Medicaid Payment and Delivery System Reform: Challenges and Opportunities for Rural Health Systems

Introduction

Medicaid is *a crucial source of health insurance coverage and provider payments for rural people, providers, and communities*. The program is growing dramatically, having nearly doubled in the percentage of people covered from 10.4% of the U.S. population in 2000[1] to 19.5% in 2014,[2] and is now the nation's largest public insurance provider. Medicaid is an important part of the fabric of insurance plans, providing otherwise unattainable health insurance coverage for low-income households that is essential for rural access to health care. In expansion states, Medicaid is shifting from an insurer of narrowly defined categories of people (e.g., low-income mothers and children, elderly and disabled Medicare beneficiaries) to an insurer that encompasses broadly defined populations (i.e., all those with incomes up to 138% of the Federal Poverty Level (FPL)). For providers, including hospitals, doctors, dentists, and a variety of institutional and community-based long-term services and supports, the Medicaid program is a key source of health care financing for the rural health system, and contributes significantly to local, rural economies by supporting the health care system and its workforce.

In addition to promoting significant growth in the number of people covered by Medicaid, the Patient Protection and Affordable Care Act of 2010 (ACA) has accelerated the pace of noteworthy Medicaid financing and delivery system reform initiatives. The use of new payment and delivery system models like shared savings programs (including Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs), and health homes) is a significant departure from the way providers have traditionally been paid. In response, rural providers and health systems are considering new delivery system models.

In its previous work on the rural implications of delivery system reform, the RUPRI Health Panel identified five key components ("pillars") of high performance rural health systems: (1)affordability, as systems work to reduce the total cost of care, (2) accessibility, as reflected in improving access to services across the continuum, including health maintenance and wellness,(3) community focus, as a reflection of the development and use of community-based resources and social services, (4) high quality of care, as evident in both individual and population quality metrics, and(5) patient-centeredness and patient engagement. These five pillars are the foundation for building rural health systems with the capacity to respond effectively to the evolving design of state Medicaid programs.

This paper identifies and discusses important rural considerations of changes in the design of state Medicaid programs and their adoption of new approaches to provider payments. The paper examines

[1] Mills RJ. Health Insurance Coverage: 2000. Current Population Reports, U.S. Census Bureau. Issued September 2001. P60-215. https://www.census.gov/prod/2001pubs/p60-215.pdf.

[2] Smith JC, Medalia C. Health Insurance Coverage in the United States: 2014. Current Population Reports, U.S. Census Bureau. Issued September 2015. P60-253. https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf.

these changes through a lens focused on the implications of different models and approaches for rural Medicaid beneficiaries, and for the capacity required to sustain the five pillars of high performing rural health delivery systems. We begin by reviewing the current Medicaid landscape, followed by a synopsis of Medicaid payment and delivery system reform models, and a brief summary of waivers and other tools available to the states. After a review of the different models and mechanisms for change that state Medicaid programs are using to reform service organization and delivery, we offer a set of recommendations for federal and state policymakers, and rural providers and communities.

Background

By the numbers: enrollment and expenditures

As of January 2016, roughly 72.4 million people were enrolled in Medicaid across the U.S., a change of 27% since the third quarter of 2013, shortly before the ACA's first open enrollment period.[3] Rural populations tend to be older, poorer, and sicker (compared to their urban counterparts)[4] and have less access to employer-sponsored insurance plans than in urban regions.[5,6] As a consequence, a higher proportion of rural people are potentially eligible for Medicaid. Indeed, as of 2014, 22% of rural residents were enrolled in Medicaid while 20% were enrolled in Medicare, signifying that Medicaid has surpassed Medicare as the largest source of public health coverage in rural areas, and second in coverage only to employer-sponsored insurance plans.[7]

Medicaid has grown in its importance to rural areas by virtue of Medicaid expansions, and thus its influence as a driver of delivery system reform that achieve the goals of a high performance system has also grown. The ACA, as written, required states to expand Medicaid to cover all persons under 65 years of age adults with incomes of up to 138% (133 percent plus an income offset of five percent) of the federal poverty level.[8] A 2012 Supreme Court decision ruled that the federal government cannot withhold existing Medicaid funds from states that decline to expand the program (making expansion voluntary),[9] and as a result there are 19 states that have decided not to expand Medicaid as of April 2016. Estimates are that 1.7 million people are in the 'coverage gap', meaning they are ineligible for both Medicaid and ACA subsidies.[10] Increasing the insured population in rural communities has the potential to close the coverage gap, improve health outcomes, and provide an infusion of financial resources into the rural health system.

This is complicated, however, by a lack of uniformity in the expansion of Medicaid. As of April 2016 there were 32 states that expanded Medicaid, and the growth in Medicaid enrollment in these states from July/September 2013 to January 2016 has been 36.7%. In the 19 states that have not expanded Medicaid, the growth has been only 10.6% (see Appendix 1, Table 1). States that have not expanded

[3] CMS, Medicaid & CHIP: January 2016 Monthly Applications, Eligibility Determinations and Enrollment Report, *April 13, 2016.*

[4] Rowland D, Lyons B. Triple jeopardy: rural, poor, and uninsured. *Health Serv Res*. 1989;23(6): p. 975-1004.

[5] Barker AR, et al. The uninsured: an analysis by age, income, and geography. Rural Policy Brief, 2014(2): 1-4.

[6] Bull C.N., et al. *Access and Issues of Equity in Remote/Rural Areas. The Journal of Rural Health*, 2001. 17(4): p. 356-359.

[7] RUPRI Center for Rural Health Policy Analysis, computations based on the March 2015 Current Population Survey.

[8] http://medicaid.gov/affordablecareact/provisions/eligibility.html

[9] https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8332.pdf

[10] http://www.cfra.org/sites/www.cfra.org/files/publications/Medicaid-Expansion-as-a-Rural-Issue-0514.pdf

Medicaid have, in general, a higher proportion of the population that is rural (18.6%) as compared to states that have expanded Medicaid (9.9%). Even within the two groups there is considerable variation in the rate of growth in Medicaid by state. This is in part because some states with high rural populations also have large metro areas (e.g., North Carolina, Tennessee).

Another view of the impact of changes in insurance coverage from the ACA can be seen in Appendix 1, Table 2, which is the change in health insurance coverage in non-metro and metro areas within expansion and non-expansion states over the 2013-2014 period. In states that did not expand Medicaid, the drop in overall coverage rates for people living in non-metro areas was lower (-2.7%) than it was in metro areas (-3.8%); in contrast, in Medicaid expansion states people living in non-metro areas saw a bigger drop in their uninsurance rate (-3.2%) as compared to those living in metro areas (-3.0%).

Finally, as a percentage of total state spending, Medicaid consumes a significant portion of state resources.[11] Across all states, Medicaid expenditures rose from 21.1% of total state expenditures in 2009 to 27.4% in 2014, with substantial variation across states (shown in Appendix 1, Table 3).

States design Medicaid programs

Since its inception, states have had discretion in the design of their Medicaid programs. While federal law sets minimum requirements that states must meet, states have flexibility above those levels to set eligibility, payment rates, and if desired a more comprehensive program by offering additional benefits. Over the years, the federal government has also allowed more flexibility in setting the state's Medicaid program structure through the 'waiver' process under sections 1115 and 1915 of the Social Security Act and section 1332 of the ACA.

Under the ACA, states have been simultaneously grappling with whether and how to implement eligibility expansions and finding new ways to organize and deliver Medicaid services. As state legislatures and governors have faced pressure to address rising Medicaid costs in an era of fiscal austerity, states are turning towards new methods of purchasing Medicaid services, including the use of managed care organizations (MCOs), accountable care organizations (ACOs), and value-based purchasing arrangements. Table 4 in Appendix 1 presents data on the role of the most developed of the alternative payment schemes: comprehensive MCOs. As shown, 59.7 percent of Medicaid recipients nationwide were enrolled in a comprehensive MCO in 2014, whereby all services to Medicaid beneficiaries were delivered under a health plan managed by an MCO that contracted directly with the state. The degree to which states have embarked on comprehensive MCO delivery as an alternative arrangement varies considerably, as Table 4 shows. For example, there are eleven states enrolling more than 80 percent of their Medicaid population in comprehensive managed care, yet at the other end of the spectrum there are eleven states enrolling less than 1 percent.

