



Rural Implications of the Patient Protection and Affordable Care Act (ACA) of 2010

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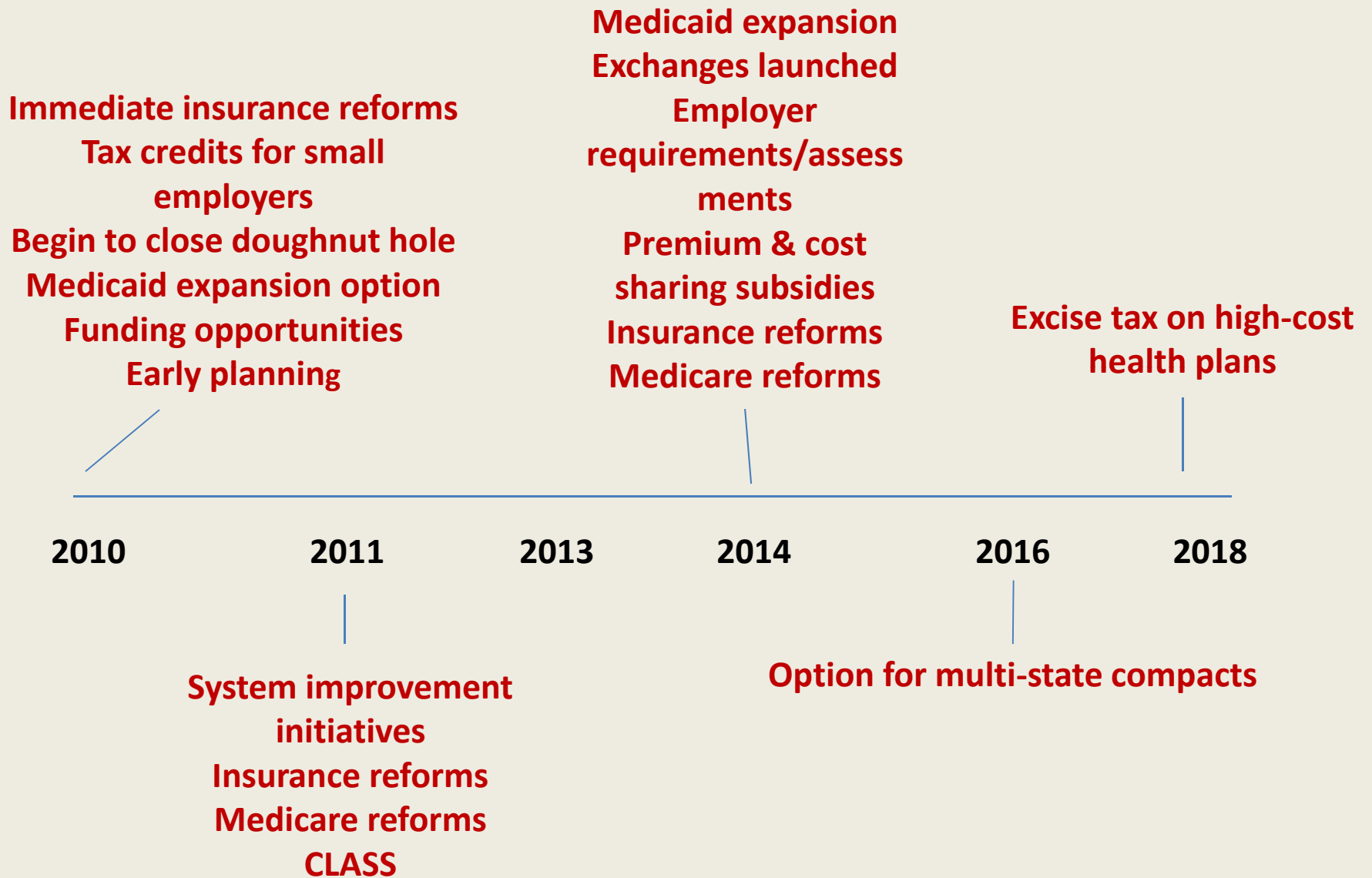
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Overview of the ACA

- Legislation has 10 titles: in addition to coverage expansions:
 - Financing and delivery system reform: links performance and payment
 - Health improvement and public health infrastructure
 - Workforce
 - Long term care
- Time line of up to 10 years
- Significant policy opportunities and challenges for rural America

Timeline for ACA Implementation



Six Areas Of Impact On Rural People, Providers, And Places

- Health insurance coverage expansions
- Medicare and Medicaid payment changes
- Quality, financing and delivery system reform
- Public health
- Healthcare workforce
- Long-term care

Health Insurance Coverage Expansions: Key Rural Considerations (1)

- Facts: rural uninsured rates are higher than urban uninsured rates, rural incomes are lower, and a greater proportion of rural employed by small business
- Four key strategies in ACA:
 - Medicaid expansions: adults and children
 - Individual mandate
 - Employer sanctions
 - Tax credits and subsidies

Health Insurance Coverage Expansions: Key Rural Considerations (2)

- Medicaid expansions for childless adults will be especially important: how far will states go beyond 133% FPL?
- Most rural businesses exempt from penalties but...
- Tax credits and subsidies for small firms and individuals: Will they be enough to get small rural firms into the market?

