RUPRI Center for Rural Health Policy Analysis
University of Iowa, College of Public Health
Keith J. Mueller, PhD, Director
www.unmc.edu/ruprihealth
(319) 384-5120 • keith-mueller@uiowa.edu

The Patient Protection and Affordable Care Act

A Summary of Provisions Important to Rural Health Care Delivery

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Keith J. Mueller, Ph.D.

RUPRI Center for Rural Health Policy Analysis
University of Iowa
200 Hawkins Drive, E203 GH
Iowa City, IA 52242
Phone: (319) 384-5120
Current Web Site: www.unmc.edu/healthpolicy
Future Web Site: www.public-health.uiowa.edu/hmp/

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(P.L. 111-148)

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Keith J. Mueller, Ph.D.[1]

PURPOSE

The purpose of this paper is to provide a wide audience of rural health policy makers, advocates, and researchers a consolidated summary of legislative provisions contained in P.L. 111-148 (the Patient Protection and Affordable Care Act of 2010, PPACA) that have particular meaning to rural residents and to the delivery of services in rural areas. Changes from the Health Care and Education Reconciliation Act of 2010 are incorporated.

OVERVIEW

The PPACA includes efforts to address the triad of challenges in health policy—ever increasing expenditures, access to care (both financial and geographic/cultural), and quality. The first nine titles of the law were drafted by two committees in the U.S. Senate, Finance and Health, Education, Labor and Pensions. The tenth title is the "mark" from Senate Majority Leader Reid, sometimes modifying the provisions in the first nine titles and sometimes adding new provisions. The Health Care and Education Reconciliation Act amended PPACA provisions related to budget matters.

At various phases in the legislative process, rural-conscious members of Congress succeeded in inserting provisions specific to rural needs, such as extending special payment policies in Medicare, extending and modifying the Rural Hospital Flexibility Program, and including rural areas in various demonstration projects and pilot programs. Their efforts are evident in this summary of provisions. Beyond those specific rural-centric provisions, the law includes new pathways to insurance coverage that benefit rural residents, new efforts in public health that could help rural communities, and new directions in payment policies whose impact on rural systems is unknown.

This document provides a rural roadmap of the PPACA so that advocates, analysts, practitioners, and policy makers focused on rural health can continue the important task of improving the system as it affects rural interests. Two sections follow this brief introduction, highlights of the legislation as it affects rural interests, and detailed tables presented in the order of the sections of the PPACA. As it summarizes the legislation, this document often uses the direct language of PPACA, as printed in the final enrolled text by the Government Printing Office (H.R. 3590 (ENR)—Patient Protection and Affordable Care Act. Washington, DC: Government Printing Office).

[1] The author wishes to thank those who reviewed and commented on an earlier draft of this paper, including advisors to the RUPRI Center for Rural Health Policy Analysis and staff of the RUPRI Center. The author is solely responsible for the content of this document.

HIGHLIGHTS
(control+click on the section number to jump to the relevant section)

Special note on funds for new programs, demonstrations, and pilots: Most of the new spending proposed in this legislation is through authorizing sums (typically "such sums as necessary") to be appropriated. Therefore, funds are not yet available because Congress would need separate action to complete an appropriation. In some instances, the Secretary of Health and Human Services may be able to initiate spending from "such sums not otherwise spent," using authority in this legislation to transfer funds from programs not using full appropriations. In rare instances, this legislation directly appropriates funds; the language in the detailed tables will so indicate.

Access to Affordable Insurance

- Section 1101 (page 12): A high-risk pool is established by the federal government, with or without companion state action, thereby giving persons who were previously denied insurance because of a pre-existing condition access to health insurance.
- Section 1401 (page 15): Refundable tax credits are available for individuals in households with incomes between 100% and 400% of the federal poverty guidelines; for use toward health insurance premiums.
- Section 1421 (page 16): Tax credits are available for small businesses (those with no more than 25 employees with average annual incomes less than $50,000) for up to 50% of contributions toward either premiums or the aggregate amount of contributions the employer would have made if each employee enrolled.
- Section 2001 (page 17): Medicaid eligibility will include all persons under age 65 with household incomes below 133% of federal poverty guidelines, effective January 1, 2014, unless done sooner by states.
- Section 8002 (page 71): A new voluntary insurance program will be created to cover community living assistance services for persons needing assistance with activities of daily living (long-term care insurance or home and community benefits).

Insurance Market Reforms

- Section 1001-2711 (page 10): Insurance plans will have no limits on lifetime or annual spending on covered benefits.
- Section 1001-2712 (page 10): Insurers of small groups and individuals will not be able to cancel the plan during the coverage year.
- Section 1002-2793 (page 11): Grants will be available to states, or exchanges in states, to establish consumer assistance programs, including in rural areas.
- Section 1103 (page 12): The Secretary of Health and Human Services will establish an Internet portal to provide information on coverage options by July 1, 2010.
- Section 1201-2704 (page 2): Insurers will not be able to deny enrollment due to a pre-existing condition or health status, effective January 1, 2014.

- Section 1201-2701 (page 12): Premiums will not vary by more than specified ranges, and only based on age, tobacco use, and rating area, effective January 1, 2014, for small group and individual plans.
- Section 1201-2703 (page 13): Insurers must renew policies in the individual market, effective January 1, 2014.
- Section 1311 (page 14): This section provides grants to establish exchanges that will develop minimum criteria for health plans to be certified. The criteria include network adequacy and the inclusion of essential community providers. Exchanges must consult with stakeholders to maximize enrollment into certified plans.

Quality Improvement

- Section 1001-2717 (page 10): Private insurers will be required to report actions designed to improve quality and results; examples of such actions include case management, chronic disease management, use of medical home, and activities to prevent hospital readmission.
- Section 2703 (page 20): States may provide Medicaid assistance to persons with chronic conditions who designate a provider or a team of professionals as their health home; a health home could include a rural clinic, a community health center, a physician, a clinical practice, or a clinical group practice.
- Section 3001 (page 22): A value-based purchasing program (VBP) is instituted by October 12, 2012, covering five conditions, affecting prospective payment system (PPS) hospitals, including sole community hospitals, Medicare dependent hospitals, and small rural PPS hospitals. The Secretary is required to consult with small rural and urban hospitals about how provisions apply to them, and a Government Accountability Office (GAO) study of the program includes assessment of quality performance among small rural and urban hospitals and the barriers they face in meeting performance standards.
- Section 3001 (page 22): The Secretary shall establish a VBP demonstration program for Critical Access Hospitals (CAHs), a three-year demonstration that starts within two years of enactment. A GAO report on the three-year demonstration will be due 18 months after the three-year demonstration ends.
- Sections 3002–3007 (page 23): VBP is incorporated into payment to physicians, skilled nursing facilities, and home health agencies.
- Section 3011 (page 24): A national strategy will be developed for improving the delivery of health care services, patient health outcomes, and population health, with initial submission in January 1, 2011.
- Section 3013 (page 25): During FY 2010 through 2014, the Secretary will develop quality measures to assess health outcomes and functional status, management and coordination across episodes and care transition, use of information provided to and used by patients, and meaningful use of health information technology.
- Section 3502 (page 39): The Secretary shall contract with entities to establish health teams centered on primary care that will receive capitated payments.

Public Health

- Section 4001 (page 42): A new National Prevention, Health Promotion and Public Health Council, composed of Cabinet secretaries and other agency directors, will provide recommendations to the President and Congress concerning the most pressing health issues and changes in Federal policy to achieve national wellness, health promotion, and public health goals.
- Section 4001 (page 42): There will be an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health composed of up to 25 non-Federal members appointed by the President.
- Section 4002 (page 43): A new national prevention and public health fund is created to expand and sustain investment in improving health and restraining growth in cost, with an initial authorization of $500 million in FY 2010, growing to $2 billion in FY 2015 and thereafter.
- Section 4003 (page 43): Three agencies will have responsibilities related to clinical preventive services, community preventive interventions, and immunization practices.
- Section 4004 (page 44): A national prevention and health promotion outreach and education campaign will be conducted, using competitively bid contracts.
- Section 4101 (page 44): The Secretary shall establish a grant program for eligible entities to operate school-based health centers, with preference given to entities that serve a large population of children eligible for medical assistance.
- Section 4102 (page 45): The Secretary shall establish a five-year national, public oral health education campaign that targets specific populations and uses science-based strategies that include community water fluoridation and dental sealants.
- Section 4103 (page 45): Medicare coverage will include an annual wellness visit that includes a health risk assessment and a personalized prevention plan, with referral as appropriate.
- Section 4201 (page 46): Grants will be made to state and local governmental agencies and community-based organizations for evidence-based community preventive health activities to reduce chronic disease, prevent development of secondary conditions, address health disparities, and develop a strong evidence-base of effective prevention programming.
- Section 4202 (page 47): Grants will be awarded to state and local health departments and Indian tribes for five-year pilot programs to provide public health community interventions, screenings, and necessary clinical referrals for individuals between 55 and 64 years of age.
- Section 4206 (page 47): The Secretary shall establish a pilot program to test the impact of providing an individualized wellness plan to populations using community health centers (up to 10 centers will be funded).
- Section 10408 (page 47): The Secretary shall award grants to small businesses (those with fewer than 100 employees who work 25 or more hours per week) to provide employees with access to comprehensive workplace wellness programs.

- Section 4302 (page 48): Any federally conducted or supported program, activity, or survey collects and is required to report, to the extent practicable, data specific to population subgroups, including data at the smallest geographic level such as state, local, or institutional levels, if such data can be aggregated.
- Section 9007 (page 72): Non- profit hospitals must perform community health needs assessments in one of two taxable years immediately preceding the current one and adopt an implementation strategy to meet the community health needs identified by the assessment.

Healthcare Workforce

- Section 5101 (page 50): A National Health Care Workforce Commission is to be appointed by September 30, 2010, to develop and commission evaluations of education and training activities to determine if demand is met, to identify barriers to improved coordination across governmental entities and recommend actions, and to encourage innovation to meet needs. Special topics priorities include workforce needs of special populations such as rural populations. High priorities include integration in the health care delivery system of nursing, oral health care, mental and behavioral health care, allied health and public health, emergency medical services, and geographic distribution of health care providers as compared to need.
- Section 5102 (page 51): A grant program will enable state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies.
- Section 5103 (page 51): A National Center for Health Care Workforce Assessment will develop information describing and analyzing the workforce; appropriations include state and regional centers as eligible entities.
- Section 5201 (page 52): The practice commitment in the primary health care loan repayment program is changed to 10 years (including residency training in primary health care) or when the loan is paid in full.
- Section 5202 (page 52): The level of funds available per student loan in the nursing student loan program is increased.
- Section 5204 (page 52): The Secretary shall establish a Public Health Workforce Loan Repayment Program; $195 million is authorized for FY 2010.
- Section 5205 (page 52): A new loan forgiveness program is created for allied health.
- Section 5206 (page 52): Grants will be awarded to entities to award scholarships to mid-career public health and allied health professionals for additional training.
- Section 5207 (page 53): Funding for the National Health Service Corps is increased to $1,154,510,336 by FY 2015.
- Section 5301 (page 53): The Secretary may make grants or enter into contracts with entities to plan, develop, operate, or participate in an accredited professional training program in the field of family medicine, general internal medicine, or general pediatrics. Grants can also be awarded for a demonstration program for training in new

competencies, including patient-centered medical homes. Priorities include having a record of training the greatest percentage of providers in primary care.

- Section 5303 (page 54): A grant or contract may be awarded to a training program to operate a faculty loan repayment program; priorities include programs that have formal relationships with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), or accredited teaching facilities and that train at those facilities.
- Section 5304 (page 55): The Secretary may award grants to 15 entities to establish programs to train or employ alternative dental health care providers to increase access in rural and other underserved communities. Eligible entities include community colleges and FQHCs.
- Section 5310 (page 57): Loan repayment and scholarship repayment programs are extended to include nursing.
- Section 5311 (page 57): Loan repayment agreements will be available for full-time nursing faculty, requiring a commitment of four years.
- Section 5313 (page 58): The director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to support community health workers who educate and provide guidance or outreach regarding health problems, strategies to promote positive health behaviors, enrollment in health insurance, enrollment into appropriate health care agencies and community-based programs, and home visitation services regarding maternal health and prenatal care. Priority will be given to areas with a high percentage of residents eligible for health insurance but who are uninsured or underinsured.
- Section 5403 (page 59): The Secretary shall make two types of awards to Area Health Education Centers (AHECs)—for infrastructure development and/or to maintain and improve effectiveness and capabilities of existing programs.
- Section 5501 (page 61): An additional 10% payment will be made to qualifying primary care providers for cognitive care services as defined by specific codes, and for surgical procedures furnished by general surgeons in health professional shortage areas. Primary care providers include physicians, nurse practitioners, clinical nurse specialists, or physician assistants for whom primary care services are at least 60% of allowed charges.
- Section 5503 (page 62): A reduction in unused residency positions does not apply to hospitals located in rural areas with fewer than 250 acute care beds. Hospitals that receive increases from redistribution must show that at least 75% of the positions are in primary care or general surgery. Priorities in distribution of residency slots include whether the hospital has an accredited rural training track.
- Section 5508 (page 62): Grants for increased teaching capacity may be used for primary care residency programs; preference will be given to applications that document an affiliation with an AHEC program. Teaching health centers include FQHCs, RHCs, and Indian Health Service health centers.

- Section 5602 (page 63): A negotiated rulemaking process will be used to establish criteria for designation of medically underserved populations and health professions shortage areas.

Medicaid and Medicare Payment

- Section 1202 (page 17) of the Reconciliation Act (page): Primary care physicians will be paid Medicare rates when treating persons this legislation makes newly eligible for Medicaid. This provision will apply to 2013 and 2014, with a federal match of 100% of the cost.
- Section 3023 (page 27): A pilot program is established to create a bundled payment that encompasses all elements of care during a single episode, defined as 30 days prior to admission through 30 days following discharge. The Secretary is required to consult with representatives of small rural hospitals and CAHs regarding participation in this program. The five-year pilot program begins by January 1, 2013.
- Section 3025 (page 28): Payments for excess readmission to PPS hospitals will be reduced, including to rural PPS hospitals, effective October 1, 2012.
- Sections 3102–3107 (page 29): Special payment policies benefitting rural providers are extended: floor payment for geographic index in physician payment through 2011, ambulance add-ons until January 1, 2011, and physician mental health add-on through December 31, 2010.
- Sections 3121–3124 (page 30): Special payment policies that benefit rural providers are continued beyond current expiration dates: outpatient hold harmless until January 1, 2011 (and all sole community hospitals are eligible); reasonable cost payment for certain clinical diagnostic lab tests furnished to hospital patients in certain rural areas for hospitals under 50 beds for one year starting July 1, 2010; the rural community hospital demonstration program for five years and modified to include up to 20 states; and the Medicare dependent hospital program through FY 2012.
- Section 3125 (page 31): For FY 2011 and 2012, the hospital payment adjustment for low-volume hospitals is modified to lower the mileage requirement from 25 to 15 and increase the volume threshold from 800 to 1,600 total discharges per year.
- Section 3127 (page 32): MedPAC will conduct a study of payments to rural providers and access by Medicare beneficiaries to items and services in rural areas, with a report due January 1, 2011.
- Section 3131 (page 32): In 2014, the Secretary will rebase payments per episode in home health payment to include changes in the number of visits in an episode, mix of services, level of intensity of services, average cost of providing care, and other factors. The rural home health add-on is extended to January 1, 2016.
- Section 3137 (page 33): By December 31, 2011, the Secretary shall submit a plan to reform the hospital wage index system.
- Section 3201 (page 33): Payment to Medicare Advantage plans will be based on a benchmark based on fee-for-service spending, from 95% to 115%.