Efforts to reform the health care delivery system are gaining momentum among all payers, and Medicaid in particular given the significance of the program to an expanding population as well as to state budgets. While a significant proportion of spending occurs on behalf of Medicaid beneficiaries in

[11]http://www.nasbo.org/publications-data/state-expenditure-report/state-expenditure-report-fiscal-2013-2015-data.

need of Long Term Services and Supports (LTSS),[12] those populations are significantly different than others that receive services in the context of new Medicaid reform initiatives discussed herein; thus, the focus of this paper is on reforming delivery of and payment for services other than LTSS. The following section describes many of the payment and delivery system strategies that states are increasingly using to improve service delivery while slowing the growth of health care costs.

I. Medicaid Payment and Delivery System Reform Strategies

Just as Medicare is pursuing value-based payment reforms to drive quality and cost improvements in healthcare delivery from the federal level, Medicaid programs are employing a variety of alternate payment models and contracting mechanisms to drive improvements in care delivery, cost, and outcomes for Medicaid populations at the state level. Reforms of this kind may be implemented state-wide or in specific geographies. Some reforms, especially those linked to expanding eligibility to the limits provided in the ACA, are increasingly implemented as state-wide initiatives. Where possible, we have identified rural applications of the reforms discussed in this paper.

Given Medicaid's significant role in ensuring access to care for rural people, and its significance as a payer to rural providers, it is critical to understand the unique aspects of the rural context that make many health care delivery system reform strategies particularly challenging. For example, rural places are characterized by low population densities, making achieving efficiency and the measurement of care quality (both important components of a value-based payment system) difficult, regardless of payer. Furthermore, asking rural providers to take on financial risk-sharing in a low-volume environment may have catastrophic consequences, leading to providers not participating in contracts with certain payers, or closure if losses are high enough. For many rural providers, particularly Critical Access Hospitals (CAHs) and rural health clinics (RHCs), payment incentives are difficult to implement because of unique current payment methodologies (e.g., cost-based reimbursement, payment caps), which are intended to preserve the rural safety net, yet in a rapidly changing payment environment, can result in barriers to participation. Workforce shortages, too, are an enduring problem in many rural areas. This makes implementation of certain reform efforts that promote team-based, comprehensive, integrated, and coordinated care especially challenging, given the absence of providers of various types. Lastly, many rural health systems are centered around acute care hospitals with high fixed costs and low average daily census and which no longer fit the needs of contemporary rural communities given changes in how people use the health care system. New systems development requires changing the way care is organized and delivered, resulting in care that is less costly and focused on the types of services (such as preventive and primary care) that are truly beneficial to creating better health.

Despite these challenges, new Medicaid value-based payment models present an opportunity to re-examine and transform rural health services and delivery systems around a strengthened primary care system. Medicaid delivery system reform initiatives that promote community partnerships, that pay for services outside clinic walls, that reward individual providers or networks of providers who take steps to improve practice quality and efficiency across the care continuum, and that reward investment in

[12] Reaves EL, Musumeci M. Medicaid and Long-Term Services and Supports: A Primer. The Henry J. Kaiser Family Foundation. 2015. http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/. Accessed May 9, 2016.

infrastructure create the potential for enabling rural providers to be involved and adapt to new delivery paradigms. To fit the rural context, however, changes in Medicaid policies must recognize the unique circumstances and challenges rural providers face and accommodate these challenges with thoughtful policy action. For example, phasing the implementation of new models to allow rural providers to plan for and adjust to the new approaches, as well as providing resources or technical assistance for rural providers should all be considered as strategies to implement reform in rural areas.

Today, state Medicaid programs are using a variety of purchasing options to incentivize improved care coordination, and integration, quality, and cost control. This section describes key features of payment and delivery models, organized into three categories by how state Medicaid programs pay for services – Direct Payment to Providers, Payment to Managed Care Companies, and Waivers. We call attention to two compelling reasons to consider the role of Medicaid reform in achieving the high performing rural health care delivery system of the future:

1. Growth in the proportion of rural residents insured through state Medicaid programs, which in turn means Medicaid has a critical role in linking payment design to system improvement.
2. Widespread use of new approaches to Medicaid payment, including using private organizations such as managed care companies, in certain states and rural areas.

A. Provider Payment Systems

The following paradigms are characterized by state Medicaid programs contracting directly with service providers. Under many of these models, the providers are held accountable for the care provided to Medicaid beneficiaries either through risk-sharing agreements and/or performance standards.

- **Accountable Care Organizations (ACOs)**
  An ACO is a health care provider group (generally hospitals and/or physicians) that contracts with a payer (e.g., Medicare, Medicaid, commercial health insurers) to provide high clinical quality and positive patient experience at a reduced cost.[13] The provider group is responsible for the care of a defined patient population, managing both quality and cost of care through clinical and financial integration.[14] Quality is expected to improve across the care continuum, including acute care, post-acute care, long-term care, and behavioral and mental health care.[15] As such, this type of model can be an effective way to deliver a set of integrated services to Medicaid populations, including, but not limited to, physical, behavioral, dental, and long-term services and supports. Currently, 9 state Medicaid programs are utilizing ACO arrangements as either demonstration projects or as the payment arrangement for providers. Payment arrangements to ACOs vary, but generally continue

[13] MacKinney AC, Vaughn T, Zhu X, Mueller K, Ullrich F. "Accountable Care Organizations in Rural America". RUPRI Center for Rural Health Policy Analysis, Rural Policy Brief. Brief No. 2013-7. July 2013.
[14] FAQ on Accountable Care Organizations. AAFP. http://www.aafp.org/practice-management/payment/acos/faq.html. Accessed February 18, 2016.
[15] "A Closer Look at ACOs". Families USA. January 2012. http://familiesusa.org/sites/default/files/product_documents/ACOs-Payment-and-Quality-Measurements.pdf. Accessed February 18, 2016.

using fee-for-service payment, with total expenditure targets as a basis for calculating shared savings. Adjustments are made based on meeting or exceeding quality metrics. Minnesota, for example, is implementing an ACO model through its Integrated Health Partnerships (IHP) demonstration for its Medical Assistance program (Medicaid), with 19 IHPs in place as of early 2016 encompassing nearly 350,000 Medicaid enrollees.[16] IHP demonstration participants are delivery systems that are implementing, and demonstrating, innovative approaches to payment and care designed to achieve higher quality and lower cost health care for patients enrolled in Minnesota's Medicaid program.[17]

- **Capitated Per Member Per Month (PMPM) or Global Payment Models**[18]
  Capitated PMPM and global payment models pay providers an upfront lump sum for the projected total cost of care for a population.[19] Payment arrangements may cover physical health services only, or services that are integrated, such as physical and behavioral health, dental services, and long-term services and patient support services. Medicaid beneficiaries under the Oregon Health Plan, for example, receive care from one of 16 local Coordinated Care Organizations (CCOs) which in turn receive a global payment for the provision of physical and behavioral health services, and sometimes dental care.[20] The global payment allows the CCO flexibility in how to provide care that is integrated and coordinated, with a focus on prevention and chronic condition management. The providers in the CCO network are accountable for the health outcomes of their population, and share financial responsibility and risk through a formal partnership.

- **Health Homes (HHs)**
  Health Homes are focused on the provision of integrated and coordinated care to Medicaid populations with chronic care needs. Under Section 2703 of the ACA, states may opt to provide Medicaid beneficiaries having two or more chronic conditions (including mental health, substance abuse, asthma, diabetes, heart disease, and being overweight) a Health Home benefit which consists of a provider or providers who integrate and coordinate all primary, acute, behavioral health, and even long term services and supports for this population.[21] Health Home services are expected to include comprehensive care management, care coordination, health promotion, transitional care and follow up, patient and family support, and referral to community and social support services. Currently, 19 state Medicaid programs have implemented health home payment programs that include rural providers. Health Homes are financed by a 90 percent enhanced Federal Medical Assistance Percentage (FMAP) for HH services (eight quarters only, with potential for extension) and

[16] Integrated Health Partnerships (IHP) Overview. Minnesota Department of Human Services. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441. Accessed February 23, 2016.
[17] Ibid.
[18] McGinnis T, Houston R. "An Overview of Emerging State Health Care Purchasing Trends". 2015 Medicaid Health Care Purchasing Compendium. National Governors Association (NGA).
[19] McGinnis T, Houston R. "An Overview of Emerging State Health Care Purchasing Trends". 2015 Medicaid Health Care Purchasing Compendium. National Governors Association (NGA).
[20] Oregon Health Policy Board. "Coordinated care: the Oregon difference". Oregon Health Authority. http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx. Accessed February 18, 2016.
[21] Medicaid.gov. Health Homes. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html. Accessed February 22, 2016.

