Health Care Reform, What's in It?
*Rural Communities and Rural Medical Care*
a series examining health care issues in rural America
values.worth.action.
No. 9 • July 2010

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A critical component of the Patient Protection and Affordable Care Act (PPACA), the federal health care reform law, is the expansion of health insurance coverage and a resulting improvement in health outcomes through access to affordable and timely medical care. One notable concern expressed in the wake of passage of the law is the ability of the health care system to effectively serve over 30 million newly insured, plus deliver effective services to the currently insured in order to meet the goals of the new law. (McMorrow) We have long said the ultimate goal of health care reform is to help make people healthier. Access to health services is a crucial need to meet that goal, and constraints on access will make the health care reform law less meaningful than it should. (McMorrow)

Access issues are even more acute in rural communities. As we have shown, many rural communities have severe medical professional shortages, few of the nation's medical professionals practice in rural areas, rural health professionals are aging, fewer professionals are being trained in primary care and fewer new professionals are being educated and trained. (Top 10 paper) Medicare and Medicaid—major components of rural medical care—pay rural medical providers and facilities less than do private insurers and less than providers in urban areas. All of these exist at a time when, in general, rural people have greater medical care needs than do nonrural people. (National Advisory Committee on Rural Health and Human Services, Center on an Aging Society)

Access provisions turned out to be a major part of the health reform law, but an unsung part that received little attention compared to the politically volatile coverage issues. The two issues represent opposite sides of the same coin, issues that need each other for an effective response to the health care issues facing the nation and to meet the goal of making people healthier.

Rural access to medical care not only helps improve health outcomes, but acts as an important economic development strategy for many rural communities. For both reasons, the PPACA contains numerous provisions, many of them specifically aimed at rural areas, to enhance programs and develop strategies to enlarge the health care workforce, particularly the primary care workforce, and to address other rural access challenges. This paper will summarize some provisions of the PPACA directly targeted to rural communities and to rural medical care.

## Expanding the Rural Health Care Workforce

Among the provisions of the law concerning training of, education of and recruitment of rural ***physicians*** are:

| ***Provision*** | ***Funding*** |
|---|---|
| Rural Physician Training Grants—Grants to medical schools to develop programs to recruit students most likely to practice in underserved rural areas | $4 M/yr. (2010-13) |
| National Health Service Corps—Increased funding | Additional $290 M (2011) to $310 M (2015) |
| Increased Primary Care Teaching Capacity—Grants to support new primary care residency programs; priority to those with affiliation with AHECs | $25 M (2010); $50 M (2011); $50 M (2012) |

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| ***Provision*** | ***Funding*** |
|---|---|
| Rural Graduate Medical Education<br>1) Grants/contracts to train medical residents in community-based settings such as Rural Health Clinics and Federally Qualified Health Clinics<br>2) Grant/contract program to train primary care residents in community-based settings; preference to programs in underserved communities | $125 M through 2014 |
| Redistribution of Residency Slots—Redistribute unused slots to primary care positions; preference to states with low physician numbers and large population in health profession shortage areas | N/A |
| Health Care Workforce Loan Program—Loans of $35,000/yr. up to 3 years for pediatric, medical or surgical specialists or child behavioral specialists in underserved/ health professional shortage areas | $150 M/yr. (2010-14) |
| U.S. Public Health Sciences Track—Selected sites for team-based service in public health and emergency preparedness; will graduate a specific number of physicians, dentists, RNs, public and behavioral health professionals, PAs, nurse practitioners. Priority to students from rural /underserved areas | As needed |

The law also has provisions to expand other types of medical professionals needed in rural communities, including ***nurses, dentists and behavioral health professionals.***

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| Nurse Managed Health Clinics—grants for clinics providing primary or wellness care to underserved or vulnerable populations | $50 M/yr. (2010-14) |
| Nursing student loan program—increases the loan amounts for nursing students | |
| Training for mid-career public health and allied health professionals—grants for state and local programs for scholarships for those working in public health programs at all levels | $60 M for 2010 and sums as necessary for 2011-15 |
| Training opportunities for direct care workers—grants to institutions of higher education for tuition assistance for those who wish to work in geriatrics, disability services, long-term services or chronic care management | $10 M (2010-13) |
| Training in general, pediatric and public health dentistry—grants to schools of dentistry, hospitals or nonprofit entities for financial assistance to students; priority to entities with a record of training students for rural populations or with a relationship with health clinics | $30 M for 2010 and sums as necessary for 2011-15 |