- Section 3401 (page 34): This section reduces annual market updates in inpatient payment to PPS hospitals, skilled nursing facilities, home health agencies, hospice care, ambulance services, and lab services, generally by a "productivity adjustment."
- Section 3403 (page 36): An Independent Payment Advisory Board (IPAB) is created, with the charge to reduce the per capita rate of growth in the Medicare program. The Board will make recommendations that will be implemented unless Congress acts to change or reject them.
- Section 3403 (page 36): A Consumer Advisory Council of 10 members appointed by the Comptroller General will be established to advise the IPAB.
- Section 7102 (page 70): CAHs, rural referral centers, and sole community hospitals with disproportionate share payments equal to or greater than 8% are added as entities eligible for the 340B drug purchasing program, for outpatient drugs.
- Section 10324 (page 75): Floor payments are established on the area wage index for hospitals in frontier states (states in which at least 50% of the counties are frontier counties).

Overall System Change

- Section 3021 (page 25): The Center for Medicare and Medicaid Innovation (CMI) is established in the Centers for Medicare and Medicaid Services to test payment and service delivery models where evidence exists that the model addresses a defined population for which there are deficits in care leading to poor outcomes or avoidable expenditures.
- Section 3022 (page 26): Accountable care organizations (ACOs) will be groups of providers such as hospitals and physicians, operating under a shared governance arrangement, accountable for the patients assigned to them, and eligible to share in savings to the Medicare program that result from more cost-effective treatment. A demonstration program will begin in January 2012.
- Section 3024 (page 28): A demonstration program is created to support Independence at Home Medical Practices that can reduce hospitalizations and improve health outcomes by using electronic health information systems, remote monitoring, and mobile diagnostic technology to care for chronic conditions in patients' homes. Demonstrations must start by January 1, 2012.
- Section 3026 (page 28): Community-based organizations providing care transition services across a continuum of care through arrangements with PPS hospitals will be supported. Priority is given to entities that participate in a program administered by the Administration on Aging or that provide services to medically underserved populations, small communities, and rural areas.
- Section 3126 (page 31): The demonstration project on community health integration models in rural counties is changed to eliminate the six-county limit and the requirement that CAHs must provide rural health clinic services to participate.

- Section 3129 (page 32): The Medicare Rural Hospital Flexibility program is extended through FY 2012 and now allows the use of funds to participate in reforms created by this legislation (VBP, ACOs, bundled payment).
- Section 3505 (page 40): At least four (multiyear) contracts or grants will be made to support projects involving innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems; priority will be given to entities serving a population in a medically underserved area.
- Section 3510 (page 41): Grants are to be awarded for up to four years to create patient navigator programs.
- Section 10333 (page 77): The Secretary may award grants to establish community-based collaborative care networks for low-income populations that provide comprehensive and integrated health care services.

TITLE I: QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Section	Provision	Rural Relevance	Effective
Subtitle A: Immediate Improvements in Health Care Coverage for All Americans Part A: Individual and Group Market Reforms			
Section 1001-2711 *No lifetime or annual limits*	A group plan and a health insurance issuer of group and individual plans may not establish lifetime limits on the dollar value of benefits or unreasonable annual limits on the dollar value in issuing new plans. Plans may limit benefits that are not essential. Many provisions under this subtitle are likely to increase insurance premiums and/or drive insurers from the market reducing choice, competition, and availability of insurance.	Insurance purchased in the individual and small group markets, which characterize much of rural America, will not include lifetime limits. Restrictions on annual limits will apply immediately to individual and small group plans.	The annual limits are effective for plan years beginning on or after 6 months after date of enactment; lifetime limits are effective January 1, 2014
Section 1001-2712 *Prohibition on recissions*	An insurance plan cannot rescind a plan or coverage once someone is enrolled, except for reasons of fraud or misrepresentation of fact.	This section protects persons in individual and small group plans, which characterize a disproportionate percentage of rural private insurance.	For plan years beginning on or after 6 months after enactment
Section 1001-2717 *Ensuring the quality of care*	The Secretary, in consultation with stakeholders, will develop reporting requirements for private health plans that improve health outcomes through implementation of activities such as quality reporting, case management, chronic disease management, use of the medical home model; implement activities to prevent hospital readmissions; implement activities to improve patient safety and reduce medical errors; and implement wellness and health promotion activities. A report is due from the Government Accountability Office (GAO) within 180 days after regulations are promulgated regarding the impact of activities under this section on quality and cost of health care. The Secretary shall promulgate regulations that are criteria for determining if a reimbursement structure is to be described in the reporting requirement.	This section creates an expectation for changes in health care delivery that may require capital investment to achieve. Securing the capital may be challenging in some rural communities. If not appropriately calibrated to reflect different resources and time required to achieve change across providers and places, these requirements could create unachievable expectations.	Within 2 years of enactment

Section	Provision	Rural Relevance	Effective
Section 1001-2718 *Bringing down the cost of health care coverage*	Hospitals must make public a list of standard charges, including for diagnosis-related groups (DRGs). Insurers must report the percentage of premiums used for • Clinical services • Quality improvement • All other non-claims costs Insurance plans must experience a medical loss ratio (MLR) of at least 85% for large groups and 80% for small groups and individuals. If the loss ratio is less, the difference shall be rebated to the policy holder.	This section creates a public reporting requirement for rural hospitals and standardization of charges. The use of a single national MLR creates equity across different plan areas, a benefit to rural policy holders.	For plan years beginning on or after 6 months after enactment
Section 1001-2719a, as amended by Section 10101 *Appeals*	The Medical Reimbursement Data Centers shall be established 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 • Regularly update such fee schedules and other database tools to reflect changes in charges for medical services • Make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services • Regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers	The decisions made by the Centers may have a greater impact than merely public reporting, similar to recommendations of the Medicare Payment Advisory Commission. Fee schedules developed by the Centers may influence provider payment policies, which for rural providers is a potential negative consequence. Academic medical centers or nonprofit institutions could assemble data and make it available. There may be opportunity for continuous work on variation in fee schedules, including quantifying any rural differential, which could provide evidence for further payment policy decisions to enhance equity.	
Section 1002-2793 *Health insurance*	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.	$30,000,000 are appropriated for the first fiscal year, some of which could be spent on particular needs for information and assistance in rural areas.	Immediately

Section	Provision	Rural Relevance	Effective
consumer information			
Subtitle B: Immediate Actions to Preserve and Expand Coverage			
Section 1101 *Immediate access to insurance for uninsured individuals with a pre-existing condition*	The Secretary shall establish a temporary high risk pool program for persons with pre-existing conditions precluding access to insurance coverage. Existing state programs must maintain current levels of support.	Such a pool will be helpful to persons not in large employer groups. Reaching rural residents will be challenging.	Within 90 days of enactment
Section 1103 *Immediate information that allows consumers to identify affordable coverage options*	The Secretary shall establish an Internet portal to provide information on coverage options.	Making this available to rural consumers requires access to the Internet through connections capable of processing the information. These may exist in community facilities, such as public libraries.	By July 1, 2010
Subtitle C: Quality Health Insurance Coverage for All Americans			
Section 1201-2704 *Prohibition of preexisting condition exclusions or other discrimination based on health status*	Denial of insurance based on pre-existing conditions and health status is prohibited.	Rural residents in poor health status (proportionately more in rural areas than in urban areas) and those with pre-existing conditions will have access to insurance coverage. This affects a comparatively small number of persons and households who will benefit considerably.	January 1, 2014
Section 1201-2701 *Fair health insurance premiums*	The premium rate in the individual or small group market shall vary only by whether the plan covers an individual or a family; rating area; age, limited to 3 to 1 for adults; and tobacco use, limited to 1.5 to 1. Each state establishes 1 or more rating areas.	Restricting age rating has implications for rural areas because of the aging of the population. Rates may moderate for elderly adults, but may increase for young adults. There may be more than one rating area in a given state, raising possibilities of different rating areas having different consequences for plans offered in rural areas.	January 1, 2014

Section	Provision	Rural Relevance	Effective
Section 1201-2703 *Guaranteed renewability of coverage*	Insurers must renew policies in the individual market.	The individual market is likely to attract a higher percentage of rural places than urban places.	January 1, 2014
Section 1201-2705 *Prohibiting discrimination against individuals based on health status*	Employer wellness programs will be eligible to participate in state-driven programs. A wellness program demonstration project shall be created in 10 states, with authority to expand to additional states beginning on July 1, 2014. A report from the Secretary to appropriate committees of Congress is due no later than 3 years after the date of enactment	State applications could include an emphasis on programs in rural areas.	Upon enactment
Section 1201-2706 *Non-discrimination in health care*	Health plans cannot discriminate against any health care provider acting within the scope of the provider's license. A group health plan is not required to contract with any provider willing to abide by the terms and conditions for participation.	Non-discrimination includes rural providers accepting contracts from health plans. Group health plans can refuse to contract with providers, including rural providers.	January 1, 2014
Subtitle D: Available Coverage Choices for All Americans			
Section 1301, as amended by 10104 *Qualified health plan defined*	Qualified health plans include Consumer Operated and Oriented Plans (CO-OPs) (detailed in section 1322) and community health insurance plans (detailed in Section 1323). If an item or service that is covered by a qualified health plan is provided by a Federally Qualified Health Center (FQHC) to a plan enrollee, the plan offeror must pay the FQHC at least as much as the FQHC would have been paid under section 1902(bb) of 42 U.S.C 1396a(bb).	CO-OP and community health insurance plans may create new options for all enrollees, including rural residents. If the intent is to protect safety net providers from loss of revenue from their current level, consideration may be given during implementation to extending this provision to other rural providers.	2014
Section 1302 *Essential health benefits requirements*	The levels of coverage described in this section provide benefits that are actuarially equivalent to a percentage of the full actuarial value of the benefits provided under the plan, as follows: • Bronze level: benefits actuarially equivalent to 60%	Rural residents will have access to at least the bronze level of coverage.	2014

Section	Provision	Rural Relevance	Effective
	of the full actuarial value • Silver level: benefits actuarially equivalent to 70% of the full actuarial value • Gold level: benefits actuarially equivalent to 80% of the full actuarial value • Platinum level: benefits actuarially equivalent to 90% of the full actuarial value		
Section 1311 *Affordable choices of health benefit plans*	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. At a minimum, exchanges must operate a toll-free hotline, maintain an Internet website, rate qualified health plans, and certify individual exemptions from penalty for not enrolling. Exchanges shall consult with stakeholders, including representatives of small businesses and self-employed individuals and advocates for enrolling hard to reach populations, in carrying out activities in this section. This section allows for regional or other interstate exchanges. Health plans may contract with hospitals with more than 50 beds if those hospitals use a patient safety evaluation system and implement a mechanism to ensure each patient receives	The design of exchanges in the state submissions for funding is important to rural residents' access to exchanges. Network adequacy is defined in Section 2702(c) of the Public Health Service Act. Information must be provided to enrollees and prospective enrollees on the availability of in-network and out-of-network providers. Federally Qualified Health Centers (FQHCs), FQHC look-alikes, and Migrant Health Centers will be included. Using standard tools to measure, as well as giving consumers access to the data, is a step toward enhancing equity across providers. The ways that exchanges are required make information available to enrollees includes outlets that are useful in rural areas. Rural-oriented groups are likely to be consulted within the operational definitions of small business, self-employed, and advocates for hard-to-reach populations. Regional exchanges may benefit sparsely populated states and places in which insurance markets are logically multi-state. Small rural hospitals are excluded from being required to meet patient safety standards. There is a reporting requirement for hospitals with more than 50 beds. Hopefully	Grants to states within 1 year of date of enactment By July1, 2012

Section	Provision	Rural Relevance	Effective
	a comprehensive program for discharge or if a health care provider implements such mechanisms to improve quality as the Secretary may by regulation require. Exchanges shall establish grant programs for entities to conduct public education activities, distribute fair and impartial information, facilitate enrollment in qualified health plans, and provide referrals to any applicable office of health insurance consumer assistance.	the reports will inform the design of a system for reporting patient safety in small institutions. Eligible entities include ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, and licensed insurance agents and brokers.	
Section 1313 *Financial integrity*	The Comptroller General shall conduct a study of Exchange activities and the enrollees in qualified health plans to review how many physicians are not taking or accepting new patients enrolled in Federal Government health care programs and the adequacy of provider networks of Federal Government health care programs.	The results of this study will include information about access to providers by government program beneficiaries in rural areas. The study should include analysis of the likelihood of physicians and others continuing to accept new patients.	Within 5 years after first date on which Exchanges are operational
Section 1322 *Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers*	The Secretary shall establish a Consumer Operated and Oriented Plan (CO-OP) program. Grants and loans will be made to start at least 1 CO-OP plan in each state. The Government Accountability Office will study market concentration in the health insurance market and will make reports to Congress at the end of even-numbered years.	The purpose of the CO-OP program is to foster creation of insurers to offer qualified plans in the individual and small group markets, which characterizes much of rural America.	Start awards no later than July 1, 2013 First report due in 2014
Section 1333 *Provisions relating to offering of plans in more than one State*	This section creates conditions for states to enter into interstate health care choice compacts, subject to the laws and regulations of the state in which the plan was written or issued. This section creates the authority for nationwide plans.	Such compacts could increase options in rural areas because of pooling larger numbers of individuals. Plans have to be offered in all geographic regions and in all states that adopted adjusted community rating.	By July 1, 2013
Subtitle E: Affordable Coverage Choices for All Americans			
Section 1401 *Refundable tax credit providing premium assistance for*	As amended by the Reconciliation Act, taxpayers in low income households will be eligible for tax credits. The amount of the tax credit is a function of income level above poverty.	This provision is designed to provide assistance to low income households, which are more prevalent in rural areas.	After December 31, 2013

Section	Provision	Rural Relevance	Effective
coverage under a qualified health plan			
Section 1421 *Credit for employee health insurance expenses of small businesses*	Small businesses will receive tax credits equal to 50% (35% for tax-exempt eligible small employers) of the lesser of (1) nonelective 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.	Many small businesses in rural areas are likely to qualify for these credits. Seasonal workers would need to work more than 120 days during the taxable year before being included in the determination of full-time equivalent workers.	Taxable years beginning after December 31,2010
Subtitle F: Shared Responsibility for Health Care			
Section 1561 *Health information technology enrollment standards and protocols*	The Secretary will develop interoperable and secure standards and protocols to facilitate enrollment in Federal and state health and human services programs that include capability for individuals to manage their information online, including at home, at points of service, and at other community-based locations. Grants shall be made available to develop new systems and adapt existing systems to implement the health information technology enrollment standards and protocols.	There will be an opportunity to improve access to Internet services in rural places. No specific amount of funds is authorized.	