payment from the states who implement the HH initiative, including PMPM fees, monthly case rates, and flat fee per enrollee per year.[22] Missouri, for example, has a Primary Care Health Home (PCHH) initiative based on a Patient-Centered Medical Home (PCMH) model that provides intensive care coordination and care management and addresses social determinants of health for a medically complex Medicaid population.[23]

- **Patient-Centered Medical Homes (PCMHs)**
  Like Health Homes, PCMHs launched by state Medicaid programs are designed to provide integrated and coordinated care for high-risk patients. Through a team-based approach to care, where clinicians and other health professionals work together to provide coordinated, comprehensive, and accessible services, Medicaid PCMHs deliver services that are designed to meet the specialized needs of low income populations. Financing mechanisms vary by state, but can include PMPM care management fees to perform coordination activities, linking payment to meeting standards of care (utilization, quality, patient satisfaction), up-front payments to practices to invest in PCMH transformation activities (e.g., patient registries, health information technology), and shared savings approaches.[24] Twenty-one states have implemented the PCMH model in rural areas. The PCMH model used in Arkansas is designed to be flexible, adapting to variation in the efficiency of state-wide primary care practices. It benefits providers that meet a targeted, risk-adjusted per member per year spending level regardless of spending reduction, and gives smaller, graduated rewards to less efficient practices that achieve spending reduction toward meeting a threshold for risk-adjusted per member per year expenditures.[25] Practices serving as a primary care provider for at least 300 Medicaid patients are eligible to enroll as a PCMH, and must participate in a primary care case management program. Medical home support payments in the form of a PMPM fee are made prospectively by Medicaid to facilitate, practice transformation to a medical home model.

- **Accountable Communities for Health (ACHs)**
  The premise of an ACH is that community-based, cross-sector coalitions can drive health system transformation, and consequently the health of a community, by extending the care coordination and service integration goals of the PCMH, HH, and ACO models to include community services and providers that address social, environmental, and other factors that impact individual and community health. Local organizations connected to, and complementary of, the contributions of others nearby can facilitate collaboration to address both clinical care and health-related social

[22] "Interim Report to Congress on the Medicaid Health Home State Plan Option". Department of Health and Human Service, Office of the Secretary. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/integrating-care/health-homes/downloads/medicaid-health-home-state-plan-option.pdf. Accessed February 22, 2016.
[23] MO HealthNet's Primary Care Health Home Initiative. Missouri Department of Social Services. http://dss.mo.gov/mhd/cs/health-homes/. Accessed February 22, 2016.
[24] Takach M. "About Half of the States Are Implementing Patient-Centered Medical Homes for their Medicaid Populations". *Health Affairs*, Nov. 2012 31(11):2432:40.
[25] Golden W, Thompson JW, Olson S, Hill R, Fendrick A.M., Mathis C, Chernew M. "Patient-Centered Medical Homes in Arkansas". *Health Affairs* Blog. May, 2014. http://healthaffairs.org/blog/2014/05/20/patient-centered-medical-homes-in-arkansas/. Accessed February 23, 2016.

needs, such as poor nutrition and inadequate housing.[26] ACHs address health from a community perspective and consider the total investment in health across all sectors.[27] This model has only recently been built into some state Medicaid programs, and is just being implemented as a demonstration project in the Medicare program. Minnesota is increasingly employing the ACH model for Medicaid populations through its Integrated Health Partnerships (IHPs). Southern Prairie Community Care (SPCC) in southwest Minnesota, for example, is a rural accountable community focused on integrated health and social service delivery to Medicaid populations in a 12 county region. SPCC is creating and supporting a strong primary care system built on Minnesota's Patient Centered Health Care Homes concept, which in turn is integrated and engaged with all county provided services and supports, with a strong emphasis on behavioral and mental health services.[28]

B. Prepaid Capitation Models

Under these types of models, state Medicaid programs contract with managed care companies rather than directly with providers. In use for decades for specific Medicaid populations or covered benefits (i.e., mental health services), these arrangements are becoming increasingly common as a way for states to deliver the entire range of Medicaid covered benefits at a predictable, contracted amount.

- **Managed Care Organizations (MCOs)**
  States that contract with Managed Care Organizations (MCOs) pay a capitated amount to deliver Medicaid health benefits and additional services, such as non-emergency medical transportation, expanded care coordination services, and health education classes, to beneficiaries with the objectives of reducing program costs and improving care quality.[29] In 37 states, contracts with MCOs are used for eligible Medicaid clients, regardless of rural/urban residence. Many states are using their contracts with MCOs to implement value-based delivery system reform initiatives, including those that align payment incentives with performance and those that are focused on improving care for complex patients (i.e., care coordination and integration across provider types and sectors). State Medicaid agencies are using some of the following strategies in the pursuit of value driven payment in their MCO contracts: requiring MCOs to adopt a specific value-based payment model developed by Medicaid or other purchasers (Minnesota and Tennessee); requiring MCOs to make a percentage of payment to providers tied to approved value-based payment arrangements (Arizona, Pennsylvania, and South Carolina); requiring MCOs to move toward implementation of more sophisticated value-based purchasing approaches over the contract life (New York); requiring MCOs to actively participate in a multi-payer value-based payment alignment initiative (Tennessee); and requiring MCOs to launch value-based pilot projects approved by the state (New Mexico,

[26] "Building the Foundation for Regional Health Improvement: Evaluating Washington's Accountable Communities of Health". Center for Community Health and Evaluation. Washington State Health Care Authority. January 2016. http://www.hca.wa.gov/hw/Documents/ach_evalreport_year_1.pdf. Accessed February 23, 2016.
[27] Tipirneni R, Vickery KD, Ehlinger EP. "Accountable Communities for Health: Moving From Providing Accountable Care to Creating Health". *Annals of Family Medicine*, July/August 2015, 13(4):367-369.
[28] About SPCC. Southern Prairie Community Care. http://www.southernprairie.org/?page=about_us_spcc. Accessed April 11, 2016.
[29] Medicaid.gov. Managed Care. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html. Accessed February 18, 2016.

Minnesota).[30] More than 59% percent of all Medicaid enrollees are served through comprehensive managed care delivery systems.[31]

- **Primary Care Case Management (PCCMs) programs**
  PCCM programs are a type of managed care that link Medicaid beneficiaries to primary care providers who are typically paid fee-for-service plus a PMPM fee for case management services.[32] Care management activities in early PCCM plans were somewhat limited, such as providing authorization for emergency room visits or care with specialists, but states are increasingly developing and implementing enhanced PCCM services that include more intensive care management and coordination activities for high-need beneficiaries and disease management programs.

C. Waivers

In addition to the delivery system reform models discussed above, CMS encourages continuous innovation through other means such as waivers and through projects sponsored by the Center for Medicare and Medicaid Innovation (CMMI). Furthermore, CMS is providing states technical support for Medicaid innovation in order to accelerate new payment and delivery system reforms. The vehicles by which states may pursue innovative solutions and obtain technical support are discussed below.

- **§ 1115 Waivers.**
  Under Section 1115 of the Social Security Act, states can apply to participate in experimental demonstrations with a waiver from the Centers for Medicare and Medicaid Services. The goal of such waiver programs is to provide increased access to care, expand eligibility, or design alternative delivery system models, without increasing costs to the Medicaid program.[33] If a waiver application is approved by CMS, a state may engage in a new demonstration for an initial five-year period with optional three-year extensions.[34] Twenty-eight states have used the § 1115 waiver to implement some aspect of the Medicaid program.[35] Although § 1115 waivers have been used to expand services to additional populations, they have also been used recently to test new program models as

[30] Leddy T, McGinnis T, Howe G. "Value-Based Payments I Medicaid Managed Care: An Overview of State Approaches". Center for Health Care Strategies, Inc. Brief, February 2016.
[31] Medicaid Managed Care Enrollment and Program Characteristics, 2013. Mathematica Policy Research. Winter 2015 (revised). https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-managed-care-enrollment-report.pdf.
[32] Verdier JM, Byrd V, Stone C. Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States. Center for Health Care Strategies, Inc. September, 2009.
[33] 42 CFR Part 431(I)(a)(1)
[34] Medicaid.gov; Section 1115 Demonstrations. Retrieved February 18, 2016, from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html
[35] Medicaid.gov. (n.d.). Demonstrations & Waivers. Retrieved April 06, 2016, from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html

part of Medicaid expansions.[36] Under § 1115 waivers, states also receive payment from CMS through Delivery System Reform Incentive Payments (DSRIPs). These payments are tied to performance in the context of both process improvements and outcome improvements.[37] In Kansas, for example, hospitals receiving DSRIPs are required to implement system reforms that align with improvement in individual care, population health, and cost containment.[38] With the use of DSRIPs, states are able to engage in delivery system reform while pursuing CMS's goals of value-based purchasing.

