants are opportunities to include demonstrations of innovative methods of increasing access to oral health services in rural areas.
4103: Medicare beneficiaries will receive health risk assessments and be given personalized health advice based on the results.	In a rural context, plans for beneficiary activities to improve health risk assessment scores will need to include use of local and regional community-based resources for physical activity and access to clinical services not based in the community.
4201: Funding is authorized through fiscal year 2014 for grants to state and local governmental agencies and community-based organizations for public health activities.	The legislation requires that not less than 20% of the grants be awarded to rural and frontier areas. Project reports should provide sufficient detail to facilitate replication.
4202: Pilot programs will be supported to provide community interventions, screenings, and necessary clinical referrals for individuals between 55 and 64 years of age; screenings are to occur in both urban and rural areas.	Rural public health departments and healthcare providers should take advantage of the data generated by the screenings.
4301: Funding will be provided for research on how to effectively deliver public health services.	Research should include a focus on strategies to deliver services in sparsely populated rural areas, and should draw upon the knowledge base built in recent years, supported by the Robert Wood Johnson Foundation.
4302: Federally conducted or supported programs should include data at the smallest possible geographic level and sufficient data to generate statistically reliable estimates by subpopulations.	Opportunities will be created for analysis of program effects on rural populations. Rural health researchers and advocates will need to take advantage of the resources.
10408: A grant program is established for small businesses to provide comprehensive wellness programs.	Rural applicants should be encouraged, perhaps with technical assistance in grant writing.
Healthcare Workforce	
5101 – 5103: These sections will establish a National Healthcare Workforce Commission, a National Center for Workforce Analysis, and a program of grants for state healthcare workforce development.	Devoting resources to healthcare workforce analysis and planning across all professions will benefit all interested parties; rural interests should be represented at all critical points, including in the grant awards to states.
5201: The practice commitment required to receive a federally supported student loan for medical students in primary care is changed to 10 years or complete repayment, whichever comes first.	Commitments to rural-based practices are strengthened.

Section	Rural Implementation/Impact
5207: Funding is increased for the National Health Service Corps.	Providers in the National Health Service Corps and are an important source of primary care in rural shortage areas.
5301: Support under the Public Health Service Act Title VII for training programs in primary care is changed to emphasize training in new competencies (such as patient-centered medical homes), give preference to establishing new programs or substantially expanding existing ones, and meet one or more of a list priorities that include working with rural providers and having a record of training individuals from underserved or rural backgrounds.	Programs seeking support from Title VII funding will need to provide more specific evidence of success in meeting the needs of rural and underserved areas. This is consistent with a long-standing RUPRI Panel recommendation that federal support for health professions training be targeted to programs with proven *outcomes*.
5301, 5303, 5394, 5305, 5309: New grant programs for workforce development create financial incentives for students to choose career paths that will include practicing in underserved areas. New training opportunities are supported for primary care (family medicine, general internal medicine, general pediatrics, physician assistants), nursing professionals in geriatric care and education, and advanced practice nurses. Innovations in the legislation include allowing training to occur in community-based care settings that include Federally Qualified Health Centers and Rural Health Clinics, creating faculty loan programs for dentistry and nursing, supporting a career ladder for nurses, and training programs in public health (including mid-career).	The new training programs and loans include statements of preference for persons serving in underserved and rural areas; identifying community-based providers as training sites is important, and rural-oriented programs should take advantage of the opportunities created by this legislation.
5302, 5403: The ACA authorizes funds to support training direct care workers in long-term care settings and training health workers who function similar to extension service workers, providing support to community residents interacting with exchanges and other new elements of the healthcare system. Funding is also provided to Area Health Education Centers, making all of them eligible for infrastructure development and effectiveness grants.	Programs functioning outside of training institutions but which contribute to the likelihood of attracting and retaining health professionals in rural and underserved areas are supported by the ACA. These programs should be monitored to be sure that to the greatest extent possible rural needs are addressed.
5503, 5602: The distribution of any unused residency positions will follow priorities that include hospitals being located in rural areas. A negotiated rulemaking process is required to develop criteria for designation of Medically Underserved Populations and Health Professional Shortage Areas.	The new designation criteria will influence distribution of federal funds through special programs such as bonus payments for primary care physicians. A broad array of rural interests will need to be considered, including staffing needs of hospitals and clinics, payment linked to recruitment and retention of professionals, and historical patterns of care, when stating the geographic parameters in designation.

Section	Rural Implementation/Impact
Long-Term Care	
Title VIII-CLASS Act: Implementation of the national voluntary long term care (LTC) insurance will require, among other provisions, the establishment of a CLASS Independence Advisory Council and a Personal Care Attendants Workforce Advisory Panel, and the development of "advice and assistance counseling services."	It will be important to ensure rural representation on the CLASS Advisory Council and the PCA Workforce Advisory Panel. Consideration of rural implementation concerns with "advice and counseling" will be vital. Rural outreach and enrollment strategies may be needed.
Sections 2401-2405: These provisions give states greater flexibility and increased financial support for home and community-based service expansions and extend/expand existing demonstrations to expand home- and community-based services.	The law does not explicitly take into account the needs of rural LTC beneficiaries and providers to ensure a balanced implementation of these expansions. Access to home- and community-based services in some rural areas is limited due to limited service availability (e.g., personal care services, alternative housing arrangements), workforce limitations and other problems. Lacking rural infrastructure for the delivery of home- and community-based services, states may choose not to expand services in rural areas.
3131: Medicare payments will be adjusted for skilled nursing facilities, home health, and hospice care (Title III, Sub-Title E, Section 3401), and MedPAC must conduct an analysis of the rural impact of home health payment changes (Section 3131).	Medicare provider payment adjustments for skilled nursing, home health, and hospice services could have unintended consequences for rural beneficiaries and providers. Except for Section 3131, which requires MedPAC to study the impact of the proposed home health changes, the law does not provide for the monitoring of rural impacts of these changes.
3140, 5302, and 6114: State demonstration projects will support the training of direct care workers (Section 5302), a Hospice Concurrent Care demonstration (Section 3140), and Skilled Nursing Facility Culture Change and Health Information Technology demonstrations (Section 6114).	Unlike the Medicare Hospice Concurrent Care Demonstration (3140), which requires the Secretary to select hospice agencies from both rural and urban areas to participate in this demonstration, neither the state demonstration projects to support the training of direct care workers (Section 5302) nor the Skilled Nursing Facility Culture Change and Health Information Technology demonstrations (Section 6114) reference or require rural participation.

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