TITLE II: ROLE OF PUBLIC PROGRAMS

Section	Provision	Rural Relevance	Effective
Subtitle A: Improved Access to Medicaid			
Section 2001 As amended by Section 1201 of the Reconciliation Act *Medicaid coverage for the lowest income populations*	Medicaid will be expanded to include all persons under age 65 who are not enrolled in Medicare in households with income below 133% of the federal poverty guidelines. *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.	Rural residents, disproportionately low income, will have an opportunity to enroll.	January 1, 2014; states could expand as early as April 1, 2010
Section 2002 *Income eligibility for nonelderly determined using modified gross income*	Medicaid eligibility will be based on modified gross income; states may not use an assets test.	The lack of an assets test opens eligibility to all residents, including those who may own acreage.	January 1, 2014
Reconciliation Bill Section 1202 *Payments to primary care physicians*	Payment to primary care physicians for persons newly eligible for Medicaid as a result of this legislation shall be their Medicare rates for 2013 and 2014, with a federal match of 100% of those costs.	This will provide higher marginal payment for rural primary care physicians than would be true if Medicaid rates were used.	2013
Subtitle B: Enhanced Support for the Children's Health Insurance Program			
Section 2101 *Additional federal financial participation for CHIP*	The match for enrollees into the Child Health Insurance Program (CHIP) will be increased by 23 percentage points, up to 100%.	CHIP has been a vehicle for increasing insurance coverage of rural children.	October 1, 2015, through September 30, 2019

Section	Provision	Rural Relevance	Effective
Subtitle C: Medicaid and CHIP Enrollment Simplification			
Section 2202 *Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations*	Hospitals can make a presumptive eligibility determination for Medicaid eligible populations.	Rural hospitals could make presumptive eligibility decisions.	January 1, 2014
Subtitle E: New Options for States to Provide Long-Term Services and Supports			
Section 2401 *Community First Choice Option*	States can amend their state plans to provide home and community-based attendant services for persons whose income does not exceed 150% of the federal poverty level. States must make home and community-based services and supports available as needed and must establish and maintain a comprehensive, continuous quality assurance system.	Given the disproportionate percentage of elderly residents in rural areas, making home and community-based services routine to state plans instead of including such services in special waiver programs could meet the needs of rural communities. This provision is especially important for states that lack this option now. The additional services will also generate new jobs.	October, 2011
Section 2405 *Funding to expand State Aging and Disability Resource Centers*	Funding to state aging and disability resource centers will be increased.	Rural centers would receive funding from the $10,000,000 *appropriated* funds for each FY 2010 through 2014.	FY 2010
Section 2406 *Sense of the Senate regarding long-term care*	It is the sense of the Senate that during the 111th session of Congress, long-term services and supports should be addressed in a comprehensive way and services should be made available in the community in addition to in institutions.	Further improvements in long-term care services and supports would be supported in all areas.	
Subtitle F: Medicaid Prescription Drug Coverage			
Section 2503	The upper payment limit for pharmaceuticals will be calculated as no less than 175% of the weighted average of	Local independently owned rural pharmacies rely more on revenue from filling prescriptions than do large chain	First day of first calendar year

Section	Provision	Rural Relevance	Effective
Providing adequate pharmacy reimbursement	the most recently reported monthly average manufacturer prices for purchases from retail pharmacies. The Secretary shall implement a smoothing process.	pharmacies, making payment formulas especially salient in rural communities. This is an improvement from previous policies, but rural pharmacies could still experience financial difficulty related to third-party contracts being less financially rewarding.	quarter that begins at least 180 days after enactment
Subtitle G: Medicaid Disproportionate Share Hospital (DSH) Payments			
Section 2551 *Disproportionate share hospital payments*	Medicaid disproportionate share hospital (DSH) allotments will be reduced by 50% or 35% when a state's uninsurance rate decreases by 45% or by 25% or 17% for low DSH states. As modified by reconciliation, aggregate reductions would equal $500 million in FY 2014, $600 million in FY 2016, $1.8 billion in FY 2017, $5.0 billion in FY 2018, $5.6 billion in FY2019, and $4.0 billion in FY 2020. To achieve reductions the Secretary is required to 1. Impose the largest percentage reductions on • States that have the lowest percentage of uninsured individuals during the most recent FY with available data or • States that do not target their DSH payments to hospitals with high volumes of Medicaid patients and hospitals that have high levels of uncompensated care 2. Impose a smaller percentage reduction on low DSH states 3. Take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under Section 1115 as of July 31, 2009	Reductions may affect different hospitals differently given in-state differences in the percentage of uninsured. The law assumes reductions in DSH allotment are offset by decreased burdens related to the uninsured. The basis for determining state allocations is reasonable; the effects of this approach on hospitals that may serve disproportionate shares of the remaining uninsured and Medicaid populations should be monitored.	October 1, 2011
Subtitle H: Improved Coordination for Dual Eligible Beneficiaries			
Section 2602 *Providing Federal coverage and payment*	A Federal Coordinated Health Care Office (FCHCO) will be established to improve coordination between the Federal government and states for dually eligible individuals. The goals of this office will be 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	The FCHCO could be helpful to coordination of care efforts in all areas, including rural areas, where doing so may be more challenging than in places with more service availability. Implementation of coordination of services could generate	Establish office by March 1, 2010 (obviously will be adjusted)

Section	Provision	Rural Relevance	Effective
coordination for dual eligible beneficiaries	performance of providers of services and suppliers under Medicare and Medicaid programs.	new requirements for rural providers.	
Subtitle I: Improving the Quality of Medicaid for Patients and Providers			
Section 2701 *Adult health quality measures*	The Secretary shall publish a recommended core set of adult health quality measures for Medicaid eligible adults. The Secretary shall publish an initial set of measures by January 1, 2012. By January 1, 2013, the Secretary shall develop a standardized format for reporting information. By January 1, 2014, and every 3 years thereafter, the Secretary shall report to Congress. $60,000,000 is appropriated for each FY from 2010 through 2014.	As with any set of quality measures, a potential is created for measures that assume a high volume of services and availability of resources that may not be found in rural areas. The format may or may not be applicable to any particular rural circumstances.	January 1, 2011
Section 2702 *Payment Adjustment for Health Care-Acquired Conditions*	The Secretary shall incorporate into Medicaid current state practices that prohibit payment for health care-acquired conditions through Medicaid program regulations.	Payment to rural providers may be altered. Quality of care in rural areas may be improved. As currently worded, this section would not apply to Critical Access Hospitals.	July 1, 2011
Section 2703 *State option to provide health homes for enrollees with chronic conditions*	A state may provide medical assistance to individuals with chronic conditions who designate a provider or a team of professionals as their health home. Planning grants will be awarded to states developing a plan amendment under this section; total funding will not exceed $25,000,000. States plan amendments shall include methodology for tracking avoidable hospital readmissions and calculating savings and a proposal for use of health information technology.	Designated providers include rural clinics, community health centers, physicians, clinical practices, or clinical group practices. A team of professionals may include professionals based at a hospital, community health center, or rural clinic. There may be opportunities for small rural practices to participate in innovative approaches to treating individuals with chronic conditions.	January 1, 2011
Section 2704	The Secretary shall establish a demonstration project to evaluate the use of bundled payments for integrated care for	States can target a demonstration project to categories of beneficiaries, beneficiaries with particular diagnoses, or	January 1, 2012, through

Section	Provision	Rural Relevance	Effective
Demonstration project to evaluate integrated care around a hospitalization	a Medicaid beneficiary for an episode of care that includes hospitalization and for concurrent physician services. Grants will be made to up to 8 states based on the potential to lower costs while improving care.	beneficiaries in particular geographic regions. The Secretary shall insure that as a whole the demonstration is representative of the demographic and geographic composition of Medicaid beneficiaries nationally.	December 31, 2016
Section 2705 *Medicaid Global Payment System demonstration project*	The Secretary shall establish a demonstration project in no more than 5 states 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.	Rural providers could be included as part of the system.	FY 2010 through 2015
Subtitle L: Maternal and Child Health Services			
Section 2951 *Maternal, infant, and early childhood home visiting programs*	This section strengthens maternal, infant, and early childhood home visiting programs. States must conduct a statewide needs assessment. Grants will be made for early childhood home visiting programs. The Secretary shall carry out a program of research and evaluation and shall report to Congress by December 31, 2015. $100 million is appropriated in FY 2010, $250 million in FY 2011, $350 million in FY 2012, and $400 million each FY 2013 and 2014.	There are opportunities for new programs.	FY 2011

TITLE III: IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Section	Provision	Rural Relevance	Effective
Subtitle A: Transforming the Health Care Delivery System Part I: Linking Payment to Quality			
Section 3001 *Hospital value-based purchasing program*	A value-based purchasing (VBP) program is instituted that covers at least 5 specific conditions: acute myocardial infarction; heart failure; pneumonia; surgeries, as measured by the Surgical Care Improvement Project; and healthcare-associated infections. Additional measures must have been included on the Hospital Compare website for at least 1 year prior to the beginning of a performance period. Performance standards shall take into account practical experience, historical performance standards, improvement rates, and opportunity for continued improvement. The total performance score will be based on the higher of the achievement or improvement score for each measure. The value-based incentive is a percentage of the Diagnosis-Related Group (DRG) payment, as part of the total pool of funds available from a DRG carve-out of 1% in FY 2013, and 2% in FY 2017 and beyond. A hospital's performance on each measure and condition, and the total performance score that applies to that hospital, will be reported publicly. The Secretary shall provide for risk adjustment to maintain incentives to treat patients with severe illnesses or conditions. The Secretary shall conduct a study of the program to include an analysis of the program's effect on Medicare spending and the appropriateness of Medicare sharing in any savings. The Secretary shall establish a VBP demonstration program for inpatient Critical Access Hospitals (CAHs), and hospitals	Hospitals that do not have a minimum number of measures, or for which there are not a minimum number of cases, as determined by the Secretary, are excluded. Rules are established for sole community hospitals, Medicare dependent hospitals, and small rural hospitals. The Secretary shall consult with small rural and urban hospitals on how the provisions apply to them. The Government Accountability Office study of the VBP program includes quality performance among small rural and urban hospitals and barriers they face in meeting performance standards. The effect of the scheduling of the demonstration, evaluation, and reporting is that a national VBP program for CAHs	On or after October 1, 2012 GAO interim study report due October 1, 2015, final July 1, 2017 HHS study due January 1, 2016 CAH demonstration not later than 2 years after enactment

Section	Provision	Rural Relevance	Effective
	excluded based on numbers of measures and cases. • Three-year demonstration • Representative sample of CAHs • Budget neutrality • Report with recommendations to establish permanent VBP program	based on the results of the demonstration would not begin until 2018.	Report due 18 months after completion of program Within 2 years of enactment
Section 3002 *Improvements to physician quality reporting system*	Payment to eligible professionals will be reduced if data on quality measures is not submitted: to 98.5% in 2015 and to 98% in 2016 and each year thereafter. The Secretary shall develop a plan to integrate quality reporting and requirements for meaningful use of electronic health records.	Rural physicians and their employers need to be ready for this change in 2015. This timeline remains aggressive, similar to what was legislated in the American Recovery and Reinvestment Act of 2009.	2015 January 1, 2012
Section 3003 *Improvements to physician feedback program*	The Secretary shall develop an episode grouper to create episodes of care. Physicians will be given reports comparing patterns of resource use.	The impact on rural providers will vary as a function of what is included in the grouper. The reports are adjusted for demographics and severity of illness, and eliminate the effect of geographic adjustments in payment rates.	January 1, 2012
Section 3006 *Plans for VBP program for skilled nursing facilities and home health agencies*	The Secretary shall develop and implement a VBP program for skilled nursing facilities, including methods for public disclosure. The Secretary shall develop a VBP plan for home health agencies, including a development, selection, and modification process for measures; reporting, collection, and validation of quality data; and methods for public disclosure.	The Secretary shall consult with relevant parties, which could include rural providers and stakeholders. The Secretary shall consult with relevant parties, which could include rural providers and stakeholders.	Report by October 1, 2011 Report by October 1, 2011
Section 3007 *VBP modifier under physician fee schedule*	Differential payment to a physician or a group of physicians will be based on quality of care compared to cost during a performance period. Quality measures, such as those that reflect health outcomes, shall be risk adjusted. Costs shall be evaluated based on a composite of appropriate measures of cost that eliminate the effect of geographic adjustments and take into account risk factors.	This adjustment is separate from the geographic adjustment factors.	

Section	Provision	Rural Relevance	Effective
	The Secretary shall publish measures of quality and costs, dates for implementation of the payment modifier, and the initial performance period. The Secretary shall implement the payment modifier through the rulemaking process during 2013.	 The Secretary shall take into account special circumstances of physicians or groups of physicians in rural areas and other underserved communities.	By January 1, 2012 Initiate rule making during 2013; initial performance period in 2015; all physicians by January 1, 2017
Section 3008 *Payment adjustment for hospital-acquired conditions*	The payment adjustment applies to hospitals in the top quartile of all subsection (d) hospitals. Payment for hospital-acquired conditions will be reduced to 99% of what would otherwise be paid.	The payment reduction could be significant for small rural hospitals with thin or even negative operating margins.	FY 2015
Subtitle A: Transforming the Health Care Delivery System Part II: National Strategy to Improve Health Care Quality			
Section 3011 *National strategy*	The Secretary will ensure that the priorities for the strategy for improving the delivery of health care services, patient health outcomes, and population health will • Have the greatest potential for improving outcomes, efficiency, and patient-centeredness • Identify areas in health care with the greatest potential for rapid improvement in quality and efficiency • Address gaps • Improve federal payment policy to emphasize quality and efficiency • Address patients with high-cost chronic diseases • Improve research and dissemination of strategies and best practices • Reduce disparities across populations and geographic areas •	Rural interests will need to be represented in the national strategy. Therefore, rural stakeholders will need to be engaged in the process.	Initial submission in January 1, 2011

Section	Provision	Rural Relevance	Effective
Section 3013 *Quality measure development*	The Secretary shall give priority to the development of quality measures that assess • Health outcomes and functional status • Management and coordination across episodes and care transition • Experience, quality, and use of information provided to and used by patients • Meaningful use of health information technology • Safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care • Efficiency of care • Equity of services across health disparity populations and geographic areas • Patient experience and satisfaction • Use of innovative strategies and methodologies	The same quality measures may affect urban and rural providers differently. Including measures of care transition is especially important to small rural clinics and hospitals that are likely to include patient transport as part of transitioning care.	FY 2010 through 2014, $75 million authorized to be appropriated
Section 3015 *Data collection; public reporting*	The Secretary shall collect and aggregate data on quality and resource use measures from information systems used to support health care delivery and may award grants for this purpose. Entities that receive grants or contracts must support the provision of information to health care providers and other groups and organizations, with an opportunity for providers to correct inaccurate measures. Where appropriate, information will be provider-specific and disaggregated and specific to meet the needs of patients with different clinical conditions.	The Secretary will ensure that data and analysis systems span the range of patient populations, providers, and geographic areas. Incorporating data related to all rural providers regardless of size or assets may present challenges for how data are presented and used.	FY 2010 through 2014
Subtitle A: Transforming the Health Care Delivery System Part III: Encouraging Development of New Patient Care Models			
Section 3021 *Establish Center for Medicare and Medicaid Innovation (CMI) within*	The purpose of the CMI is to test payment and service delivery models where evidence exists that model addresses a defined population for which there are deficits in care leading to poor outcomes or avoidable expenditures. Specific types of models to be tested include those that • Promote broad payment and practice reform in primary care, including patient-centered medical	The development of new models creates an opportunity to showcase innovations in rural places.	January 1, 2011 Appropriates $5 million for FY2010; $10 billion for FY 2011 through 2019 and each