- **§ 1332 Waivers.**
  Established by Section 1332 of the ACA, these waivers are intended to offer states a broad exemption from many provisions of the ACA, beginning in January, 2017.[39] In return, states must utilize the waiver to create new delivery or insurance systems.[40] If states choose to employ § 1332 waivers, they must do so in pursuit of the aims of the ACA. The purpose of the waiver is to allow states to choose the methods for achieving the goals of increased coverage, affordability, comprehensiveness, and deficit neutrality.[41] Currently Rhode Island, California, Hawaii, Minnesota, New Mexico, and Arkansas have expressed interest in the § 1332 waiver.[42] Each of these states is considering the § 1332 waiver for different reasons. For example, Minnesota is hoping to more thoroughly align its marketplace with the Medicaid program, while Hawaii is hoping to bolster its statewide employer mandate.[43]

- **§ 1915(b) Waivers.**
  Waivers under Section 1915(b) of the Social Security Act are also known as Managed Care Waivers. As with the § 1115 waivers, use of § 1915(b) waivers precedes the implementation of the Affordable

[36] Rudowitz, R., & Musumeci, M. (2015, November 20). The ACA and Medicaid Expansion Waivers – Issue Brief – 8551-04. Retrieved February 21, 2016, from http://kff.org/report-section/the-aca-and-medicaid-expansion-waivers-issue-brief/

[37] Gates, A., Rudowitz, R., & Guyer, J. (2014, September 29). An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers. Retrieved February 29, 2016, from http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/

[38] Kancare. (n.d.). Delivery System Reform Incentive Payment (DSRIP) Pool. Retrieved April 06, 2016, from http://www.kancare.ks.gov/download/Delivery_System_Reform_Incentive_Payment_Overview.pdf

[39] Howard, H., & Benshoof, G. (2014, December 05). Section 1332 Waivers And The Future Of State Health Reform. Retrieved February 19, 2016, from http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/

[40] Howard, H., & Benshoof, G. (2014, December 05). Section 1332 Waivers And The Future Of State Health Reform. Retrieved February 19, 2016, from http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/

[41] 45 CFR Part 155, Waivers for State Innovation: Guidance

[42] Howard, H., & Benshoof, G. (2015, June 24). Section 1332 Waiver Activity Heating Up In States (Update: New CMS Hub). Retrieved February 23, 2016, from http://healthaffairs.org/blog/2015/06/24/section-1332-waiver-activity-heating-up-in-states/

[43] National Governors Association. (2015). Medicaid Health Care Purchasing Compendium - nga.org. Retrieved February 22, 2016, from http://www.nga.org/files/live/sites/NGA/files/pdf/2016/1601NGAMedicaidCompendium.pdf

Care Act. There are four ways to use a § 1915(b) waiver in implementing Medicaid managed care.[44] This waiver can be used to implement a delivery system that will limit the types of providers a Medicaid beneficiary can see, allow local governments to assist beneficiaries in choosing providers, redirect program savings to provide additional services to beneficiaries, or restrict how many or which providers can provide Medicaid services. These waivers are distinct from § 1115 or § 1332 waivers in that they apply only to the already existing Medicaid population in a state and do not provide for expansion of services to the currently uninsured population.[45]

- **SIM Models**
  The State Innovation Model (SIM) is a federal initiative sponsored by CMMI to provide grants to states to build and implement innovative multi-payer payment and delivery systems.[46] The design of state innovation models stress the importance of flexible systems that support state-specific populations, geographic areas (including rural, providers and healthcare organizations), and transformation readiness.[47] The SIM initiative encourages grantees to lower costs associated with Medicaid, Medicare, and CHIP, improve patient care by convening public and private stakeholders, improve the health information technology infrastructure of the state, and develop a comprehensive plan specific to the state's population. For example, Minnesota is using its SIM grant award to implement and test both health homes and Medicaid ACOs.[48] Their Accountable Health Model strives to fill gaps in the healthcare continuum and tests the state's comprehensive program encompassing health information, quality improvement, and workforce capacity. There are currently 38 SIM awardees, including 34 states, three territories, and the District of Columbia.[49]

- **Medicaid Innovation Accelerator Program (IAP)**
  The Medicaid Innovation Accelerator Program is a technical assistance program launched by CMS in 2014 to accelerate delivery and payment reform.[50] As an additional resource to states, the IAP emphasizes program priority areas and provides support for states that want to pursue additional action in select areas. As of March 2016, these priority areas include physical and mental health

[44]Medicaid.gov. (2016). 1915(b) Managed Care Waivers. Retrieved March 28,2016 from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/managed-care-1915-b-waivers.html

[45]McCarthy, R. & Schafermeyer, K. (2007). Introduction to Health Care Delivery, A Primer for Pharmacists, Fourth Edition, page 475.

[46] Van Vleet A, Paradise J. The State Innovation Models (SIM) Program: An Overview. 2014. The Kaiser Family Foundation.http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/. Accessed February 9, 2016.

[47] The State Innovation Models (SIM) Program: A look at Round 2 Grantees. 2015. http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-a-look-at-round-2-grantees/. Accessed February 9, 2016.

[48]Patient-Centered Primary Care Collaborative. CMS State Innovation Model (SIM) Test Award – Minnesota. www.pcpcc.org/initiative/cms-state-innovation-model-sim-test-award-minnesota. Accessed March 3, 2016.

[49] State Innovation Models Initiative: General Information. Centers for Medicare & Medicaid Services. CMS.gov. https://innovation.cms.gov/initiatives/state-innovations/. Accessed April 11, 2016.

[50] Medicaid Innovation Accelerator Program (IAP). Medicaid.gov. https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/innovation-accelerator-program.html. Accessed March 2, 2016.

integration, community integration of long-term services and supports, Medicaid beneficiaries with complex needs and high costs, and Medicare and Medicaid data integration program support.[51]

Appendix 2 contains a state-by-state summary of delivery system models and contracting arrangements in use as of April 1 2016.

The Opportunities and Challenges for Rural Health Systems of Medicaid Delivery System and Payment Reform Models

There are a number of assumptions that must be met for new payment and delivery system models to be not only viable, but effective and efficient, in rural health systems. As alluded to previously, first there must be sufficient patient volume to support shared savings and/or shared risk payment models. Volume is also essential to support valid quality measurement, a central component of many shared savings arrangements. Second, rural systems must have the health workforce needed to support integrated care models (e.g., behavioral health) and with the skills needed to assume the new roles of care integrators, care coordinators, case managers, and social workers that are integral to PCMH/Health Homes, and ACO models. Third, rural providers and systems need to have health information technology capabilities in place (e.g., electronic medical records, telehealth, health information exchanges), and the staff competent in their use, to communicate and use information to support more efficient, higher quality, and patient-centered care processes. These assumptions, which are tied to the capacity and infrastructure of rural health systems, make achieving delivery system reform objectives in rural communities particularly challenging. Thus, multiple federal and state policy strategies will be needed to enable rural health systems to make the transition. Payment policy, for example, will be a critical determinant of whether rural providers participate in system reform. Payment policies implemented at the national level can enhance Medicaid reform policies at the state level by "clearing the way" and creating incentives for practice and system transformation. State-level policies, on the other hand, can encourage a broader state-wide focus on population health by connecting Medicaid to other important and impactful state level resources, like human and social support services and public health.

More broadly, however, if provider participation in these changing delivery systems is to be encouraged, policies that promote reform must strike a balance between incentivizing change and limiting the adverse effects and unintended consequences of these changes on rural providers. While innovation through various Medicaid payment and delivery models is welcome (as an effort to provide higher quality care at lower cost to the system), states must recognize the burden to providers of responding to multiple value based payment systems. States have a tremendous opportunity to support innovative reform while limiting the effect of its intricacies by having policies that stress uniformity in the definition of value and its indicators, consistency in the methods and styles of reporting, and common elements across performance payment methodologies that affect delivery systems. Excessive complexity in Medicaid payment and delivery could inhibit rural provider participation in the program and ultimately reduce access, affordability and quality for rural Medicaid beneficiaries.

[51] Innovation Accelerator Program News and Activity. Medicaid.gov. https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/news-and-activity/news-and-activity.html. Accessed March 9th, 2016.