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| Increased authorization for nursing workforce programs—increases authorizations for sections of the Public Health Services Act for advanced nursing education grants and nurse education, quality and retention grants | $338 M for 2010 and sums as necessary for 2011-16 |
| Mental and behavioral health education grants—grants to institutions of higher education for recruitment and education of students in social work, psychology and child mental health; priority to programs producing professionals serving high-need populations | $35 M (2011-13) |
| U.S. Public Health Sciences Track—Selected sites for team-based service in public health and emergency preparedness; will graduate a specific number of physicians, dentists, RNs, public and behavioral health professionals, PAs, nurse practitioners. Priority to students from rural and underserved areas | Funding transferred from the Public Health and Social Services Emergency Fund |
| Demonstration grants for family nurse practitioner training programs—funding for one additional year of training for careers as primary care providers in health clinics | Sums as necessary (2011-14) |

The law also contains provisions concerning ***recruiting young rural students*** for health care careers and the ***development of health care workforce strategies***.

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| Continuing and Expanding Area Health Education Centers (AHECs)—local organizations providing health care workforce training programs to high school and younger students | $125 M/yr. (2010-14) |
| State Health Care Workforce Development Grants—Partnerships with states and National Health Care Workforce Commission to develop comprehensive workforce development strategies | $8 M (planning)<br>$150 M (implementation) |
| Public health workforce recruitment and retention—loan program for public health students | $195 M/yr. (2010-15) |

The law also provides a 10 percent incentive payment under Medicare for primary care physicians, nurse practitioners and other professionals meeting certain conditions practicing in health professional shortage areas. Additional bonus payments are provided under the law for Medicare services by general surgeons in health professional shortage areas and for home health providers in rural areas. Several adjustments were made in the law to the Geographic Practice Cost Indices of Medicare reimbursements that generally provide lower reimbursements for rural providers. And the law orders a study on the adequacy of Medicare payments to rural providers and access to items and services by rural beneficiaries that is due on January 1, 2011. None of these payment provisions will necessarily develop more rural providers, but they may make rural practice more financially viable and allow rural communities to retain the providers they have and provide some incentive for those interested in rural medical practice.

## Rural Hospitals and Clinics

Expanding medical care facilities in rural and other underserved areas is a major component of the new law. The new law authorizes and appropriates $9.5 billion to a new Community Health Centers Fund to expand the operational capacity of health centers and clinics across the nation (starting with $1 billion in 2011, gradually increasing to $3.6 billion in 2015). It is estimated this will allow community health centers to serve 20 million new patients.

The new law, Patient Protection and Affordable Care Act (PPACA), also authorizes and appropriates $1.5 billion over five years to help Community Health Centers meet new construction and expansion needs.

The PPACA also authorizes significant new investments in Federally Qualified Health Clinics (FQHCs). In total, there is authorized nearly $34 billion in additional funding for FQHCs, starting with an additional $3 billion in 201l, increasing to $8.3 billion in 2015, with increases thereafter based on costs per patient served and the number of patients served. This funding will allow additional FQHCs to be started in communities that need them, particularly rural communities.

The new law contains several provisions that provide grants to medical schools, institutions of higher education, nonprofits and community-based organizations for workforce expansion strategies, and nearly always require a linkage with a community health center, rural health clinic or FQHC.

The PPACA also allows rural hospital outpatient departments to participate in the 340B Prescription Drug Discount Program (Section 340B of the Public Health Service Act). This program allows prescription drugs to be sold at a discount in certain rural hospitals.

Finally, the new law contains provisions regarding payment provisions for rural hospitals. Most try to better equalize rural hospitals and non-rural hospitals in Medicare and Medicaid reimbursements. Others assist rural hospitals in implementation of delivery system reforms in the law (items such as Value Based Purchasing and bundling). Still others represent a series of rural hospital provisions that expired and were temporarily extended to the end of 2010. These "extenders" concern Medicare payments to rural hospitals and will temporarily soothe economic challenges for rural hospitals. The exception to the temporary extension is a provision for a three percent bonus payment for home health services in rural areas; that is extended through 2016.