Section	Provision	Rural Relevance	Effective
CMS	homes that transition from FFS • Promote innovative care models such as risk-based comprehensive payment or salary-based payment • Use geriatric assessment and comprehensive care plans • Promote care coordination between providers and suppliers that transitions providers away from FFS • Support care coordination for chronically ill individuals at high risk of hospitalization through a network that includes care coordinators, a disease registry, and home tele-health technology • Utilize medication therapy management services • Establish community-based health teams to support small-practice medical homes by assisting primary care providers • Pay providers of services and supplies for patient decision-support tools • Allow states to test and evaluate fully integrating care for dual eligibles • Promote quality and reduced cost through collaborative of high-quality, low-cost health care institutions • Facilitate inpatient care, including intensive care, at local hospitals through electronic monitoring by specialists • Promote greater efficiencies and timely access to outpatient services through models that don't require a physician or other provider to refer the service or be involved in establishing a plan of care for the service where such service (e.g., outpatient physical therapy) is provided by a professional who has the authority to furnish the service under existing state law		10 years thereafter
Section 3022 *Medicare shared savings program*	Under this program, groups of providers work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (ACO).	Rural participation in this program is not well established. Demonstration projects in rural areas could help future policy considerations in places where the governance structures implied in establishing ACOs do not exist.	January 1, 2012

Section	Provision	Rural Relevance	Effective
	ACOs meet quality standards and are eligible to receive payments for shared savings. Groups with mechanisms for shared governance that are eligible to be ACOs include • ACO professionals in group practice arrangements • Networks of individual ACO practices • Partnerships or joint venture arrangements between hospitals and ACO professionals • Hospitals employing ACO professionals • Others the Secretary may determine An ACO must be willing to be accountable for the patients assigned to it, participate for not less than 3 years, have a formal legal structure to receive and distribute payment, have at least 5,000 beneficiaries assigned to it, and meet patient-centeredness criteria. ACOs share in the savings from the Medicare program.	Hospitals for the purpose of this section are defined as prospective payment system hospitals.	
Section 3023 *National pilot program on payment bundling*	The Secretary shall establish a pilot program for integrated care during an episode around a hospitalization. A partial list of applicable conditions includes those that take into consideration • A mix of chronic and acute conditions • A mix of surgical and medical conditions • Evidence of opportunity to improve quality while reducing expenditures • Variation in the number of readmissions and amount of expenditures for post-acute care • High volume and high post-acute care expenditures • Amenability to bundling across the spectrum of care An episode of care encompasses 30 days prior to admission, the length of stay, and 30 days following discharge. Quality measures include • Functional status improvement	The Secretary shall consult with representatives of small rural hospitals, including CAHs, regarding participation in the program, with consideration of innovative methods of implementing bundled payments, taking into consideration difficulties that result from low volume of services.	Establish pilot program not later than January 1, 2013 Pilot program for 5 years

Section	Provision	Rural Relevance	Effective
	• Reducing rates of avoidable hospital readmissions • Rates of discharge to community • Rates of admission to emergency room after hospitalization • Incidence of health care-acquired infections • Efficiency • Patient-centeredness • Patient perception of care The Secretary shall submit a plan for implementation of an expansion of the pilot program if it would result in improving or not reducing quality while reducing spending.		Submit plan no later than January 1, 2016
Section 3024 *Independence at home demonstration program*	The demonstration program will test a model that uses physician- and nurse practitioner-directed teams to reduce expenditures and improve health outcomes to determine whether the model results in • Reducing preventable hospitalizations • Preventing hospital readmissions • Reducing emergency room visits • Improving health outcomes • Improving efficiency • Reducing cost of services • Improving beneficiary and family caregiver satisfaction An Independence at Home Medical Practice must serve at least 200 applicable beneficiaries and use electronic health information systems, remote monitoring, and mobile diagnostic technology.	Preference will be given to practices located in high-cost areas with experience in serving beneficiaries in the home and use of electronic medical records and individualized plans of care. These could include rural sites.	No later than January 1, 2012
Section 3025 *Hospital readmissions reduction program*	Payments for excess readmissions to a prospective payment system (PPS) hospital will be reduced. The Secretary shall make a program available to improve readmission rates through the use of patient safety organizations.	All rural PPS hospitals could be affected by this provision. Hospitals that have not yet done so may want to incorporate information and other systems to minimize readmissions.	October 1, 2012 Within 2 years after enactment of this section (October, 2014)
Section 3026 *Community-*	This program provides funding for improved care transition services to high-risk beneficiaries.	Priority will be given to entities that participate in a program administered by the Administration on Aging or who provide services to medically underserved populations, small	January 1, 2011 for 5-year period

Section	Provision	Rural Relevance	Effective
based care transitions program	An appropriate community-based organization is one that provides care transition services across a continuum of care through arrangements with hospitals. A high-risk beneficiary is one who has multiple chronic conditions or other factors associated with hospital readmission or transition into post-hospitalization care.	communities, and rural areas. "Eligible entity" excludes critical access hospitals (only section d hospitals will participate), but includes priority participation for medically underserved populations, small communities, and rural areas.	
Subtitle B: Improving Medicare for Patients and Providers Part I: Ensuring Beneficiary Access to Physician Care and Other Services			
Section 3102 As amended by section 1108 of the Reconciliation Act *Extension of work geographic index floor and revisions to practice expense geographic adjustment*	During 2010, the employee wage and rent portions of the practice expense index shall reflect 1/2 of the difference between the relative costs of employee wages and rents in each of the different payment areas and the national average of same. During 2011, the wage and rent portion will be ½ of the difference. The Secretary shall analyze methods of establishing practice expense geographic adjustments and evaluate data that fairly and reliably establishes distinctions in the costs of operating in different fee schedule areas, including evaluating • The feasibility of using actual data or reliable survey data developed by medical organizations • The office expense portion of the practice expense geographic adjustment, including the extent to which types of office expenses are determined in local markets The Secretary shall make appropriate adjustments to the practice expense geographic adjustment to ensure accurate adjustments across fee schedule areas, including • Basing office rents on office expenses that vary among payment areas • Considering a representative range of professional and non-professional personnel based on use of American Community Survey data or other reliable	The change to the index creates greater equality across payment areas in 2010 and 2011. Rural stakeholders should monitor this process and provide insight when appropriate.	January 1, 2010 January 1, 2011 January 1, 2012

Section	Provision	Rural Relevance	Effective
	data for wage adjustments		
Section 3105 *Extension of ambulance add-ons*	The bonus payment and increased payment for ground ambulance services are extended until January 1, 2011.	This helps rural ambulance services remain financially viable.	Effective April 1, 2010
Section 3107 *Extension of physician fee schedule mental health add-on*	The physician fee schedule mental health add-on is extended through December 31, 2010.	This could help continuous care.	Upon enactment
Section 3108 *Permit physician assistants to order post-hospital extended care services*	Physician assistants are permitted to order post-hospital extended care services.	This scenario may occur in communities served by RHCs employing physician assistants.	January 1, 2011
Section 3114 *Improved access for certified nurse-midwife services*	Fees paid to a certified nurse-midwife for the same service performed by a physician are increased to 100% of the fee schedule for physicians.	This enhances financial viability for an alternative to physician services in rural communities currently lacking physicians.	January 1, 2011
Subtitle B: Improving Medicare for Patients and Providers Part II: Rural Protections			
Section 3121 *Extension of outpatient hold harmless provision*	The outpatient hold harmless provision is extended for calendar year 2010. All sole community hospitals are eligible for hold harmless.	Sole community hospitals are included without regard to the 100-bed limitation.	Upon enactment
Section 3122 *Extends*	The Medicare reasonable cost payment for certain clinical diagnostic lab tests furnished to hospital patients in qualified (low population density) rural areas for hospitals under 50	This benefits rural providers.	One year extension starts July 1, 2010

Section	Provision	Rural Relevance	Effective
Medicare reasonable costs payments for certain clinical diagnostic lab tests	beds is extended.		
Section 3123 As amended by Section 10313 *Extends rural community hospital demonstration program*	The rural community hospital demonstration program is extended. The extension continues for 5 years after the initial 5-year period, until January 1, 2012. The extension is for cost reporting periods beginning after September 30, 2009.	During the 5-year extension, the program expands to include 20 states with low population densities. Prior to the extension it was limited to 10 states. The number of hospitals that may participate in the demonstration program during the 1-year extension increases from 15 to 30.	Upon enactment
Section 3124 *Extends Medicare dependent hospital program*	The Medicare dependent hospital program is extended.	There are no substantive changes.	Upon enactment, through FY 2012
Section 3125 *Temporary improvements to hospital payment adjustment for low-volume hospitals*	Temporary improvements are made to the hospital payment adjustment for low-volume hospitals. (Note—these payments will be very significant for the eligible hospitals. The add-on applies to all prospective payment system hospitals, urban and rural, not just rural.)	For FY 2011 and 2012, the miles criteria changes from 25 to 15 and the volume threshold changes from 800 to 1,600. During FY 2011and 2012, payment on a sliding scale increases from 25% for hospitals with 200 or fewer discharges, to 0% at 1,600 discharges.	Upon enactment
Section 3126 *Improvements to demonstration project on community health integration models*	Improvements are made to the demonstration project on community health integration models in certain rural counties.	The six-county limit is eliminated. The requirement that critical access hospitals must provide rural health clinic services to participate is removed.	Upon enactment

Section	Provision	Rural Relevance	Effective
Section 3127 *MedPAC study on adequacy of Medicare payments for rural providers*	MedPAC will conduct a study analyzing • Adjustments in payments to providers and suppliers • Access by Medicare beneficiaries to items and services in rural areas • Adequacy of payment to providers and suppliers • Quality of care furnished in rural areas	The Secretary has requested an Institute of Medicine study on the appropriateness of geographic variation, creating parallel studies. Comparisons of the two studies are inevitable, and rural interests will be affected by each study.	Report due January 1, 2011
Section 3128 *Technical correction related to CAHs*	Medicare will pay the facility component of the all-inclusive critical access hospital payment at 101% of reasonable costs. Medicare will pay for ambulance services provided by CAHs at 101%.	This corrects a drafting error in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and renders moot a Centers for Medicare and Medicaid Services regulation change they implemented in 2010 the inpatient prospective payment system rule that was effective for cost reporting periods beginning after September 30, 2009.	Upon enactment
Section 3129 *Extension of and revisions to Medicare Rural Hospital Flexibility Program*	The program is revised and extended through FY 2012.	The program purpose now includes participating in reforms under provisions of this legislation (value-based purchasing, accountable care organizations, payment bundling).	Upon enactment
HR 4872 Section 1109	Creates a $400,000,000 fund to pay out to the hospitals in the areas in the country with the lowest adjusted Medicare cost per beneficiary.	This will benefit both urban and rural hospitals in those areas for FY 2011 and FY 2012	FY 2011
Subtitle B: Improving Medicare for Patients and Providers Part III: Improving Payment Accuracy			
Section 3131 As amended by Section 10315 *Payment adjustments for home health care*	In 2014, the Secretary will rebase the payments per episode to include changes in the number of visits in an episode, mix of services, level of intensity of services, average cost of providing care, and other factors. The Secretary shall provide for a four-year phase in. MedPAC will conduct a study to analyze the impact of the payment adjustments on access to care; on quality outcomes; on the number of home health agencies; and on rural agencies, urban agencies, for-profit agencies and nonprofit agencies.	The 3% rural home health add-on is extended to January 1, 2016. This will be an important study potentially affecting payment to rural providers.	Upon enactment

Section	Provision	Rural Relevance	Effective
	The Secretary shall conduct a study of to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies.		
Section 3133 *Improvement to the Medicare dispropor-tionate share payments*	Section 1104 of the Reconciliation Act sets forth specific reduction amounts in disproportionate share hospital (DSH) payment as follows: • In FY 2014 a subtraction of .1 percentage point • In FY 2015-19 subtract .2 percentage points	The scope and timing of DSH reductions should be timed to parallel increases in privately insured patients.	Upon enactment
Section 3137 *Hospital wage index improvement*	The Secretary will submit a report to reform the wage index system. A new hospital compensation index system should: • Use Bureau of Labor Statistics data • Minimize adjustments between and within metropolitan statistical areas and statewide rural areas • Minimize the volatility of index adjustments • Take into account the effect on health care providers and on each region • Address issues related to occupational mix As of one year after the Secretary submits a report to Congress, the criteria to determine reclassifications reverts to the criteria in place as of September 30, 2008.	The Secretary shall consult with relevant affected parties. Hospitals reclassified as a result of section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act are again reclassified.	Upon enactment The Secretary's report is due December 31, 2011.
Section 3140 *Medicare hospice concurrent care demonstration*	The Medicare Hospice Concurrent Care demonstration program shall be conducted for 3 years in not more than 15 hospice programs.	Sites shall be located in urban and rural areas.	
Subtitle C: Provisions Relating to Part C			
Section 3201, as amended by Section 10318 and by Section 1102 of the	A Medicare Advantage (MA) benchmark is created based on the current levels of a Medicare fee-for-service area, to be 95% of that level in an area in the highest quartile and 115% of that level in an area in the lowest quartile.		

Section	Provision	Rural Relevance	Effective
Reconciliation Act *Medicare Advantage payment*	Payment is frozen at current levels for 2011, and payment for Indirect Medical Education will be phased out. An MA local plan service area is changed to be an entire urban or rural area in each state. In 2015 and later, the Secretary may adjust the service area boundaries for local plans based on recent analyses of actual patterns of care. Performance bonuses will be paid for care coordination and management performance and for quality performance.	As of 2012 and succeeding years, the Secretary may combine counties into a payment area.	Effective 2014
Section 3206 *Extension of reasonable cost contracts*	Reasonable cost contracts are extended to January 1, 2013.	Most of these contracts are in rural areas.	Upon enactment
Subtitle D: Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans			
Section 3301 as amended by Section 1101 of the Reconciliation Act *Medicare coverage gap discount program*	The Secretary shall enter into agreements with manufacturers to provide access to discounted prices for applicable drugs. The discounts are 50% in 2011, increasing to 75% by 2020.	This will lower beneficiary costs of drugs in the Medicare program's "donut hole."	July 1, 2010
Section 3306 *Funding outreach and assistance for low-income programs*	Additional funds are available for outreach and assistance for low-income programs—$15 million for FY 2010 through 2012; $15 million for FY 2010 through 2012 for Area Agencies on Aging.	Rural agencies will be eligible for this funding.	Upon enactment
Subtitle E: Ensuring Medicare Sustainability			
Section 3401 As Amended by Section 1105 of	<u>Inpatient Acute Care Hospitals</u> The productivity adjustment is equal to the 10-year moving average of changes in annual economy-wide private nonfarm	The productivity adjustment is estimated to be an annual 1% cut to the update factor. Changes to payment should be considered in the context of all changes to revenues (positive	

Section	Provision	Rural Relevance	Effective
the Reconciliation Act *Revision of market basket updates and incorporation of productivity improvements into updates*	business multi-factor productivity. The productivity adjustment may result in the applicable percentage increase being less than 0.0 for a fiscal year, and may result in lower payment than in the previous year. The Secretary shall reduce increases in FY 2010 and 2011 by 0.25 percentage point. For each FY 2012 through 2019, the Secretary shall reduce the increases by 0.2 percentage points. For each FY 2012 through 2019, the reduction shall be 0.0 if the total percentage of the non-elderly insured population for the preceding fiscal year is at least 5 percentage points less than projected. <u>Skilled Nursing Facilities</u> For FY 2012 and each subsequent FY, the percentage increase shall be reduced by the productivity adjustment. <u>Home Health Agencies</u> For 2015 and following years, the percentage increase shall be reduced by the productivity adjustment. For 2011 through 2013, the percentage increase shall be reduced by 1 percentage point. <u>Hospice Care</u> For FY 2013 and each subsequent FY, the percentage increase shall be reduced by the productivity adjustment. For each FY 2013 through 2019, the percentage increase shall be reduced by 0.5 percentage point or by 0.0 if the total percentage of the non-elderly insured population for the preceding fiscal year divided by the total percentage of the non-elderly insured population exceeds 5 percentage points. <u>Ambulance Service</u> For 2011 and each subsequent year, the percentage increase	and negative) for rural providers as all changes are implemented.	