Policy Recommendations: Shaping Medicaid Payment and Delivery System Reforms to Support Rural Health System Transformation

As we have noted in the context of Medicare delivery system reform,[52] the transition in payment policies from volume to value is already producing widespread delivery system changes. The momentum and direction for reform in state Medicaid programs is similar, as evidenced by rapid adoption of new payment and delivery arrangements.

The policy recommendations that follow are organized into two themes that affect the five pillars of high performance rural health systems: those that promote and enhance integrated and comprehensive care, and those that facilitate rural health systems' ability to participate in value-based payment arrangements with Medicaid.

I. Policy Recommendations Supporting Integrated and Comprehensive Care Delivery

Expansion of Medicaid alternative payment models should be designed to enable rural health delivery systems to move toward the Panel's framework for high performing rural health systems. The following recommendations emphasize building accountable systems for Medicaid populations that result in improved community health through better care integration based on a strengthened primary care platform and a stronger capacity and infrastructure to deliver comprehensive, integrated services.

1. Promote integrated and comprehensive primary care delivery.

A. Expand the development of integrated and comprehensive primary care.

Comprehensive primary care, as defined in the CMMI Comprehensive Primary Care (CPC) initiative launched in 2012, means primary care practices are able to deliver on five functions: access and continuity; planned care for chronic conditions and preventive care; risk-stratified care management; patient and caregiver engagement; and coordination of care across the medical neighborhood.[53] Start-up grants, cooperative agreements (i.e., funding from SIM awards), technical assistance programs (i.e., Practice Transformation Network under the Transforming Clinical Practice Initiative [TCPI] awarded by CMMI), and payment policies that support primary care practice transformation and expansion are necessary to meet the goals of patient-centered and comprehensive health care, delivered and coordinated by primary care providers. States play a critical role in these federally-funded programs defining project scopes, managing projects, and supporting successful innovations. Medicaid programs should actively participate in the new Comprehensive Primary Care Plus initiative (a five year model beginning

[52] Medicare Value-based Payment Reform: Priorities for Transforming Rural Health Systems. RUPRI Health Panel, Rural Policy Research Institute (RUPRI). November 2015. http://www.rupri.org/wp-content/uploads/FORHP-comments-km-DSR-PANEL-DOCUMENT_PRD_Review_112315.clean-4_sn-3.pdf.

[53] Taylor EF, Dale S, Peikes D, et al. Evaluation of the Comprehensive Primary Care Initiative: First Annual Report. Mathematica Policy Research. January 2015. https://innovation.cms.gov/files/reports/cpci-evalrpt1.pdf. Accessed April 27, 2016.

January, 2017 and which builds on the CPC initiative)[54] to expand value-based payment and consequently value-based care (such as care provided through a PCMH) to Medicaid enrollees. In Missouri, for example, federal start-up funding has successfully supported state efforts to develop PCMHs that address both the behavioral and physical health needs of the state's Medicaid population.[55]

B. Develop team-based care strategies.

Despite the increased need for primary care providers, primary care providers alone cannot significantly improve population health. Medicaid populations have greater needs related to social determinants of health than the general population. New strategies that add team-based care (including care coordinators, care navigators, health coaches, social workers) to the traditional office visit will be needed. In recognition of this, Medicaid should support community health worker training programs (in addition to support from CMMI's State Innovation Models) and Teaching Health Centers and Area Health Education Center programs that provide training and practice in interdisciplinary settings based in primary care. Programs that develop teamwork, such as TeamSTEPPS should be made widely available.

C. Support non-visit-based care strategies.

Payment that requires face-to-face patient visits limits cost-saving innovations. Medicaid programs should actively support demonstrations and or payment policy change that recognizes new health care visit alternatives such as group visits, email or other non-visual electronic communications, chat room management, telehealth consultations, and virtual office visits with primary care providers. Policies, such as capitated payment and patient satisfaction rewards, will be required to avoid over-utilization.

2. Promote integrated and comprehensive care across the health care continuum.

A. Integrate care across settings, emanating from a local base.

Medicaid should facilitate, through primary care providers, the integration of health-related care across the care continuum. Rural providers need demonstration programs and technical assistance to develop care integration models that encompass the full continuum of care across settings and over time. One illustration is coordinating prenatal services across settings that include clinical and social services. Similarly, services in the Early Periodic Screening Diagnosis and Treatment (EPSDT) program include social and clinical services that benefit from integration. Another is coordinating existing services meeting the needs of elderly beneficiaries (dual eligible) by coordinating service providers in multiple settings including skilled nursing, home health, and home- and community-based health and social services supports. Likewise,

[54] Comprehensive Primary Care Plus. Centers for Medicare & Medicaid Services. https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus. Accessed April 27, 2016.

[55] Missouri Foundation for Health, *In-Depth: Missouri Foundation for Health Helps Missouri Lead the Way with Patient Centered Medical Homes*. Accessed March 4, 2016. Retrieved from: https://www.mffh.org/content/873/patient-centered-medical-homes.aspx

models for expanding and integrating end-of-life services such as hospice are needed to achieve the goals of payment and delivery system reform.

B. Develop a new healthcare workforce to serve the continuum of care.

Payment and policies like those provided through State Innovation Model (SIM) grants should support the provision of comprehensive population health management to Medicaid beneficiaries. New expectations of lower cost and improved population health will require new healthcare professional types such as health coaches, community health workers, care coordinators, and community paramedics. Although developing the relationships to effectively utilize new healthcare professional types may be straightforward in rural areas, the additional cost (even if low) to already financially stressed rural providers may be challenging. Therefore, demonstrations and grants are necessary to fund new health care worker training programs and direct compensation until new payment systems (i.e., shared savings) recognize cost savings.

C. Design Medicaid network adequacy policies to ensure access to essential rural health care services.

Medicaid programs should ensure access to essential health services locally, including public and preventive health, emergency medical services, and primary care. Rehabilitative, dental care, and long-term services and supports may also be included. In rural areas, the full continuum of health care and human services may not always be local. When not, Medicaid policies should support alternative access options such as telehealth, rotating specialty services and providers, and service and data sharing agreements between local and distant providers to ensure coordinated access along the care continuum.

3. Promote accountability for the health of the Medicaid population in rural communities.

A. Support new governance models that align with new partnerships and the continuum of care.

Rural providers, and their communities, should be provided models and facilitation expertise to move toward new shared and collaborative decision-making arrangements that strengthen community-based systems of care. Traditional and siloed local governance models, such as separate hospital and public health boards, are not conducive to the new partnerships required under alternative payment models in rural places. Changing governance structures can be challenging, yet there are examples where the Medicaid program is a key force in driving these new arrangements. The counties and providers that comprise Southern Prairie Community Care (SPCC), for example, came together to form the first multi-county partnership in the Integrated Health Partnership (IHP) demonstration for its Medicaid population. SPCC is successfully integrating care across the continuum and across sectors by integrating health services with county-based services (including public health, human and social services, police, courts, treatment, and housing) in its 12-county collaboration under a joint powers organization with county commissioners from each of the 12 counties involved. Furthermore, in recognition of the need for commitment from multi-sector stakeholders to ensure the success of SPCC's mission and initiatives, a second complementary organization (Southern Prairie Center for Community Health Improvement) was formed to allow the stakeholders to play a role in the development and governance of Southern Prairie. These two organizations are linked by a charter agreement

that specifies the relationship between the organizations (SPCC and CCHI) and defines roles in furthering the Southern Prairie mission.[56]

B. Support the development and implementation of population health data management platforms and skills, health information exchanges, and electronic health records.

Managing the health of a population (or a "panel" of patients) requires managing and integrating multiple data sets to support population health improvement, including but not limited to social services and needs, clinical records, and administrative data such as claims. Furthermore, the ability to exchange information among providers of mental/behavioral health, dentistry, public health, and long-term/post-acute care is a fundamental requirement of integrated and comprehensive care delivery. Rural providers should be offered federal and state incentives through demonstration programs and payment systems to invest in (and use) population health management software, to adopt health information exchange systems and electronic health records that help integrate care providers, and the staff training and skills needed to effectively use this technology. Federal funding, for example, is available to states at a 90 percent matching rate for state expenditures on activities to promote health information exchange and encourage the adoption of certified electronic health record (EHR) technology by certain Medicaid providers.[57] States can help coordinate or consolidate multiple sources of support such as those from public health, social and human services, and economic development via USDA loans.

II. Facilitate Rural Participation in Value-based Payment and Delivery System Reforms

Rural providers will need to assess the financial implications (e.g., effects on ability to finance operations) of payment changes and new approaches to financial risk based on populations served. Aligning payment policies and incentives across all public and private payers is critical to achieving payment reform goals and reducing the administrative burden on rural providers. Following the emerging all-payer models of Maryland, Vermont, and other states, Medicaid policies should work in tandem with those of other payers to promote change. Payment strategies will need to expedite the transition to new payment systems without jeopardizing rural access to essential healthcare services.

