A Second Look at the Patient Protection and Affordable Care Act of 2010

The Rural Policy Research Institute (RUPRI) Health Panel
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Rural Policy Research Institute (RUPRI)
Rural Health Panel

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Affordable Care Act

- Major ACA titles
  - Insurance coverage and reform (I)
  - Public programs (II)
  - Quality and efficiency (III)
  - Public health (IV)
  - Workforce (V)
  - Transparency (VI, VII)
  - Long-term care (VIII)
  - Revenues, financing (IX)
- New emphases
  - Insurance coverage
  - Primary care
  - Financing innovations

Overview of RUPRI Analysis

- The "First Look" was released by the Panel in 2010, focused on what was to come in first three years
- Second "look back" at what has occurred
  - and looking ahead to further implementation
- Focus on effects on rural with comments and recommendations

Sources of Information and Analysis

- Appropriations history
- Programs being implemented as described those involved
- Research literature, including the work of ORHP-funded rural health research centers
- Expertise of members of the Panel

Outline of Document and Presentation

- Part 1: Health Insurance Coverage
- Part 2: Medicare and Medicaid Payment
- Part 3: Quality and Delivery System Reform
- Part 4: Public Health
- Part 5: Health Care Workforce
- Part 6: Long-Term Care

1. Health Insurance Coverage

- Rural differentials in the impact of Medicaid expansion, including assessment of any unique circumstances due to waivers should be monitored.
- Both internal (e.g., Centers for Medicare and Medicaid Services (CMS) and other Health and Human Services 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.

Enrollment in Affordable Care Act Marketplaces and Medicaid

(October 2013-March 1,2014)

By Type of Marketplace (Federal or State)

Type of Marketplace	TOTAL	Medicaid	Marketplace Plans	Percent of Uninsured Covered	Average population density
State-based	4,620,300	2,999,061	1,621,239	37.4%	321
Federally-facilitated	3,999,957	1,378,871	2,621,086	16.6%	212
TOTAL	8,620,257	4,377,932	4,242,325	23.7%	248

By Whether State Expanded Medicaid or Not

Medicaid Expansion Decision	TOTAL	Medicaid	Marketplace Plans	Percent of Uninsured Covered	Average population density
Medicaid Expansion: Yes	5,677,840	3,239,418	2,438,422	27.6%	322
Medicaid Expansion: No	2,942,417	1,138,514	1,803,903	18.5%	164
TOTAL	8,620,257	4,377,932	4,242,325	23.7%	248

Source: RUPRI Center analysis of HHS/ASPE data, http://aspe.hhs.gov/

Enrollment in Affordable Care Act Marketplaces and Medicaid

(October 2013-March 1,2014)

By Type of Marketplace ,
and by Whether State Expanded Medicaid or Not

	Percent of Eligible for Marketplace Plans Covered	Percent of Eligible for Medicaid Covered	Total Percent of Uninsured Covered	Odds of Being Covered as Compared to FBM/Medicaid-No
State-Based/Medicaid-Yes	29.1%	47.2%	38.6%	2.39
State-Based/Medicaid-No	22.3%	40.3%	31.7%	1.96
Federal/Medicaid-Yes	17.3%	17.3%	17.3%	1.07
Federal/Medicaid-No	14.9%	20.2%	16.1%	1.00
TOTAL	18.9%	31.4%	23.7%	

Source: RUPRI Center for Rural Health Policy Analysis, analysis of HHS/ASPE data, http://aspe.hhs.gov/

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.

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.

Actions Related to Quality and Delivery System Reform

- National Prevention Council released National Prevention Strategy in June, 2011 and Action Plan in June, 2012
- Medicaid and Children's Health Insurance Plan Payment and Access Commission (MACPAC) now active, issuing March and June Reports
- Centers for Medicare and Medicaid Innovation (CMMI) very active across at least 8 major initaitives

Actions Related to Quality and Delivery System Reform

- Measures Applications Partnership (MAP) established in 2011, submitted first annual review of performance for use in federal rulemaking in February, 2012
- First iteration of National Quality Strategy (NQS) submitted to Congress in March 2011, updates in 2012 and 2013, including agency-specific quality plans in support of the NQS

Future for Quality and Delivery System Reform

- Commissions and Agencies have been active, with strategies and demonstration opportunities that could be relevant and useful in the rural health environment
- Requires vigilance to assure application to rural needs
- Push for rural-relevant measures in the move to better measures and increased transparency

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 by federal partners that facilitate rural participation
- Evaluations of these grant programs should include assessment of impact on rural communities.

4: Public Health

- 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 impacts on rural communities.

Actions Related to Public Health

- Prevention and Public Health Fund (PPHF) appropriations, but reduced from $15 billion over 10 years to $8.75 billion
- Preventive Health Services now covered, reports indicate 71 millions persons received expanded coverage through March 2013
- Medicare coverage of preventive services: HHS report showed more than 25 million beneficiaries used one or more free preventive services in 2011

Actions Related to Public Health

- Community Transition Grants to states have been used by rural communities
- October, 2011 data collection standards did not include standards related to geographic location or socioeconomic status
- Small business (fewer than 100) wellness program funded at $10 million in FY 2011 and $10 million in FY 2012, from the PPHF

Future for Public Health Activities

- With reduced funding and expectations for results, natural pressure to show "population health" results challenges maintaining balance of rural and urban projects
- Monitor actual use of preventive services after financial barrier removed

5: Health Care Workforce

- Given increased demand from newly insured persons, Panel recommends vigilance to be sure sufficient personnel inclined to practice in underserved rural areas benefit from programs designed to increase the workforce.
- Research undertaken by the National Center for Healthcare Workforce Analysis and recently funded Centers for Workforce Analysis will provide a critical source of data to inform rural workforce development strategies.
- National Center for Healthcare Workforce Commission: should be funded to take full advantage of workforce study results to help shape further policy enhancing the spread of needed health care workers into rural areas.
- 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.

6: Long-Term Care

- ACA-related expansions of options for home and community-based services have great potential for expanding these services in rural areas.
- 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. These challenges must be monitored to ensure that home- and community-based services in rural areas are adequately supported.
- Important to monitor the impact of payment chnages for long-term care providers.