Section	Provision	Rural Relevance	Effective
	shall be reduced by the productivity adjustment. <u>Lab Services</u> For 2011 and each subsequent year, the adjustment to the fee schedules shall be reduced by the productivity adjustment. For each year 2011 through 2015, the adjustment to the fee schedules shall be reduced by 1.75 percentage points.		
Section 3403 *Independent Medicare Advisory Board*	The purpose of this section is to reduce the per capita rate of growth in the Medicare program. If the projected growth rate exceeds the target growth rate for any year (after 2017 the target rate is the nominal gross domestic product per capita growth rate plus one percent), the Board will submit recommendations to reduce the growth rate, and the Secretary will implement the recommendations unless Congress acts. The Board may develop and submit advisory reports that may, in years prior to 2020, include recommendations for improvements to payment systems. The Board's recommendations cannot include rationing care, raising revenues or Medicare beneficiary premiums, or increasing Medicare beneficiary cost-sharing. The Board should give priority to recommendations that extend Medicare solvency. The Board should include recommendations that • Improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, quality and efficiency improvement • Protect and improve access to necessary and evidence-based items and services, including in rural and frontier areas • Target reductions in Medicare program spending to sources of excess cost growth	The basis for setting a targeted growth rate is overall economic growth, not growth in medical care costs. This may create a squeeze on margins for rural providers.	January 15, 2014

Section	Provision	Rural Relevance	Effective
	• Consider effects on beneficiaries of changes in payments to providers of services and suppliers • Consider the effects of recommendations on providers of services and suppliers with actual or projected negative cost margins • Consider the unique needs of dually eligible beneficiaries		
	Savings targets by FY are as follows: • 0.5% in 2015 • 1.0% in 2016 • 1.25% in 2017 • 1.5% in FY 2018 and subsequent years	The relationship of these savings targets to the changes in provider payment in section 3401 is not clear.	
	The Board shall have 15 members appointed by the President with the advice and consent of the Senate.	Rural representation on this Board, and rural input during its deliberations, will be essential.	
	The Secretary and Centers for Medicare and Medicaid Services and Health Resources and Services Administration administrators are ex-officio Board members.		
	The appointed members shall include persons with national recognition for expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, physicians, and other providers who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.	The terminology of "balance" between urban and rural representatives does not specify what the mix shall be.	
	The appropriation for FY 2012 is $15 million, increased by the rate of inflation thereafter.		
	A Consumer Advisory Council will be established to advise the Board on the impact of payment policies on consumers. The Consumer Advisory Council shall include 10 members appointed by the Comptroller General, one from each of 10 regions established by the Secretary.	Rural representation on the Council will be important.	

Section	Provision	Rural Relevance	Effective
	The Council shall meet at least 2 times each year. The Government Accountability Office shall conduct a study of the effects of the Board's recommendations on • Medicare beneficiary access to providers and items and services • The affordability of Medicare premiums and cost-sharing • The potential impact of changes on other government or private-sector purchasers and payers of care • Quality of patient care		
Subtitle F: Health Care Quality Improvements			
Section 3501 *Health care delivery system research; quality improvement technical assistance*	The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality or other agencies or departments shall • Carry out functions using research from a variety of disciplines • Conduct or support activities for best practices for quality improvement in the delivery of health care, including changes in processes of care and redesign of systems that will result in intended health outcomes, improve patient safety, and reduce medical errors • Identify health care providers that deliver consistently high-quality efficient health care services and employ best practices that are adaptable to diverse health care settings • Assess research, evidence, and knowledge about strategies and methodologies most effective in improving quality • Translate information rapidly and effectively into practice and document sustainability • Create strategies for quality improvement through development of tools, methodologies, and interven-tions that reduce variations in the delivery of care • Identify, measure, and improve organizational, human, or other causative factors • Provide development of best practices that have a	Rural interests may be well served if the research includes projects specific to rural delivery systems, and if translation of research to practice includes considerations of how to do so with small rural provider organizations and institutions.	FY 2010

Section	Provision	Rural Relevance	Effective
	high likelihood of success, are specified in detail, and are readily adaptable by providers in a variety of settings • Fund activities of organizations with recognized expertise and excellence in improving the delivery of health care services • Build capacity at the state and community level to lead quality and safety efforts A Quality Improvement Network Research Program may be established to test, scale, and disseminate interventions to improve quality and efficiency in health care. Requirements for research conducted under the Network research program are specified. Research findings and results will be shared with the Office of National Coordinator of Health Information Technology to inform the activities of the health information technology extension program. Funding of $20 million is authorized for FY 2010 through 2014 for previously listed activities. <u>Quality Improvement Technical Assistance</u> Technical assistance grants or contracts will be available to support institutions that deliver health care and to health care providers, including rural and urban providers.		
Section 3502 *Establishing community health teams to support the patient-centered medical home*	The Secretary shall provide grants or enter into contracts with entities to establish community-based interdisciplinary, interprofessional teams to support primary care practices within hospital service areas served by them. Grants or contracts will be used to establish health teams and provide capitated payments to primary care providers. Entities will collaborate with local primary care providers and existing state and community-based resources. Entities will submit a plan for integrating clinical and community preventive and health promotion for patients,	Rural entities are likely to compete for these grants or contracts. Collaboration with rural primary care providers could be done in a number of ways, some of which may be more favorable to those providers and therefore impact access to their services.	FY 2010

Section	Provision	Rural Relevance	Effective
	with priority given to those amenable to prevention and with chronic diseases or conditions. A health team that is established will provide support necessary for local primary care providers to coordinate and provide services included in the patient-centered medical home model.	Plans should include providing local access to the continuum of health care services in the most appropriate setting.	
Section 3503 *Medication management services in treatment of chronic disease*	A Patient Safety Research Center provides grants or contracts to entities to implement medication management services provided by licensed pharmacists. Medication management will be targeted to individuals who • Take 4 or more prescribed medications • Take any high-risk medications • Have 2 or more chronic diseases, or • Have undergone a transition of care or other factors likely to create high risk of medication-related problems	Medication reconciliation is a challenge for different circumstances in rural than in urban, so grants to a variety of places/providers would be helpful. Securing competitive grants from rural entities may be a challenge.	May 1, 2010
Section 3504 *Design and implementation of regionalized systems for emergency care*	At least four multiyear 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. The Secretary shall support programs to accelerate research in emergency medical care systems and emergency medicine, including model of service delivery, translation of basic scientific research into improved practice, and development of timely and efficient delivery of health services.	Integration of trauma services is a laudable goal in rural areas, especially those with vast sparsely populated regions that host major transportation corridors.	FY 2010
Section 3505 *Trauma care centers and service availability*	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. $100 million for FY 2009 and such sums as necessary for FY 2010 through 2015 are authorized.	The objectives include providing for individual safety net trauma center fiscal stability and costs, with priority to centers located in urban, border, and rural areas. As the program is implemented, it may foster integration of rural systems and providers; improvements in trauma services in rural areas, including timely and quality transfers;	

Section	Provision	Rural Relevance	Effective
	Grants to states will be made to promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties. $100 million for each FY 2010 through 2015 is authorized.	and opportunities to use telecommunications within trauma systems.	
Section 3506 *Program to facilitate shared decisionmaking*	The purpose of this program is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians. This program provides patients with information about trade-offs among treatment options and incorporates patient preferences and values into the medical plan. The Secretary shall establish a program to award grants or contracts to develop and update decision aids for patients and providers and to test materials to ensure they are balanced and evidence based. The Secretary shall establish a program to provide grants to establish and support Shared Decisionmaking Resource Centers to enhance and promote adoption of patient decision aids and shared decisionmaking. Such sums as necessary area authorized.	The program is likely to consider special needs in shared decisionmaking, including cultural barriers that may be especially problematic in rural areas with limited resources.	FY 2010
Section 3510 *Patient navigator program*	The total period of a grant shall not exceed 4 years. $3.5 million for FY 2010 and such sums as necessary for each FY 2011 through 2015.	These grants could be helpful in rural areas, especially if navigators are familiar with care across the continuum and help rural residents identify and access care.	FY 2010

TITLE IV: PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Section	Provision	Rural Relevance	Effective
Subtitle A: Modernizing Disease Prevention and Public Health Systems			
Section 4001 *National Prevention, Health Promotion and Public Health Council*	The Council will be composed of the Secretaries of Health and Human Services, Agriculture, Education, Transportation, Labor, and Homeland Security; the chair of the Federal Trade Commission; the Administrator of the Environmental Protection Agency; the Director of Office of National Drug Control Policy; the Director of Domestic Policy Council; the Assistant Secretary for Indian Affairs; the Chair of the Corporation for National and Community Service; and the head of other Federal agencies as appropriate. The Surgeon General will be appointed to chair the Council. The Council will provide coordination and leadership at the Federal level to develop a strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability. The Council will provide recommendations to the President and Congress concerning the most pressing health issues and changes in Federal policy to achieve national wellness, health promotion, and public health goals. The Council will consider and propose evidence-based models, policies, and innovative approaches for promotion of transformative models of prevention, integrative health, and public health on individual and community levels. The President will establish an advisory group to the Council (Advisory Group on Prevention, Health Promotion, and Integrative and Public Health), composed of the following: • Not more than 25 non-Federal members appointed by the President • Health practitioners with expertise in worksite health promotion and community services, including	The eclectic composition of the Council and chairmanship by the Surgeon General may lead to more comprehensive approaches to community health based on a public health framework. The recommendations should accommodate different models for successful public health interventions based on geography, diversity, and community size. The Advisory Group should include rural representation knowledgeable of variation in community capacity to execute new programs.	Upon enactment March 2011 report due

Section	Provision	Rural Relevance	Effective
	community health centers, preventive medicine, health coaching, public health education, geriatrics, and rehabilitation medicine The Council shall develop a national prevention and health promotion strategy and make it public within 1 year after enactment. Through January 1, 2015, the Council will submit an annual report that describes activities and efforts on prevention, health promotion, and public health; describes national progress in meeting goals in the strategy; contains specific science-based initiatives to achieve the goals of Healthy People 2010; and contains specific plans to consolidate Federal health programs and Centers to promote healthy behavior and reduce disease risk.		First report due July 1, 2010
Section 4002 *Prevention and Public Health Fund*	This section establishes a national prevention and public health fund to expand and sustain investment in improving health and restraining growth in cost. $500 million is authorized to be appropriated and appropriated in FY 2010, growing to $2 billion in FY 2015 and after. Funds will be used for programs in prevention, wellness, and public health activities, including prevention research and health screenings.	The portfolio of grant projects should include projects that can develop best practices for small rural communities.	FY 2010
Section 4003 *Clinical and community preventive services*	The Agency for Healthcare Research and Quality will convene an independent Preventive Services Task Force to review clinical preventive services and publish a guide for providers of clinical services. The Centers for Disease Control and Prevention (CDC) will convene an independent Community Preventive Services Task Force to review community preventive interventions, including consideration of social, economic, and physical environments that can affect health and disease, and publish a guide for deliverers of population-based services.	The Office of Rural Health Policy could have a role in helping the CDC by either being part of the Task Force or helping to select appropriate rural representatives.	

Section	Provision	Rural Relevance	Effective
	Both task forces will coordinate with the US Preventive Services Task Force and the Advisory Committee on Immunization Practices.		
Section 4004 *Education and outreach campaign regarding preventive benefits*	The Secretary shall plan and implement a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. The Centers for Disease Control and Prevention will implement a national science-based media campaign on health promotion and disease prevention. The campaign will be carried out through competitively bid contracts. The campaign will have an independent evaluation every 2 years, with a report to Congress. Health promotion and disease prevention information will be disseminated to health providers participating in Federal programs. The Secretary will provide information to states and health care providers regarding preventive and obesity-related services available to Medicaid enrollees, with reports to Congress by January 1, 2011, and every 3 years thereafter through January 1, 2017.	There may be special challenges for this campaign to reach rural residents.	Within one year of enactment
Subtitle B: Increasing Access to Clinical Preventive Services			
Section 4101 *School-based health centers*	The Secretary shall establish a grant program for eligible entities to operate a school-based health center. Preference will be given to entities that serve a large population of children eligible for medical assistance. No funds can be used for providing health services. $50 million is appropriated each FY 2010 through 2013.	Rural school districts may want to band together to increase chances of participating in this grant program.	Upon enactment

Section	Provision	Rural Relevance	Effective
	The grant program will target children in areas designated as medically underserved or a health professional shortage area. Preference will be given to communities with evidence of barriers to primary health care and mental health and substance use disorder prevention; communities with high per capita numbers of children and adolescents uninsured, underinsured, or enrolled in public health insurance programs; and populations of children and adolescents with historic difficulty accessing health and mental health and substance use disorder prevention services. Grant funds may be used for equipment, training, management, and operation of programs and for salaries for physicians, nurses, and other personnel. Funds as necessary are authorized FY 2010 through 2014.	Rural schools in health professional shortage areas may be successful in obtaining funding. These criteria can favor some rural communities.	
Section 4102 *Oral healthcare prevention activities*	The Secretary shall establish a 5-year national, public oral health education campaign. The campaign will target specific populations and use science-based strategies that include community water fluoridation and dental sealants. Grants shall be made available to community-based providers to demonstrate the effectiveness of research-based dental caries disease management activities. Funds as necessary are authorized FY 2010 through 2014. The Secretary shall develop oral healthcare components that include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. The Secretary shall ensure that Medicare Expenditure Panel Survey includes verification of dental utilization, expenditure, and coverage findings.	Grant recipients may incorporate analysis of the delivery system and how it can be improved to increase access to dental health services.	Not later than 2 years after date of enactment; conduct planning activities during those 2 years
Section 4103 *Medicare*	Medicare beneficiaries will receive a health risk assessment. Beneficiaries will have a screening schedule established for	Service providers to rural beneficiaries will be able to use tools such as health risk assessments and coverage for health advice to help sustain beneficiary health status.	