The following policy recommendations focus on how rural participation in value-based payment systems may be facilitated.

1. Promote measures, reporting standards, and payment approaches relevant to rural providers.

[56]Introduction to Southern Prairie. http://c.ymcdn.com/sites/www.southernprairie.org/resource/resmgr/Docs/SPCC-Leave-Behind_%28006%29.pdf. Accessed April 11, 2016.

[57] Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers. Letter from CMS to State Medicaid Directors, February 29, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf. Accessed May 9, 2016.

A. Develop rural appropriate healthcare value measures.

Measures of healthcare value used by Medicaid should incorporate specific common indicators relevant to rural providers and endorsed by the National Quality Forum. Payment for healthcare value requires measurement of the various components of healthcare value—simplified within the framework of better care, better health, and smarter spending. Consistent, valid and reliable healthcare value measures will further develop and evolve. Measures pertinent to health care delivered by rural providers should recognize the statistical reliability challenge of low volume rural situations. The National Quality Forum has made significant progress toward identifying the issues and measures important to rural providers.[58] Sustained efforts are required to develop measures appropriate to rural settings.

B. Assist rural providers to implement performance measurement and reporting systems.

State Medicaid agencies and their contractors should develop rural-appropriate performance measurement and reporting tools, and technical assistance should be made universally available to rural providers. To receive value-based payment, healthcare providers must demonstrate the delivery of value-based care. This may be more challenging for rural providers with less experience collecting, measuring, and reporting performance data. To improve rural provider data gathering and reporting, Medicaid programs should align Medicaid performance measures with other payers and facilitate data acquisition and dissemination through health information exchanges. Arkansas, for example, is implementing quality metrics for its Medicaid program and is hoping to integrate clinical data into its metrics as it progresses in building comprehensive health information exchanges.[59]

C. Align and make transparent Medicaid managed care data and performance.

States with multiple managed care organizations and systems for payment and delivery should standardize data collection, reporting, outcome expectations, and payment for performance structures in order to reduce administrative burden for rural providers. As suggested previously, Medicaid encounter data from MCOs should be provided consistently and in a timely fashion to support efforts to monitor, manage, and improve population health.

2. Promote payment designs that recognize the nature and circumstances of rural providers and systems.

A. Recognize the challenge of low volumes in payment design.

New payment policies that shift financial risk to providers will prove especially challenging to rural providers with low patient volumes. Care coordination and fiscal management investments may not be recovered through a limited number of patient encounters. However, low volume rural providers should not, and many do not want, to be exempt from new value-based payment policies. Therefore, additional financial support through novel payment strategies may be

[58] National Quality Forum Rural Health Committee. (2015). Performance Measurement for Rural Low-Volume Providers. Final Report. Washington, DC: National Quality Forum.

[59] Golden W, Thompson JW, Olson S, Hill R, Fendrick A.M., Mathis C, Chernew M. "Patient-Centered Medical Homes in Arkansas". *Health Affairs* Blog. May, 2014. http://healthaffairs.org/blog/2014/05/20/patient-centered-medical-homes-in-arkansas/. Accessed March 4, 2016.

necessary to encourage continuous care delivery and fiscal management innovation without risking essential local services. For example, "tiered" payment design strategies that blend incentives for service and value while providing baseline payments necessary to sustain service delivery could be adopted. These payment designs recognize the importance of PMPM support to a primary care practice (based on patient mix), plus incentives for providing high-quality preventive and primary care (i.e., fee-for-service payments for primary care), and value-based payments that are incentives to meet desired outcomes (i.e., shared savings) which together can help create a system that promotes optimal care for Medicaid populations while covering fixed costs associated with sustaining a low-volume system. Additionally, to mitigate financial risk to providers, Medicaid programs should participate in multi-payer programs to increase the number of patients included in new provider payment systems and thus reduce financial risk attributable to low patient volumes. Medicaid programs also should actively participate in all-payer demonstrations such as the CMMI Comprehensive Primary Care Plus demonstration and the CMMI Regional Multi-Payer Prospective Budgets concept. Furthermore, new payment systems affecting rural providers who are necessary to maintain access to primary care services by local residents or underserved populations should hold those providers fiscally harmless during a transition to new payment systems.

B. Support new rural hospital configurations through payment policies.

Alternative rural hospital configuration proposals (such as the Rural Emergency Acute Care Hospital Act [S. 1648] proposed by Iowa Senator Grassley and Title IV of the Save Rural Hospitals Act [H.R. 3225] proposed by Representatives Graves of Missouri and Loebsack of Iowa) are designed to assist low volume rural hospitals prioritize essential rural health care services, but require multi-payer particpation for success. In Georgia, the Rural Hospital Stabilization Committee was formed to identify and address the needs of the rural hospital community and provide potential solutions, including regulations for rural free-standing emergency rooms and hub-and-spoke model pilots.[60] Under the hub-and-spoke pilot program, four regional hospitals (hubs) would direct patients to the facility providing the most appropriate care to help offset smaller rural hospitals (spokes) from having to offer specialized services. Medicaid programs should align payment policies (including managed care organization contracts) with new rural health care delivery configurations to ensure essential services access for Medicaid enrollees.

3. Provide technical assistance to rural providers during the Medicaid transition to value-based payment.

A. Provide technical assistance for transitions to value-based care.

Value-based care and management strategies (including population health management and financial risk management) will require new healthcare provider skills and infrastructure. To facilitate a smooth transition to value based care, health systems and providers should utilize health information technology and enrollment technology to provide improved care

[60] Rural Hospital Stabilization Committee. Georgia Department of Community Health. https://dch.georgia.gov/rural-hospital-stabilization-committee. Accessed April 13, 2016.

coordination, better tracking, and increased enrollee access. Since financing new or expanded technology can be a challenge for states and rural providers, we suggest the following:

i. Medicaid policies should should support federal grant programs (including Health Resources and Services Administration, CMMI, and Flex Program portfolios) providing technical assistance to rural providers ready to transition to new payment systems;
ii. Medicaid demonstration programs, such as those supported by SIM initiatives, should support transitions from volume-based to value-based payments, especially for providers who care for a disproportionate share of Medicaid patients;
iii. Medicaid programs should encourage use of Enhanced Funding for Eligibility and Enrollment Systems (90/10) to help support population health management and financial risk management technologies and staff training;[61]
iv. Medicaid programs should encourage use of the Medicaid Innovation Accelerator Program to support states in four function areas: Payment Modeling and Financial Simulations, Data Analytics, Performance Improvement, and Quality Measurement.[62]

B. ***Help identify and disseminate proven population health and financial risk management strategies.***

Population health management and financial risk management are relatively new strategies, especially for rural providers currently focused on volume-based payment and volume-based care. One strategy that can be used to monitor the health of a population and identify high cost areas of care involves analyzing Medicaid encounter data from state Medicaid MCOs. With requirements bolstered under the ACA, states have been obligated to submit Medicaid encounter data quarterly under federal law since 1999.[63] Some states, like Pennsylvania, have used these data to develop a strategy for creating a risk pool with enrollment of all state MCOs to cover particularly high cost cases.[64] States should work to find ways to utilize existing data sets in order to manage risk, monitor, and address population health. Further, research funds should prioritize development and testing of new population health and risk management strategies to ensure appropriateness for rural providers.

[61]Department of Health and Human Services, Center for Medicaid and CHIP services (2012).Medicaid and CHIP FAQs: Enhanced Funding for Eligibility and Enrollment Systems (90/10). Accessed April 11, 2016 from https://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-E-and-E-systems-90-10.pdf

[62] Medicaid.gov. (2016). IAP Functional Areas: Targeted Technical Support for State Medicaid Agencies. Accessed March 9, 2016 from https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/iap-functional-areas.html

[63]Byrd, Vivian; Nysenbaum, Jessica; Lipson, Debra (2013). Encounter Data Toolkit. Mathematica Policy Research. Accessed April 12, 2016 from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-encounter-data-toolkit.pdf

[64]Byrd, Vivian; Nysenbaum, Jessica; Lipson, Debra (2013). Encounter Data Toolkit. Mathematica Policy Research. Accessed April 12, 2016 from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-encounter-data-toolkit.pdf.