### Rural Emergency Services

Emergency medical services are often the first-line medical and health care providers in rural areas. For many rural specific demographic and health care system issues, emergency services have had placed on them growing demands and health care responsibilities. At the same time, many rural emergency service providers are underfunded and facing workforce and volunteer shortages. Distance and geographic barriers play a major role in the need for timely and effective emergency medical services in rural areas. Those same factors, in addition to lower patient numbers, lead to greater costs per patient for rural ambulance and emergency services. PPACA includes provisions to build a stronger and more financially viable rural emergency network.

PPACA temporarily extends the existing Ground Ambulance Add-on Payments until December 31, 2010. This provision increases Medicare reimbursement for ground ambulance transports originating in rural areas by three percent. Under PPACA, air ambulance payments under Medicare are also based on 2006 geographic designations until December 31, 2010, so that an air ambulance transport originating in a place designated rural in 2006, but which may have changed classification since, is still considered rural through 2010.

PPACA also extends until December 31, 2010, the "Super Rural" Ambulance Add-on Payments for ambulance

transports that originate in rural areas with low population densities. This provides a 22.6 percent bonus payment under Medicare.

The needs of rural emergency medical services (and rural health care workforce in general) are also contained as study topics for the newly created National Health Workforce Commission. The Commission is charged with studying the educational and training capacity and demand for emergency medical service personnel, including professional and volunteer ambulance personnel and firefighters trained to perform emergency medical services.

Of course, the best way to meet the health reform law's ultimate goal for healthier people is through prevention. Initiatives focusing on healthier eating and living and earlier access to primary care providers to prevent, detect and treat conditions all will play a role in making healthier individuals, families and communities. To meet those goals, the health reform law created two new programs dedicated to community-based prevention which could work well in rural communities.

The **Community Transformation Grants** program will provide grants to state, local and tribal governments, non-profit organizations and national networks of community-based organizations for the "implementation, evaluation, and dissemination of evidence-based community preventive health activities" in order to "reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming." This provision was based on an Iowa program started by Senator Tom Harkin that funded prevention and health initiatives in Iowa communities, including many rural communities.

The **Primary Care Extension** program uses a model familiar to many in rural communities, the Extension Agent. Rather than the land grant university-based Extension Agent familiar for so long to so many, this program establishes Health Extension Agents to provide support and assistance to primary care providers and other health-related entities on preventive medicine, health promotion, chronic disease management, mental and behavioral health and evidence-based practices. The goal is to enable providers to incorporate such matters into their practice and to improve community health. State-based programs to implement such activities are funded by federal grants to states.

## Conclusion

Access issues are serious health challenges in most of rural America. The Patient Protection and Affordable Care Act has important and beneficial provisions that will improve access to needed medical care for rural individuals, families and communities. These provisions also have the potential to aid the economies of many rural communities, as new and improved medical facilities and more health care professionals in rural communities will afford more jobs, more income and more economic opportunity in rural communities. The National Center for Rural Health Works at Oklahoma State University has found that one full-time rural primary care physician generates, on average, about $1.5 million in revenue, nearly $1 million in payroll and creates or helps create 23 jobs in a community. The physician's economic contributions are direct and indirect—people coming to or staying in the town to obtain medical services and obtaining other services or doing other shopping rather than traveling to an urban area. (Elrich)

While the access provisions in the law are of great potential benefit to rural America, the key word is "potential." Many of the provisions—particularly those concerned with recruiting health care professionals and developing a pipeline of rural youth interested in both health care careers and returning to or remaining in rural communities—are long-term strategies that will not immediately alleviate rural access challenges. Further, a weakness of the law is that most of its rural access provisions are not funded. The law only gives Congress authorization to appropriate

funds, so most of these provisions must face the annual appropriations process if they are ever to take effect and help rural places. Without funding these provisions are nice words in the federal law books, and much of rural America remains in the same weak, health care access spot. Like much of the Patient Protection and Affordable Care Act the provisions concerning access are a nice start, but rural people and policymakers must be ever vigilant to make sure they go beyond a "nice start" to truly benefit rural individuals, families and communities.

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## ABOUT THE CENTER FOR RURAL AFFAIRS

Established in 1973, the Center for Rural Affairs is a private, nonprofit organization with a mission to establish strong rural communities, social and economic justice, environmental stewardship, and genuine opportunity for all while engaging people in decisions that affect the quality of their lives and the future of their communities.

This series is made possible by the generous assistance of the Nathan Cummings Foundation, the Public Welfare Foundation and the Otto Bremer Foundation.