Section	Provision	Rural Relevance	Effective
coverage of annual wellness visit providing a personalized prevention plan	the next 5 to 10 years. Beneficiaries will receive a list of risk factors and conditions for which clinical interventions are recommended or are underway. Beneficiaries will be given personalized health advice and a referral as appropriate. The Secretary shall establish publicly available guidelines for risk assessments and standards for interactive programs used to furnish health risk assessments. The Secretary shall develop and make available a health risk assessment model. The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services.		Within one year of enactment Within 18 months of enactment
Subtitle C: Creating Healthier Communities			
Section 4201 *Community transformation grants*	Grants will be made to state and local governmental agencies and community-based organizations for evidence-based community preventive health activities to reduce chronic disease, prevent development of secondary conditions, address health disparities, and develop a strong evidence-base of effective prevention programming. An entity that receives a grant must submit a detailed plan including policy, environmental, programmatic, and infrastructure changes to promote healthy living and reduce disparities. Activities in the plan may focus on • Creating healthier school environments • Creating infrastructure supporting active living and access to nutritious foods • Developing programs targeting a variety of age levels to increase nutrition, physical activity, and smoking cessation, or other chronic disease priority	The law specifies that not less than 20% of such grants have to be awarded to rural and frontier areas. Grant requirements could inspire more inter-organizational collaboration in rural communities to improve overall community health. Rural communities may have advantages over urban areas because of having fewer key stakeholders needing to coalesce for local success.	Upon enactment

Section	Provision	Rural Relevance	Effective
	area • Assessing and implementing worksite wellness programming and incentives • Highlighting healthy options at restaurants and other food venues • Reducing racial and ethnic disparities • Addressing special populations needs Sums as necessary are authorized for each FY 2010 through 2014.		
Section 4202 *Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries*	The Secretary will award grants to state and local health departments and Indian tribes for 5-year pilot programs to provide public health community interventions, screenings, and necessary clinical referrals for individuals between 55 and 64 years of age. Funds may be used for health screening among individuals in both urban and rural areas. Sums as necessary are authorized for FY 2010 through 2014.	Grants to local health departments should reach rural communities. The law specifies including rural areas.	Upon enactment
Section 4206 *Demonstration project concerning individualized wellness plan*	The Secretary shall establish a pilot program to test the impact of providing an individualized wellness plan to populations using community health centers. Not more than 10 centers will be funded. Sums as necessary are authorized for FY 2010 through 2014.	One or more centers could be located in a rural area.	
Section 10408 *Grants for small businesses to provide comprehensive wellness programs*	The Secretary shall award grants to eligible employers to provide their employees with access to comprehensive workplace wellness programs. The grant program shall be conducted for a 5-year period for employers of less than 100 employees who work 25 hours or more per week and that do not provide a workplace wellness program as of the date of this Act. The Secretary shall develop program criteria based on and	Small rural businesses can participate in this program.	

Section	Provision	Rural Relevance	Effective
	consistent with evidence-based research and best practices. $200 million for FY 2011 through 2015 is authorized for appropriation.		
Subtitle D: Support for Prevention and Public Health Innovation			
Section 4301 *Research on optimizing the delivery of public health services*	The Secretary shall provide funding for research that examines evidence-based practices relating to prevention, with a focus on high priority areas identified in Healthy People 2020 or the National Prevention Strategy, including community-based public health interventions. Research supported under this section must identify effective strategies for organizing, financing, or delivering public health services in real-world community settings, including comparing health department effectiveness and cost. There is no specific authorization for appropriation.	Implementation of the grant program could include rural sites.	
Section 4302 *Understanding health disparities: data collection and analysis*	Any federally conducted or supported program, activity, or survey collects and reports, to the extent practicable, data specific to population subgroups, including data at the smallest geographic level such as state, local, or institutional levels, if such data can be aggregated. Collected data should be sufficient to generate statistically reliable estimates by subpopulations using, if needed, oversamples. Survey health providers and establish other procedures to assess access to care and treatment for individuals with disabilities. The Secretary shall make data analysis to detect and monitor trends in health disparities available to agencies, including the Office of Rural Health. The Secretary may make data available for additional research, analyses, and dissemination to other Federal agencies, non-governmental entities, and the public in accordance with any agency's data user agreements.	Geographic subpopulations are not mentioned in this clause of the section. Rural regions could be analyzed separately. This section may provide a vehicle to obtain data for federally funded rural health services research.	Upon enactment

Section	Provision	Rural Relevance	Effective
	The Secretary shall ensure that data collected regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations. Sums as necessary are authorized for FY 2010 through 2014.		

TITLE V: HEALTH CARE WORKFORCE

Section	Provision	Rural Relevance	Effective
Subtitle B: Innovations in the Health Care Workforce			
Section 5101 *National health care workforce commission*	The Commission will • Be a national resource for Congress, the President, states, and localities • Coordinate with departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education • Develop and commission evaluations of education and training activities to determine if demand is met • Identify barriers to improved coordination across governmental entities and recommend actions • Encourage innovation to meet needs The Comptroller General will appoint 15 members to the Commission, including • Persons with national recognition for expertise in the health care labor market • Persons who represent a combination of professional perspectives, broad geographic representation, and balance between urban, suburban, rural, and frontier representatives • At least one representative each for health care workforce and health professionals, employers, third-party payers, experts in conduct and interpretation of health care services and economics research, consumers, labor unions, state or local workforce investment boards, educational institutions Members will serve 3-year staggered terms. By April 1 of each year starting with 2011, the Commission will submit a report on a minimum of one priority area. The Commission shall study effective mechanisms for financing education and training, including public health and allied health.	Rural representation is included, but without specifying a particular proportion. Special topics priorities include workforce needs of special populations such as rural populations. High priority areas include integrated health care workforce planning, enhanced information technology, and management workplace, each of which has rural implications. High priorities include integration in the health care delivery	Commission appointed by September 30, 2010

Section	Provision	Rural Relevance	Effective
	The Commission shall carry out or award grants or contracts for original research and development where existing information is inadequate.	system of nursing, oral health care, mental and behavioral health care, allied health and public health, emergency medical services, and geographic distribution of health care providers as compared to need.	
Section 5102 *State health care workforce development grants*	The purpose of this grant program is to enable state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies. The Health Resources and Services Administration will award planning grants for one year with a maximum of $150,000. An eligible partnership shall be a state workforce investment board if it includes representatives from a health care employer, a labor organization, and educational programs. A match of at least 15% is required, which may come from funds available from other Federal, state, local, or private sources. Competitive implementation grants will be awarded for state partnerships for 2 years, if the planning grant was completed or a satisfactory application is submitted. States must reserve at least 60% of implementation grant funds for competitive grants to encourage regional partnerships to address needs and promote career pathway activities. A minimum 25% match is required for implementation grants. $8 million is authorized for planning grants in FY 2010 and as necessary afterwards; $150 million is authorized for implementation grants in FY 2010 and as necessary afterwards.	State workforce commissions could consider the combined effects of state and federal policies on workforce distribution. Meeting rural needs may make some state applications more competitive. Establishing regional partnerships and promoting career pathways should be advantageous for rural places.	FY 2010
Section 5103	The Secretary shall establish the National Center for Health Care Workforce Analysis to develop information describing	Data and analysis could be helpful to entities meeting rural needs for primary care and other health care workers.	FY 2010

Section	Provision	Rural Relevance	Effective
Health care workforce assessment	and analyzing the workforce. $7.5 million is authorized for appropriations for each FY 2010 through 2014 for the National Center; $4.5 million is authorized for state and regional centers, and as necessary for longitudinal evaluations.		
Subtitle C: Increasing the Supply of the Health Care Workforce			
Section 5201 *Federally supported student loan funds*	The practice commitment is changed to 10 years (including residency training in primary health care) or when the loan is paid in full.	This provision could make loan repayment more meaningful as a means of meeting needs in rural shortage areas.	Upon enactment
Section 5202 *Nursing student loan program*	The level of funds per student loan repayment is increased.	Attracting more persons to the nursing profession could help meet rural needs.	FY 2010
Section 5204 *Public health workforce recruitment and retention programs*	The Secretary shall establish a Public Health Workforce Loan Repayment Program. $195 million is authorized for FY 2010, and such sums as necessary are authorized through FY 2015.	If appropriately designed, this program could help staff local public health departments in rural places.	FY 2010
Section 5205 *Allied health workforce recruitment and retention programs*	This section authorizes a new loan forgiveness program for allied health.	Loan repayment may be sufficient incentive to attract more allied health professionals to underserved rural areas.	FY 2010
Section 5206 *Grants for state and local programs*	This section authorizes grants to entities to award scholarships to mid-career public health and allied health professionals for additional training. $60 million is authorized for FY 2010 and as necessary for FY 2011 through FY 2015.	Scholarships may create opportunities for mid-career training among rural public and allied health professionals who otherwise may not have such opportunities because of the cost of programs and displacement.	FY 2010

Section	Provision	Rural Relevance	Effective
Section 5207 *Funding for National Health Service Corps*	Funding for the National Health Service Corps is increased to $1,154,510,336 by FY 2015, after which increases will be based on costs of health professions education and the average number of individuals residing in health professions shortage areas.	National Health Service Corps placements are helpful in meeting rural needs.	FY 2010
Section 5208 *Nurse-managed health clinics*	This sections funds the development and operation of nurse-managed health clinics that provide primary care or wellness services to underserved or vulnerable populations. Appropriations of $50 million are authorized in FY 2010 and as necessary each FY 2011 through 2014.	This program could at some time in the future be expanded to include rural health clinics as eligible for funding.	FY 2010
Subtitle D: Enhancing Health Care Workforce Education and Training			
Section 5301 *Training in family medicine, general internal medicine, general pediatrics, and physician assistantship*	For primary care training and enhancement, the Secretary may make grants to or enter into contracts with entities to plan, develop, operate, or participate in an accredited professional training program in the field of family medicine, general internal medicine, or general pediatrics. The Secretary may make grants for a demonstration program for training in new competencies, including patient-centered medical homes. The Secretary shall give preference to applicants for establishing units or programs in family medicine, general internal medicine, or general pediatrics, or substantially expanding such units or programs. Priority will be given to applicants that • Propose a collaborative project between academic units of primary care • Propose innovative approaches • Have a record of training the greatest percentage of providers in primary care • Have a record of training individuals from underrepresented minority groups or from a rural or disadvantaged background • Provide training in the care of vulnerable populations	The entities could include programs based in rural areas, or other programs designed to meet rural needs Training to practice in patient-centered medical homes (PCMHs) may include training specifically for PCMHs located in modest-sized rural practices. These primary care specialties are ones needed in rural areas. The requirement for a track record includes one of training persons with rural backgrounds, which increases the likelihood that they will practice in similar places.	FY 2010

Section	Provision	Rural Relevance	Effective
	• Establish formal relationships with Federally Qualified Health Centers, rural health clinics, Area Health Education Centers, or clinics in underserved areas; teach skills to provide interprofessional, integrated care through collaboration among health professionals • Provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, health information technology, or • Provide training in cultural competency and health literacy Appropriations of $125 million are authorized for FY 2010, and as necessary for each FY 2011 through 2014.		
Section 5302 *Training opportunities for direct care workers*	The Secretary shall award grants to provide new training opportunities for direct care workers in long-term care settings (nursing homes, assisted living and skilled nursing facilities, intermediate care facilities, home- and community-based settings). The individual being trained must agree to work in the field of geriatrics, disability services, long-term care services and supports, or chronic care management for a minimum of 2 years. Appropriations of $10 million are authorized for the period of FY 2011 through 2013.	Training opportunities should include rural sites.	FY 2011
Section 5303 *Training in general, pediatric, and public health dentistry*	A grant or contract may be awarded to a training program to operate a faculty loan repayment program. Priorities for faculty loan repayment will be given to qualified applicants who • Propose collaborative projects with primary care medicine • Have a record of training the greatest percentage of providers or demonstrated significant improvements in the percentage of providers who enter and remain	Priorities for loan repayment include rural places, and include rural providers such as RHCs as training sites.	FY 2010

Section	Provision	Rural Relevance	Effective
	in general, pediatric, or public health dentistry • Have a record of training individuals from rural or disadvantaged backgrounds, or underrepresented minorities • Establish formal relationships with Federally Qualified Health Centers, Rural Health Clinics (RHCs), or accredited teaching facilities and train at those facilities • Conduct teaching programs targeting vulnerable populations • Include educational activities in cultural competence and health literacy • Have a high rate of placing graduates in practice settings serving underserved areas or health disparity populations • Intend to establish a special populations oral health care education care center or training program The duration of an award is 5 years. $30 million is authorized for FY 2010 and as necessary for 2011 through 2015.		
Section 5304 *Alternative dental health care providers demonstration project*	The Secretary may award grants to 15 entities to establish programs to train or employ alternative health care providers to increase access in rural and other underserved communities. Eligible entities include higher education institutions, including a community college; a public-private partnership; a Federally Qualified Health Center (FQHC); an Indian Health Service facility; a state or county public health clinic; a public hospital; or a health system. Each grant shall not be less than $4 million for a 5-year period. The Secretary will contract with the Institute of Medicine to conduct a study of the demonstration programs.	The replicability of what emerges from these grant programs could be constrained or facilitated by state scope-of-practice regulations. Rural community colleges are eligible entities, as are FQHCs.	Begin demonstration projects not later than 2 years after date of enactment; conclude not later than 7 years after enactment

Section	Provision	Rural Relevance	Effective
	Such sums as necessary are authorized.		
Section 5305 *Geriatric education and training, career awards, comprehensive geriatric education*	The Secretary shall award grants to entities that operate a geriatric center. A geriatric center that receives a grant shall use the funds to offer fellowship programs that train faculty members in medical schools and other health professions schools. A geriatric center that receives a grant for family caregiver and direct care provider training shall offer at least 2 courses each year at no charge or nominal fee to provide practical training for supporting frail elders and individuals with disability, OR develop and include material on depression and other mental disorders, medication safety issues, and management of psychological and behavioral aspects of dementia and communication techniques with persons with those conditions. $10.8 million is authorized for FY 2011 through 2014 for grants. The Secretary shall award geriatric career incentive awards to advanced practice nurses, clinical social workers, pharmacists, or students of psychology pursuing a doctorate in geriatrics or related fields. A condition of the career award is that the individual will teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of 5 years. For career awards, $10 million is authorized for FY 2011 through 2014.	Trainees from geriatric centers may include practitioners working in rural areas.	FY 2011
Section 5306 *Mental and behavioral health education and training grants*	The Secretary may award grants to institutions of higher education to support the recruitment, education, and clinical experience of students in social work and psychology, and to organizations to pay for programs for pre-service or in-service training of paraprofessional child and adolescent mental health workers.	While there is no specific legislative directive to train persons that will serve rural residents, increasing the supply of professionals may benefit rural residents, who currently experience difficulty finding professional services.	FY 2010