Summary

This paper considers the policy implications of Medicaid delivery system reform in the context of rural providers and patients. In acknowledging the unique needs of rural populations, it is important to recognize both the potentials and shortfalls of new delivery system models. For example, the post Affordable Care Act §1115 waiver system has recently been criticized as providing a method for decreasing benefits or imposing additional restrictions on access to the Medicaid program.[65] On the other hand, the §1115 program has been used to provide states with the flexibility to create new delivery systems like Oregon's Coordinated Care Organization model – an innovative approach to integrated and coordinated care. Furthermore, while both national and state level policymakers shape Medicaid reform, state-level policies have the potential to encourage a broader state-wide focus on population health by connecting Medicaid to other important and impactful state level resources, like human and social support services and public health. In implementing policies that promote delivery system reform, it is important to consider how certain models may be capable of either promoting access for rural populations or diminishing it.

[65] Watson, Sidney D. "Out of the Black Box into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion". *Yale Journal of Health Policy, Law, & Ethics.* 2015;15(1).

Appendix 1

Table 1. Medicaid enrollment by state, 2013-2016

State	Rural Population*	Uninsured Population*	July/September, 2013	January 2016	Growth	Expansion State?
NON-MEDICAID EXPANSION STATES						
OVERALL	**18.6%**	**18.5%**	**19,143,366**	**21,180,651**	**10.6%**	
Maine	61.3%	11.2%	--	--	--	No
Mississippi	50.7%	17.1%	637,229	698,977	9.7%	No
South Dakota	43.3%	11.3%	115,501	118,568	2.7%	No
Alabama	41.0%	13.6%	799,176	885,444	10.8%	No
Wyoming	35.2%	13.4%	67,518	64,130	-5.0%	No
North Carolina	33.9%	15.6%	1,595,952	1,941,209	21.6%	No
Oklahoma	33.8%	17.7%	790,051	789,536	-0.1%	No
South Carolina	33.7%	15.8%	889,744	939,344	5.6%	No
Tennessee	33.6%	13.9%	1,244,516	1,571,644	26.3%	No
Wisconsin	29.8%	9.1%	985,531	1,045,752	6.1%	No
Missouri	29.6%	13.0%	846,084	951,734	12.5%	No
Idaho	29.4%	16.2%	238,150	280,753	17.9%	No
Nebraska	26.9%	11.3%	244,600	231,355	-5.4%	No
Kansas	25.8%	12.3%	378,160	398,272	5.3%	No
Georgia	24.9%	18.8%	1,535,090	1,750,551	14.0%	No
Virginia	24.5%	12.3%	935,434	953,599	1.9%	No
Texas	15.3%	22.1%	4,441,605	4,679,156	5.3%	No
Utah	9.4%	14.0%	294,029	303,684	3.3%	No
Florida	8.8%	20.0%	3,104,996	3,576,943	15.2%	No
MEDICAID EXPANSION STATES						
OVERALL	**9.9%**	**14.4%**	**37,248,644**	**50,937,288**	**36.7%**	
Vermont	61.1%	7.2%	161,081	190,532	18.3%	Yes
West Virginia	51.3%	14.0%	354,544	548,197	54.6%	Yes
Montana	44.1%	16.5%	148,974	208,754	40.1%	Yes
Arkansas	43.8%	16.0%	556,851	850,426	52.7%	Yes
Kentucky	41.6%	14.3%	606,805	1,182,852	94.9%	Yes
North Dakota	40.1%	10.4%	69,980	89,639	28.1%	Yes
New Hampshire	39.7%	10.7%	127,082	186,603	46.8%	Yes
Iowa	36.0%	8.1%	493,515	605,467	22.7%	Yes
Alaska	34.0%	18.5%	121,867	135,967	11.6%	Yes
Indiana	27.6%	14.0%	1,120,674	1,443,494	28.8%	Yes
Louisiana	26.8%	16.6%	1,019,787	1,074,896	5.4%	Yes
Minnesota	26.7%	8.2%	873,040	1,068,706	22.4%	Yes

State	Rural Population*	Uninsured Population*	July/September, 2013	January 2016	Growth	Expansion State?
Michigan	25.4%	11.0%	1,912,009	2,339,419	22.4%	Yes
New Mexico	22.6%	18.6%	457,678	737,850	61.2%	Yes
Ohio	22.1%	11.0%	2,341,481	2,907,193	24.2%	Yes
Pennsylvania	21.3%	9.7%	2,386,046	2,754,296	15.4%	Yes
Oregon	19.0%	14.7%	626,356	1,040,426	66.1%	Yes
Delaware	16.7%	9.1%	223,324	243,750	9.1%	Yes
Washington	16.0%	14.0%	1,117,576	1,771,605	58.5%	Yes
Colorado	13.8%	14.1%	783,420	1,324,193	69.0%	Yes
Maryland	12.8%	10.2%	856,297	1,159,510	35.4%	Yes
New York	12.1%	10.7%	5,678,417	6,431,583	13.3%	Yes
Connecticut	12.0%	9.4%	--	756,725	--	Yes
Illinois	11.5%	12.7%	2,626,943	3,103,597	18.1%	Yes
Arizona	10.2%	17.1%	1,201,770	1,670,422	39.0%	Yes
Rhode Island	9.3%	11.6%	190,833	278,062	45.7%	Yes
Hawaii	8.1%	6.7%	288,357	340,949	18.2%	Yes
Massachusetts	8.0%	3.7%	1,296,359	1,662,800	28.3%	Yes
Nevada	5.8%	20.7%	332,560	600,854	80.7%	Yes
New Jersey	5.3%	13.2%	1,283,851	1,703,107	32.7%	Yes
California	5.0%	17.2%	7,755,381	12,259,866	58.1%	Yes
DC	0.0%	6.7%	235,786	265,548	12.6%	Yes

SOURCE: CMS, "Medicaid & CHIP: January 2016 Monthly Applications, Eligibility Determinations and Enrollment Report", April 13, 2016, https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/january-2016-enrollment-report.pdf.

Table 2. Change in health insurance coverage in non-metro and metro areas in non-expansion and expansion states, 2013-2014

	Non-Medicaid expansion states	Medicaid expansion states	Total
2013			
All areas	18.5%	13.2%	15.2%
Non-metro	17.3%	14.3%	15.7%
Metro	18.8%	13.0%	15.1%
2014			
All areas	14.9%	10.2%	12.0%
Non-metro	14.6%	11.2%	12.7%
Metro	15.0%	10.0%	11.9%
Change, 2013-2014			
All areas	-3.6%*	-3.0%*	-3.2%*
Non-metro	-2.7%*	-3.2%*	-3.0%*
Metro	-3.8%*	-3.0%*	-3.3%*

Table 3. State Medicaid spending as a percentage of total state expenditures, 2009 and 2014

	State Medicaid Expenditures as a Percent of Total State Expenditures	
	2009	2014
TOTAL, ALL STATES	**21.1%**	**27.4%**
Alabama	25.5%	21.0%
Alaska	7.5%	12.5%
Arizona	29.4%	31.7%
Arkansas	19.7%	21.5%
California	20.6%	29.7%
Colorado	14.1%	19.0%
Connecticut	20.9%	24.8%
Delaware	12.3%	18.0%
District of Columbia	NA	NA
Florida	26.2%	30.0%
Georgia	19.5%	21.8%
Hawaii	11.3%	15.8%
Idaho	22.8%	23.4%
Illinois	30.9%	27.4%
Indiana	21.8%	33.5%
Iowa	17.9%	19.8%
Kansas	17.4%	18.8%
Kentucky	22.9%	27.3%
Louisiana	24.0%	27.0%
Maine	29.9%	30.4%
Maryland	19.5%	24.6%
Massachusetts	17.7%	26.0%
Michigan	23.0%	27.4%
Minnesota	22.2%	30.8%
Mississippi	26.4%	26.3%
Missouri	32.4%	38.5%
Montana	15.2%	17.5%
Nebraska	17.6%	17.2%
Nevada	14.7%	24.4%
New Hampshire	26.5%	26.1%
New Jersey	20.7%	23.7%
New Mexico	20.5%	25.8%
New York	26.7%	39.4%
North Carolina	24.9%	27.6%

	State Medicaid Expenditures as a Percent of Total State Expenditures	
	2009	2014
North Dakota	14.1%	9.9%
Ohio	24.3%	32.0%
Oklahoma	18.5%	22.2%
Oregon	14.3%	21.1%
Pennsylvania	30.8%	34.3%
Rhode Island	25.8%	27.4%
South Carolina	23.0%	25.2%
South Dakota	21.7%	19.1%
Tennessee	25.4%	30.2%
Texas	7.5%	29.2%
Utah	14.6%	17.2%
Vermont	19.6%	29.1%
Virginia	15.2%	16.6%
Washington	21.4%	28.2%
West Virginia	11.9%	14.0%
Wisconsin	15.4%	16.7%
Wyoming	7.0%	7.2%