Health Insurance Coverage Expansions: Key Rural Considerations (3)

- Insurance regulations and state implementation of exchanges will be critical
- Areas of opportunity and/or concern:
 - Eligibility determination
 - Risk rating: how will markets be defined? Potential for risk segmentation (e.g. geographic rating)
 - Plan choices: will more plans move into the market?
 - Merger of individual and small group market: plus or minus?
 - Intersection of Medicaid and private plans: allowing for seamless transitions
 - Plan requirements: network and access standards?

Expanded Medicaid Eligibility under the ACA

- Mandatory Expansion to 133% of the FPL
 - Coverage must meet benchmark or benchmark-equivalent level
 - If children covered through CHIP, need to move to Medicaid
 - States can expand at regular FMAP prior to 2014; enhanced FMAP begins in 2014
- Mandatory coverage for former foster children
 - Up to 26 years of age
 - Begins January 1, 2014
 - Must provide Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits
- Premium Assistance Program
 - States must offer premium assistance for ESI (for adults and children in families where parents have access to coverage)

ACA Simplifies Eligibility Determinations

Coordination of eligibility with the Insurance Exchange

- DHHS (federal) required to develop a single, streamlined eligibility form; but state can use its own form
- States are required to develop a secure electronic interface for all health subsidy programs (Medicaid, CHIP, Exchange) to allow exchange of data and determination for programs based on single application
- No wrong door approach –
 - If come in through Exchange, but eligible for Medicaid, refer and enroll in that program without further requirements.
 - If come in through Medicaid but eligible for Exchange, must enroll without further requirements
 - Medicaid website must link to Exchange website
 - Website must provide plan comparisons

Outreach and Enrollment

- ACA requires outreach to enroll vulnerable and underserved populations in Medicaid & CHIP
- States can coordinate outreach and enrollment functions with the Exchange, including the potential of utilizing navigators to assist in applications

Medicare and Medicaid Payment Changes

- Geographic practice expense disparity reduction and 10% primary care bonus
- Medicaid physician payment increases
- Hospitals: fewer uninsured and decreasing DSH payments; reduced market-basket increases in PPS payment updates; full implementation of value based purchasing

Medicare And Medicaid Payment and Delivery System Reform (1)

- Advanced Primary Care, Health Homes, Accountable Care Organizations as new permanent opportunities: how will this play out in rural areas?
- Bundled payment: effect on rural providers and where care is delivered
- Medicare Advantage plan payment changes: response from plans and alternatives available to rural beneficiaries

Medicare And Medicaid Payment and Delivery System Reform (2)

- Demonstrations tie payment to performance: measurement, reporting, and payment needs to
 - (1) recognize realities of rural services delivery (e.g. lower volumes, mix of services)
 - (2) Incentivize performance.
- Adult and child health quality measures

Medicare and Medicaid: Safety Net Investments and Payment

- Investment in Community Health Centers
- Opportunities for new financing and delivery system models for CHCs
- Collaboration among local providers all meeting some aspect of safety net demand

Medicare and Medicaid Policy: New Centers, Commissions, and Research

- Independent Payment Advisory Board: need for rural representation
- Center for Medicare and Medicaid Innovations
- Federal Coordination Health Care Office
 - Focused on simplifying access; improving quality
 - Eliminating regulatory conflicts between Medicare & Medicaid
- Studies of geographic variation in payment: MedPAC in the ACA; IOM under separate contract
- Comparative Effectiveness research

Public Health

- National Prevention, Health Promotion, and Public Health Council: an opportunity for rural input
- Will Advisory Group to the Council include rural representation?
- Public health infrastructure improvements: emphasis on performance management
- Will CDC and states target rural public health in specific grant programs in Title IV

Healthcare Workforce

- Authorized funding to expand health professions training programs
- Loan repayment extended to allied health and public health professionals
- National workforce commission and state counterparts will need to monitor to maintain growth in health professional supply to meet demand from increased coverage, including in underserved rural areas

Long-Term Care

- Two major policy goals: (1) rebalancing long term care services and (2) expanding financing of LTC (CLASS)
- Rebalancing:
 - relaxed federal requirements and funding for states to expand home and community based services
 - Spousal impoverishment provisions expanded to HCBS
 - Federal Medicaid FMAP incentives

Community Living Assistance Services and Support Act (CLASS)

- Individuals contribute through payroll deduction or alternate mechanism
 - No health screen or pre-exclusions
- Estimated average premium \$123/month
- 5-year vesting, after which eligible for cash benefit if meet level of need
 - Est. average benefit \$75/day; should cover community-based care for most people
- Voluntary, with opt-out
- Law provides employer with choice to implement payroll deduction

For Further Information

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School of Public Service, USM

<http://muskie.usm.maine.edu/ihp/ruralhealth/>

RUPRI Health Panel

<http://www.rupri.org>