Section	Provision	Rural Relevance	Effective
	To be eligible, institutions shall demonstrate participation in programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds. Cultural and linguistic competencies are priorities for an internship or a field placement program. Priority for programs in social work will be given to applicants with a graduation rate of not less than 80%. For FY 2010 through 2013, $8 million is authorized for training social work, $12 million for graduate psychology, $10 million for professional child and adolescent mental health, and $5 million for paraprofessional child and adolescent work.		
Section 5309 *Nurse education, practice, and retention grants*	The Secretary may award grants for a career ladder program for individuals to become baccalaureate prepared registered nurses or advanced education nurses, to develop and implement internships and residency programs, and to assist individuals in obtaining the education and training required to enter the nursing profession and advance within the profession. The Secretary may award grants to improve retention of nurses and enhance patient care directly related to nursing activities. Sums as necessary are authorized for each FY 2010 through 2012.	The programs funded by this grant program could be used by rural nurses wanting to advance up a career ladder, creating a pool of more highly skilled professionals that may stay in their current locations, thereby enhancing the capacity of rural delivery systems. Conversely, nurses moving up a career ladder may leave rural places to take full advantage of their enhanced status. Rural stakeholders, including researchers, should monitor the implementation of this grant program.	FY 2010
Section 5310 *Loan repayment and scholarship program*	This section extends eligibility for the loan repayment and scholarship program to include nursing.	This could increase the supply of nurses, which may benefit rural places.	
Section 5311 *Nurse faculty loan program*	The Secretary may enter into loan repayment agreements; such agreements will require a commitment of 4 years for full-time faculty. Loan repayments will be made up to $10,000 per year for persons with a master's in nursing and	Nursing faculty will be needed to increase the size of nursing classes, a necessary condition for meeting the supply needs in rural places.	FY 2010

Section	Provision	Rural Relevance	Effective
	$20,000 for those with a doctorate.		
Section 5313 *Grants to promote community health workforce*	The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to support community health workers who educate and provide guidance or outreach regarding • Health problems prevalent in medically underserved communities • Effective strategies to promote positive health behaviors and discourage risky ones • Enrollment in health insurance • Enrollment into appropriate health care agencies and community-based programs • Home visitation services regarding maternal health and prenatal care Priority will be given to applicants targeting geographic areas with a high percentage of residents who are eligible for health insurance but who are uninsured or underinsured, areas with a higher percentage of residents with chronic diseases, or areas with a high infant mortality rate. Priority will be given to applicants with experience in providing health or health-related social services to individuals who are underserved and have documented community activity and experience with community health workers. Sums as necessary are authorized for FY 2010 through 2014.	Outreach workers would be of high value in rural areas, especially more remote rural areas that lack access to organizations that might accomplish these same purposes. The priority areas will include rural places, given the high percentages of people matching the conditions stated in the legislation—uninsured and underinsured, persons with chronic disease.	FY 2010
Section 5314 *Fellowship training in public health*	The Secretary may address documented workforce shortages in state and local health departments in critical areas of applied public health epidemiology and laboratory science and informatics. $39.5 million is authorized for each FY 2010 through 2013.	Rural health departments will benefit because many of them fit the shortage criteria.	FY 2010
Section 5315 *US Public Health Sciences*	A US Public Health Sciences Track is authorized at multiple sites selected by Secretary that will grant degrees that emphasize team-based service, public health, epidemiology, and emergency preparedness.	The pool of qualified public health personnel will be increased, and rural places should see at least a modest increase from that pool.	

Section	Provision	Rural Relevance	Effective
Track	The program will annually graduate 150 medical students, 100 dental students, 250 nursing students, 100 public health students, 100 behavioral and mental professional students, 100 physician assistant or nurse practitioner students, and 50 pharmacy students. The Surgeon General will administer the program. The program will provide student tuition and stipend in exchange for service in the Commissioned Corps of the Public Health Service equal to 2 years for each school year enrolled.		
Subtitle E: Supporting the Existing Health Care Workforce			
Section 5403 *Inter-disciplinary, community-based linkages*	The Secretary shall make 2 types of awards for Area Health Education Centers (AHECs): (1) infrastructure development to initiate health care workforce educational programs or continue comparable programs by planning, developing, and evaluating an AHEC program; (2) to maintain and improve effectiveness and capabilities of existing AHEC program and make modifications appropriate due to changes in demographics, needs of the population, or similar issues. Eligible entities are schools of medicine or osteopathic medicine, or a consortium or parent institution of such schools; where there is no AHEC, schools of nursing are eligible. Eligible entities shall use grant funds for the following required activities: • Develop and implement strategies to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds and support them in attaining such careers • Provide community-based training and education to individuals seeking careers in health professions within underserved areas, with an emphasis on primary care	Students will be recruited from rural areas. Eligible entities should emphasize primary care, benefiting rural areas. Underserved areas should include rural places.	FY 2010

Section	Provision	Rural Relevance	Effective
	• Prepare individuals to more effectively provide health services to underserved areas and health disparity populations • Conduct and participate in interdisciplinary training • Deliver or facilitate continuing education and information dissemination programs for health care professionals • Implement effective program and outcomes measurement and evaluation • Establish a youth public health program Eligible entities may use the grant award for any of the following innovative activities: • Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), behavioral and mental health facilities, and public departments • Coordinate community-based participatory research with academic health centers • Other strategies to address identified workforce needs At least 75% of funds must be allocated to AHECs. Awards of at least $250,000 annually will be made; funding of $125 million is authorized for each FY 2010 through 2014.	RHCs are among the entities specified in the law to help develop and implement innovative curricula, as are FQHCs.	
Section 5405 *Primary care extension program*	The purpose of this program is to support and assist primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques. Grants will be made to states for state- or multistate-level Primary Care Extension Program State Hubs; agencies in the hubs can include hospital associations, primary care practice-	Sites for this program could include rural practices. Rural practitioners may want to consider participation in practice-based research networks.	FY 2011

Section	Provision	Rural Relevance	Effective
	based research networks, and health professional societies. Primary Care Extension Agencies shall • Assist primary care providers to implement patient-centered medical homes and improve accessibility, quality, and efficiency of primary care services • Develop and support primary care learning communities • Participate in a national network of Hubs • Develop a plan for financial sustainability Program grants will be awarded to implement a Hub for 6 years; planning grants to develop a plan for a Hub will be awarded for 2 years. An appropriation of $120 million is authorized for each FY 2011 through 2012, as necessary for FY 2013 and 2014.		
Subtitle F: Strengthening Primary Care and Other Workforce Improvements			
Section 5501 *Expanding access to primary care services and general surgery services*	An additional 10% payment will be made to qualifying primary care providers for services specified below. The term *primary care practitioner* means an individual who • Is a physician with a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine or • Is a nurse practitioner, clinical nurse specialist, or physician assistant, and • For whom primary care services are at least 60% of the allowed charges in a prior period determined appropriate by the Secretary Primary care services are the following HCPCS codes: • 99201 through 99215 • 99304 through 99340 • 99341 through 99350 For surgical procedures furnished by a general surgeon in health professional shortage area, an additional 10% will be paid for specified services	This effort favors primary care providers, but the definition of services and minimum threshold values is likely to have different meaning in communities that are some distance from providers other than primary care. In those situations, primary care providers may not meet the 60% threshold, but nonetheless be the types of practices intended to benefit from this policy.	January 1, 2011

Section	Provision	Rural Relevance	Effective
	The additional payment will be made for surgical procedures for which the 10-day or 90-day global period is used for payment under the fee schedule.		
Section 5503 *Distribution of additional residency positions*	If a hospital's reference resident level is less than the limit, the limit shall be reduced by 65% of the difference between the limit and the reference level. The reduction based on unused positions does not apply to hospitals located in rural areas with fewer than 250 acute care beds. Hospitals that receive increases from redistribution must show that at least 75% of the positions are in primary care or general surgery. In redistributions, the Secretary shall take into account the likelihood of the hospital filling positions made available and whether the hospital has an accredited rural training track. The Secretary shall distribute the increase to hospitals based on the following priorities: • Location in a state with a resident-to-population ratio in the lowest quartile • Location that is among the top 10 states in the ratio of total population living in health professional shortage area-to-total population • Whether the hospital is located in a rural area	Redistribution of residency slots may benefit rural programs, given the priority that there be an accredited rural training track. The additional priority that the hospital accepting the slots be in a rural area is also helpful.	July 1, 2011
Section 5508 *Increasing teaching capacity*	Grants will be made for up to 3 years and up to $500,000. Funds may be used for costs of establishing or expanding a primary care residency program. Preference will be given to applications that document an affiliation with an Area Health Education Center program. Teaching health centers include community-based ambulatory patient care centers, primary care residencies, Federally Qualified Health Centers, community mental health centers, Rural Health Clinics, and Indian Health Service health centers.	Rural programs are specifically identified as potential grant recipients.	FY 2010

Section	Provision	Rural Relevance	Effective
	$25 million is authorized for FY 2010, $50 million each for 2011 and 2012, and then sums as necessary.		
Section 5509 *Graduate nurse education demonstration*	A demonstration project will provide payment to up to 5 hospitals for the reasonable costs of providing clinical training to advanced practice nurses. $50 million is authorized for FY 2012 through 2015. Training can occur in a non-hospital community-based care setting that includes Federally Qualified Health Centers and Rural Health Clinics.	Rural sites are included.	FY 2012
Subtitle G: Improving Access to Health Care Services			
Section 5601 *Spending for Federally Qualified Health Centers (FQHCs)*	Authorized for appropriation FY 2010: $2,988,821,592 FY 2011: $3,862,107,440 FY 2012: $4,990,553,440 FY 2013: $6,448,713,307 FY 2014: $7,332,924,155 FY 2015: $8,332,924,155 Subsequent years will be increased by the product of one plus the average percentage increase in costs incurred per patient served and one plus the average percentage increase in the total number of patients served.	The increased funding creates opportunities for expanding safety net services in rural areas.	FY 2010
Section 5602 *Negotiated rulemaking for development of methodology and criteria for designating medically underserved populations and health professions shortage areas*	The Secretary shall establish criteria for designation of medically underserved populations and health professions shortage areas. The Secretary shall consult with relevant stakeholders who will be significantly affected. The Secretary shall take into account the • Timely availability and appropriateness of data • Impact of the methodology and criteria on communities of various types and on health centers and other safety net providers • Degree of ease or difficulty that will face potential applicants for designations	Rural programs will be affected by any changes in criteria for designations.	Target date for publication is July 1, 2010

Section	Provision	Rural Relevance	Effective
	• Extent to which methodology accurately measures various barriers that confront individuals and groups seeking health care services		
Section 5603 *Reauthorization of the Wakefield Emergency Medical Services for Children Program*	The program is reauthorized through FY 2014 for expansion and improvement of emergency medical services for children who need treatment for trauma or critical care.	Rural places would be included in this program.	Upon enactment

TITLE VI: TRANSPARENCY AND PROGRAM INTEGRITY

Section	Provision	Rural Relevance	Effective
Subtitle A: Physician Ownership and Other Transparency			
Section 6001, as amended by Section 10601 and by Section 1106 of the Reconciliation Act *Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals*	Rural providers and hospitals qualify for the exception to the ownership or investment prohibition if • There was a provider agreement for physician ownership or investment on December 1, 2010 • The number of operating rooms, procedure rooms, and beds remains no more than the number when this section was enacted • The hospital submits a report containing a description of the identity of each physician owner or investor and other owners or investors and the nature of all ownership and investment interests in the hospital • A hospital that does not have a physician available on the premises at all hours discloses that to anyone being admitted and receives a signed acknowledgement that the patient understands • The hospital has the capacity to provide assessment and initiate treatment and refer and transfer patients to hospitals with the capability to treat the needs of patients involved Hospitals can apply for an exception to the prohibition on expansion of facility capacity if there is population growth warranting doing so and the state's average bed capacity is less than the national average bed capacity, and the average bed occupancy rate is greater than the average bed occupancy rate in the state in which the hospital is located.	The exception will benefit rural communities wherein access to care has been enhanced by rural physicians investing in rural hospitals. The prohibition will benefit rural communities wherein the financial viability of general service hospitals may have been threatened.	2011 Regulations by July 1, 2011
Section 6005 *Pharmacy benefit managers (PBMs) transparency requirements*	A health plan that provides pharmacy benefits management services on behalf of a health benefits plan in an exchange or through Medicare must report the following: • The percentage of all prescriptions that were provided through retail pharmacies as compared to mail order • The percentage of prescriptions for which a generic drug was available and dispensed, by pharmacy type • The aggregate amount and type of rebates, discounts,	Transparency for the activities of PBMs may create more equity across providers and payers.	

	or price concessions that the pharmacy benefits manager (PBM) negotiates that are attributable to patient utilization • The aggregate amount of difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies and mail order pharmacies, and the total number of prescriptions dispensed		
Section 6102 *Accountability requirements for skilled nursing facilities and nursing facilities*	Skilled nursing facilities and nursing facilities must have ethics programs that includes these components: • Compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations • Individuals within high-level personnel of the organization have been assigned overall responsibility to oversee compliance • Standards and procedures are communicated effectively to all employees and other agents	Rural facilities will be required to comply. Small rural facilities may need technical assistance.	December 31, 2011
Section 6114 *National demonstration on culture change in nursing homes and health information technology*	The Secretary shall conduct two demonstration projects, one for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement and one for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care. The demonstrations are for up to 3 years.	Rural sites could be included.	Within one year of date of enactment
Subtitle D: Patient-Centered Outcomes Research			
Section 6301 *Patient-Centered Outcomes Research*	The establishment of a Patient-Centered Outcomes Research Institute is authorized. For FY 2010 and each year thereafter, amounts in the Patient-Centered Outcomes Research Trust Fund shall be available without further appropriation to the Institute. The purpose of the Institute is to assist patients, clinicians, purchasers, and policymakers in making informed health		FY 2010

	decisions by advancing the quality and relevance of evidence about disease, disorders, and other health conditions. Identified research priorities shall take into account disease incidence, prevalence, and burden; gaps in evidence in terms of clinical outcomes, practice variations and health disparities; potential for new evidence to improve patient health, well-being, and quality of care; effect on national expenditures; and relevance to patients and clinicians in making informed health decisions. The Institute shall enter contracts for management of funding and conduct of research in accordance with appropriate agencies and instrumentalities of the Federal government and appropriate academic research, private sector research, or study-conducting entities. The researcher/research entity must meet the requirements for compliance with methodological standards. Research publication must be consistent with findings or no further contracts with that researcher/organization will be entered into. The Institute shall ensure that there is a process for peer review of primary research. The Institute shall make research findings available to clinicians, patients, and the general public by 90 days after receipt of findings. The Institute's Board of Governors shall include the Director of the Agency for Healthcare Research and Quality (AHRQ), the Director of the National Institutes of Health (NIH), and 17 members appointed by the Comptroller General as follows: • 3 members representing patients and health care consumers • 5 members representing physicians and providers, including at least 1 surgeon, nurse, state-licensed integrative health care practitioner, and	This provision creates an opportunity to establish and implement an agenda for rural-relevant comparative effectiveness research.	

	representative of a hospital • 3 members representing private payers, at least 1 from insurance issuers and 1 from employers who self-insure • 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers • 1 member representing quality improvement or independent health service researchers • 2 members representing the Federal Government or the states, including at least 1 from a Federal health program or agency The Office of Communication and Knowledge Transfer at AHRQ, in consultation with NIH, shall broadly disseminate the research findings that are published by the Institute. AHRQ and NIH shall build capacity for comparative clinical effectiveness research through a grant program that provides for training of researchers in methods used to conduct such research, including systematic reviews of existing research and primary research such as clinical trials. For FY 2013, transfers from the Federal Hospital Insurance Trust fund and the Federal Supplementary Medical Insurance Trust Fund into the Patient-Centered Outcomes Research Trust Fund will be $1 multiplied by the average number of individuals entitled to benefits under Medicare part A, or enrolled under Medicare Part B; for FY 2014 through 2019, transfers will be $2 multiplied by the average number of individuals entitled to benefits under Medicare part A, or enrolled under Medicare Part B. Transfers after FY 2013 will be adjusted for increases in health care spending. Transfers to the trust fund through appropriations will be as follows: $10 million in FY 2010; $50 million in FY 2011; $150 million in FY 2012; and net revenue from the fees on health insurance and self-insured plans plus $150 million in FY 2013 – FY 2019.	Dissemination should include rural sites/providers.	

	A fee of $2 is established for each person covered by a health insurance policy and for self-insured plans.		September 30, 2012

TITLE VII: IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Section	Provision	Rural Relevance	Effective
Subtitle B: More Affordable Medicines for Children and Underserved Communities			
Section 7101 *Expanded participation in 340B program*	Critical access hospitals (CAHs) are added as entities eligible for the 340B program by exempting them from meeting the disproportionate share hospital criteria. CAHs must still meet all other 340(B) criteria. Rural referral centers and sole community hospitals with disproportionate share payments equal to or greater than 8% are added as eligible entities.	CAHs will be able to participate in the 340B program for discounts on outpatient medications. Cost savings are balanced by administrative expenses, especially for small CAHs without oncology programs.	January 1, 2010
Section 7102 *Improvements to 340B program integrity*	Manufacturers are required to offer covered drugs to covered entities for purchase at or below the applicable ceiling price if they make the drug available to any other purchaser at any price.	Rural providers, including CAHs, will benefit. Cost savings are balanced by administrative expenses, especially for small CAHs without oncology programs	January 1, 2010

TITLE VIII: CLASS ACT

Section	Provision	Rural Relevance	Effective
Section 8002 *Establishment of national voluntary insurance program for purchasing community living assistance services and support*	The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services. The Secretary shall develop 3 actuarially sound benefit plans as alternatives for designation as the CLASS Independent Benefit Plan. There is a 5 year vesting period for eligibility for benefits. The Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which an individual may be automatically enrolled in the CLASS program by an employer. An alternative enrollment process will be provided for persons who are self-employed, have more than 1 employer, or whose employer does not elect to participate in automatic enrollment. An individual may elect to waive enrollment at any time. A patient in a hospital or nursing facility, an intermediate care facility for mentally retarded, or an institution for mental diseases cannot enroll. The benefit is a cash benefit for home and community-based services.	Rural residents could benefit from this program.	January 1, 2011

TITLE IX: REVENUE PROVISIONS

Section	Provision	Rural Relevance	Effective
Subtitle A: Revenue Offset Provisions			
Section 9001, as amended by Section 1401 of the Reconciliation Act *Excise tax on high cost employer-sponsored health coverage*	A tax is imposed equal to 40% of the excess benefit, which is the aggregate of applicable employer-sponsored coverage of an employee for the month divided by an amount equal to 1/12 of the annual limitation. The dollar limit in 2018 is $10,200 for self-only coverage and $27,500 for coverage other than self-only coverage. The dollar amount is increased by $1,650 and $3,450 for a person who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines. There is a phase-down to the maximum value in the 17 states with the highest average cost during 2012 for employer-sponsored coverage: 120% for 2013, 110% for 2014, and 105% for 2015. Employees engaged in high-risk professions include law enforcement officers, employees in fire protection activities, out-of-hospital emergency medical care providers, construction, mining, agriculture, forestry, or fishing workers, or retirees from any of those professions.	Exceptions for high-risk professions will affect rural populations, to their benefit.	2018
Section 9007 *Additional requirements for charitable hospitals*	There are specific requirements for non-profit hospitals, including any facility required by a state to be licensed, registered, or similarly recognized as a hospital. If an organization operates more than 1 hospital, the provisions apply to each one separately. An organization must perform a community health needs assessment in one of two taxable years immediately preceding the current one and adopt an implementation strategy to meet the community health needs identified by the assessment. The assessment must take into account input from people representing broad interests of the community,	All rural hospitals are subject to this provision, including critical access hospitals. Community health needs assessments may benefit rural communities seeking to improve population health.	Taxable year beginning after date of enactment

	including persons in public health. An organization must have a financial assistance policy, including eligibility criteria and whether assistance includes free or discounted care, and a written policy to provide, without discrimination, emergency care. An organization limits the amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance and prohibits the use of gross charges. An organization does not engage in extraordinary collection actions before a reasonable effort has been made to determine whether an individual is eligible for assistance under the financial assistance policy. If a hospital does not meet the conditions enumerated above in any taxable year, a $50,000 tax is imposed. Tax exempt status is reviewed at least once every 3 years.		
Section 9016 *Modification of Section 833: Treatment of certain health organizations*	Blue Cross or Blue Shield or other nonprofit organizations that provide health insurance are required to reimburse at least 85% of the cost of clinical services provided to enrollees to be eligible for special tax benefits currently provided.	In some states this provision may increase coverage from nonprofit health plans, which could increase collections for rural providers.	Taxable year starting after December 31, 2009
Subtitle B: Other Provisions			
Section 9022 *Establishment of simple cafeteria plans for small businesses*	Eligible employers are those with 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.	This creates another insurance option for employees of small business in rural areas.	Insurance year beginning on or after December 31, 2010

TITLE X: STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Section	Provision	Rural Relevance	Effective
Subtitle B: Provisions Relating to Title II			
Section 10202 *Incentives for states to offer home and community-based services as a long-term care alternative to nursing homes*	This section creates an incentive payments program to increase Federal Medical Assistance Percentages for states that offer home and community-based services as an alternative to nursing homes. States in which less than 50% of the total expenditures for medical assistance for long-term services and supports are for non-institutionally based long-term care services and supports can apply for a change to the Medicaid plan for purposes of participating in this incentive program. A state will achieve threshold percentages of 25% or 50% of spending for long-term care being for home and community-based services.	States could use the incentive match to create more service options in rural areas.	FY 2012
Subtitle C: Provisions Relating to Title III			
Section 10302 *Revision to national strategy for quality improvement in health care*	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. Measures shall include, to the extent determined appropriate, • Outcome measurement for acute and chronic diseases, including, to the extent feasible, the 5 most prevalent and resource-intensive conditions • Outcome measurement for primary and preventative care, including, to the extent feasible, measurements that cover provision of such care for distinct patient populations (such as healthy children, chronically ill adults, infirm elderly individuals) The Secretary shall seek to address issues regarding risk adjustment, accountability, and sample size; include the full scope of services that comprise a cycle of care; and include multiple dimensions.	As with other initiatives to develop measures of quality, attention should be given to developing and using measures most appropriate to the care environment in rural areas.	Develop not less than 10 measures within 36 months of enactment
Section 10303	The Secretary shall develop and periodically update (at least every 3 years) provider-level outcome measures for	As with other initiatives to develop measures of quality, attention should be given to developing and using measures	

Section	Provision	Rural Relevance	Effective
Development of outcome measures *Amends Section 3013*	hospitals and physicians, as well as other providers as determined appropriate by the Secretary. Measures shall include, to the extent determined appropriate, • Outcome measurement for acute and chronic diseases, including, to the extent feasible, the 5 most prevalent and resource-intensive conditions • Outcome measurement for primary and preventative care, including, to the extent feasible, measurements that cover provision of such care for distinct patient populations (such as healthy children, chronically ill adults, infirm elderly individuals) The Secretary shall seek to address issues regarding risk adjustment, accountability, and sample size; include the full scope of services that comprise a cycle of care; and include multiple dimensions.	most appropriate to the care environment in rural areas.	
Section 10323 *Medicare coverage for individuals exposed to environmental health hazards*	Persons exposed to environmental health hazards are deemed eligible for Medicare coverage. The Secretary shall establish a pilot program for care of persons residing in emergency declaration areas. The Secretary shall establish a program for early detection of medical conditions related to environmental health hazards. Appropriations as necessary for FY 2012-FY 2019.	These provisions will be helpful to rural persons exposed to environmental health hazards.	FY 2012
Section10324 *Protections for frontier states*	Floors are established on the area wage index for hospitals in frontier states, on the area wage adjustment factor for hospital outpatient department services in frontier states, and on the practice expense index for services furnished in frontier states. A frontier state is defined as a state in which at least 50% of the counties in the state are frontier counties, meaning the population per square mile is less than 6.	Prospective payment hospitals in certain states will benefit from this provision.	October 1, 2010

Section	Provision	Rural Relevance	Effective
Section 10326 *Pilot testing pay-for-performance programs for certain Medicare providers*	The Secretary will conduct pilot programs for certain hospitals (psychiatric, long-term care, rehabilitation, PPS-exempt cancer) and hospice programs to test implementation of a value-based purchasing program.	Hospice programs in rural places will be eligible for this pilot program.	January 1, 2016
Section 10327 *Improvements to the physician quality reporting system*	An additional incentive payment of 0.5 percentage points is authorized under the physician quality reporting system, 2011 through 2014. To qualify, a physician must submit data on quality measures for a year and have data submitted on his or her behalf through a Maintenance of Certification Program. The Medicare Advantage Regional Plan Stabilization Fund is eliminated.	Rural physicians qualify for this incentive payment.	2011
Section 10329 *Developing methodology to assess health plan value*	The Secretary is required to develop methodology to measure health plan value that takes into consideration, where applicable, the following: • Overall cost to enrollees under the plan • Quality of the care provided for under the plan • Relative risk of the plan's enrollees as compared to other plans • Actuarial value or other comparative measure of the benefits covered under the plan • Other factors as determined by the Secretary	Plans enrolling rural beneficiaries will need to report costs and quality, and actuarial value.	Report not later than 18 months after enactment
Section 10331 *Public reporting of performance information*	Not later than 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. By January 1, 2013, the Secretary shall make publicly available through Physician Compare information on	Information reported by rural physicians to Physician Compare will become publicly available.	January 1, 2011, for developing a website January 1, 2013, for making

Section	Provision	Rural Relevance	Effective
	physician performance that provides comparable information, which shall include • Measures collected under the Physician Quality Reporting Initiative • Assessment of patient health outcomes and functional status of patients • Assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use • Assessment of efficiency • Assessment of patient experience and patient, caregiver, and family engagement • Assessment of the safety, effectiveness, and timeliness of care By January 1, 2019, the Secretary may establish a demonstration program to provide financial incentives to beneficiaries served by high quality physicians.		information publicly available
Section 10333 *Community-based collaborative care networks*	The Secretary may award grants to establish community-based collaborative care networks. Grants to eligible entities may be used to support community-based collaborative care networks for low-income populations. A network is a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive and integrated health care services for low-income populations. A network must include a hospital and all Federally Qualified Health Centers located in the community. Priority will be given to networks that include the capability to provide the broadest range of services to low-income individuals, the broadest range of providers that currently serve a high volume of low-income individuals, and a county or municipal department of health.	Grants should be available to rural providers seeking to form integrated care networks. Rural networks should include any Rural Health Clinics in the community.	FY 2011

Section	Provision	Rural Relevance	Effective
	Such sums as necessary are authorized for appropriation, FY 2011 through FY 2015.		
Subtitle D: Provisions Relating to Title IV			
Section 10412 *Automated Defibrillation in Adam's Memory Act*	Appropriations for grants for public access defibrillation programs are reauthorized.	Funds will be available for improving public access to defibrillation devices in rural places.	Upon enactment
Subtitle E: Provisions Relating to Title V			
Section 10501 *Amendments to the Public Health Service Act, the Social Security Act, and Title V of this Act*	<u>Family Nurse Practitioner Training Program</u> The Secretary will establish a training demonstration program for family nurse practitioners to employ and provide 1-year training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in Federally Qualified Health Centers and nurse-managed health clinics (NMHCs). The demonstration grants are 3-year grants to FQHCs or NMHCs. Priorities for the grants are entities that • Demonstrate sufficient infrastructure to undertake requisite training of a minimum of 3 nurse practitioners per year and to provide to each awardee 12 full months of full-time, paid employment • Will assign not less than 1 staff nurse practitioner or physician to each of 4 precepted clinics • Will provide to each awardee specialty rotations, including prenatal care and women's health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas • Provide sessions on high-volume, high-risk health problems and have a record of training healthcare professionals in the care of children, older adults, and underserved populations	Nurse practitioners are in important source of primary care in rural America.	FY 2011

Section	Provision	Rural Relevance	Effective
	• Collaborate with other safety net providers, schools, colleges, and universities that provide health professions training Grants are up to $600,000 each per year; authorization is FY 2011 through 2014. The Secretary shall develop a Medicare prospective payment system for FQHCs. FQHCs must submit data and evaluation by January 1, 2011. <u>Rural Physician Training Grants</u> The HRSA grant program must assist accredited medical schools in recruiting students most likely to practice medicine in underserved rural communities, provide rural-focused training and experience, and increase the number of recent graduates who practice in underserved rural communities. Priority for grants are entities that • Demonstrate a record of successfully training students who practice medicine in underserved rural communities • Demonstrate that an existing academic program produces a higher percentage of graduates who practice medicine in underserved rural communities • Demonstrate rural community institutional partnerships, through such mechanisms as matching or contributory funding, documented in-kind services for implementation, or existence of training partners with interprofessional expertise in community health center training locations or other similar facilities • Submit a plan for the long-term tracking of where the graduates of such an entity practice medicine An eligible entity must enroll at least 10 students per class year and develop criteria for admission to give priority to		

Section	Provision	Rural Relevance	Effective
	students who have originated from or lived for a period of 2 or more years in an underserved rural community and who express a commitment to practice medicine in an underserved rural community. The program must use a curricula that includes clinical rotations in underserved rural communities and coursework or training experiences focused on medical issues prevalent in underserved rural communities. <u>Preventive Medicine and Public Health Training Grant Program</u> Grants will be awarded to schools of public health or schools of medicine or osteopathic medicine; an accredited public or private nonprofit hospital; a state, local, or tribal health department; or a consortium of 2 more entities described above. $43 million is authorized for appropriation for FY 2011, and sums as necessary for each FY 2012 through 2015. Appropriations for public health workforce activities are reauthorized.		
Section 10503 *Community Health Centers and the National Health Service Corps Fund*	A Community Health Center (CHC) Fund will be established for expanded and sustained national investment in CHCs, and appropriations to the fund are authorized. Monies not otherwise appropriated to the CHC fund are authorized for appropriation and are appropriated for enhanced funding under section 330 of $700 million in FY 2011, growing to $2.9 billion in FY 2015. Transferred funds are authorized to provide enhanced funding for the National Health Service Corps at levels starting at $290 million in FY 2011 to $310 million in FY 2015.	Rural CHCs would be eligible for additional funding. These funds could facilitate more use of the National Health Service Corps in rural areas.	FY 2011 FY 2011

Section	Provision	Rural Relevance	Effective
Subtitle H: Provisions Relating to Title IX			
Section 10908 *Exclusion for assistance provided to participants in state student loan repayment programs for certain health professionals*	Payments under the National Health Service Corps Loan Repayment Program and other state loan repayment or forgiveness programs intended to increase availability of health care services in underserved or health professional shortage areas are excluded from an individual's gross income.	Newly trained professionals will find practicing in rural underserved areas more financially attractive.	Amounts received beginning taxable year ending December 31, 2008