Sources:

2009: Medicaid and total state expenditures: https://www.nasbo.org/publications-data/state-expenditure-report/state-expenditure-report-2009-fiscal-2008-2010-data

2014: Total Medicaid expenditures: http://kff.org/medicaid/state-indicator/total-medicaid-spending/

2014: Total state expenditures: https://www.nasbo.org/publications-data/state-expenditure-report/state-expenditure-report-fiscal-2013-2015-data

Table 4. Share of Medicaid enrollees in comprehensive managed care, 2014

	Total Medicaid Enrollees	Medicaid Enrollment in Comprehensive Managed Care[1]	Percentage of Medicaid Enrollees in Comprehensive Managed Care
TOTALS[2]	**70,246,197**	**41,927,010**	**59.7%**
Alabama	1,054,941	161	0.02%
Alaska	132,556	0	0.0%
Arizona	1,548,325	1,317,463	85.1%
Arkansas	595,807	157	0.03%
California	11,522,853	7,816,026	67.8%
Colorado	1,079,699	66,010	6.1%
Connecticut	724,741	0	0.0%
Delaware	227,554	196,065	86.2%
District of Columbia	257,450	172,308	66.9%
Florida	3,531,945	2,659,044	75.3%
Georgia	1,961,085	1,345,813	68.6%
Hawaii	321,027	316,354	98.5%
Idaho	266,172	697	0.3%
Illinois	3,249,835	439,899	13.5%
Indiana	1,176,447	737,122	62.7%
Iowa	593,572	58,520	9.9%
Kansas	399,299	356,630	89.3%
Kentucky	1,209,552	1,081,673	89.4%
Louisiana	1,305,671	418,500	32.1%
Maine	262,334	0	0.0%
Maryland	1,309,260	1,084,552	82.8%
Massachusetts	1,878,120	803,049	42.8%
Michigan	3,871,806	1,832,240	47.3%
Minnesota	1,112,174	791,004	71.1%
Mississippi	699,153	155,124	22.2%
Missouri	825,974	389,051	47.1%
Montana	131,923	0	0.0%
Nebraska	242,578	183,561	75.7%
Nevada	533,734	360,195	67.5%
New Hampshire	142,315	121,161	85.1%
New Jersey	1,542,022	1,315,014	85.3%
New Mexico	727,214	580,224	79.8%
New York	5,845,589	4,290,973	73.4%
North Carolina	1,717,658	1,017	0.1%

	Total Medicaid Enrollees	Medicaid Enrollment in Comprehensive Managed Care[1]	Percentage of Medicaid Enrollees in Comprehensive Managed Care
North Dakota	79,031	11,806	14.9%
Ohio	2,796,017	2,028,249	72.5%
Oklahoma	826,434	126	0.02%
Oregon	1,051,645	828,989	78.8%
Pennsylvania	2,152,846	1,671,750	77.7%
Rhode Island	263,574	217,824	82.6%
South Carolina	1,089,973	720,736	66.1%
South Dakota	122,352	0	0.0%
Tennessee	1,288,631	1,288,631	100.0%
Texas	4,137,121	3,232,307	78.1%
Utah	287,754	201,356	70.0%
Vermont	188,337	79,735	42.3%
Virginia	961,843	645,985	67.2%
Washington	1,245,322	1,245,278	100.0%
West Virginia	486,839	203,288	41.8%
Wisconsin	1,199,773	661,286	55.1%
Wyoming	68,320	57	0.08%

SOURCE: CMS, Medicaid Managed Care Enrollment and Program Characteristics, 2014. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf

1. Medicaid Enrollment in Comprehensive Managed Care represents an unduplicated count of Medicaid beneficiaries enrolled in a managed care plan that provides comprehensive benefits (acute, primary care, specialty, and any other), as well as PACE programs. It excludes beneficiaries who are enrolled in a Financial Alignment Initiative Medicare-Medicaid Plan as their only form of managed care.

2. U.S. territories not included in U.S. totals.

Appendix 2

Table 1. State by state summary of Medicaid delivery system and contracting arrangements

		ACO		Health Homes		Medical Homes		Compre-hensive MCO	
	Pop % Rural	Year Started	Rural	Year Started	Rural	Year Started	Rural	Year Started	Rural
United States									
Alabama	40.96			2012	✓				
Alaska	33.98								
Arizona	10.19					2013	UNK	1982	✓
Arkansas	43.84					2013	✓		
California	5.05							2008	✓
Colorado	13.85	2011	✓			2011	✓	1983	✓
Connecticut	12.01					2012	✓		
Delaware	16.7							1996	✓
District of Columbia	0			2016	✓			1994	✓
Florida	8.84							2014	✓
Georgia	24.93							2006	✓
Hawaii	8.07							2013	✓
Idaho	29.42			2013	✓				
Illinois	11.51	2014	✓					1974	
Indiana	27.56							2008	✓
Iowa	35.98			2012	✓			2012	✓
Kansas	25.8			2014	✓			2013	✓
Kentucky	41.62							1997	✓
Louisiana	26.81					2012	✓	2012	✓
Maine	61.34	2014	✓	2013	✓	2010	✓		
Maryland	12.8			2013	✓	2010	✓	1997	✓
Massachusetts	8.03					2012	✓	1997	✓
Michigan	25.43			2014	✓	2012	✓	1997	✓
Minnesota	26.73	2013	✓			2008	✓	1995	✓
Mississippi	50.65							2011	✓
Missouri	29.56			2014	✓			1995	✓
Montana	44.11					2014	✓		
Nebraska	26.87					2014	✓	1995	✓
Nevada	5.8							1998	
New Hampshire	39.7							2013	✓
New Jersey	5.32	2015	✓	2014		2012	✓	2011	✓

		ACO		Health Homes		Medical Homes		Compre-hensive MCO	
	Pop % Rural	Year Started	Rural	Year Started	Rural	Year Started	Rural	Year Started	Rural
New Mexico	22.57			2016	✓	2013	✓	2010	✓
New York	12.13			2012	✓	2009	✓	1997	✓
North Carolina	33.91			2011	✓	1983	✓		
North Dakota	40.1							2014	✓
Ohio	22.08			2012	✓	2010	✓	2005	✓
Oklahoma	33.76			2015	✓	2008	✓		
Oregon	18.97	2012	✓			2009	✓	2012	✓
Pennsylvania	21.34							1997	✓
Rhode Island	9.27	2016	✓	2011	✓	2008	✓	2009	✓
South Carolina	33.67					2006	✓	1996	✓
South Dakota	43.35			2013	✓				
Tennessee	33.61							2002	✓
Texas	15.3							1993	✓
Utah	9.42	2013	✓					1982	✓
Vermont	61.1	2014	✓	2013	✓	2007	✓		
Virginia	24.55							2005	✓
Washington	15.95			2013	✓			2002	✓
West Virginia	51.28			2014	✓			1996	✓
Wisconsin	29.85			2012				1999	✓
Wyoming	35.24					2014	UNK		

Notes

Data are current as of April 1st, 2016 reflected in the following sources: the Health Homes and Medical Home information is drawn from the National Association of State Health Policy and the ACO information from the Center for Health Care Strategies; MCO data was found utilizing Kaiser Family Foundation's Medicaid MCO Enrollment data as of September 2015 as a base for states with Medicaid MCOs; Medicaid State profiles from Medicaid.gov were utilized to understand the MCO's geographic expansion. If the State's managed care was not indicated to have a statewide expansion, the State government website was utilized to find the information. In all cases, the United States Office of Department of Agriculture Economic Research Services Office, Office of Management and Budget metro county rural definitions data files were utilized to determine if a county was classified as nonmetro or metro.

County Based Health Homes including rural:

-Michigan: Manistee and Grand Traverse

-New Mexico: Curry

-Ohio: Adams and Scioto

-Vermont: Addison, Washington, Lamoille, Orange, Windham, Windsor, Bennington, Rutland, Essex, Orleans, and Caledonia

-Washington: Callam, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Island, San Juan, Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Stevens, Whitman

-West Virginia: Mercer and Raleigh

Sources

		ACO		Health Homes		Medical Homes		Compre-hensive MCO	
	Pop % Rural	Year Started	Rural	Year Started	Rural	Year Started	Rural	Year Started	Rural

Population Percent Rural: https://www.census.gov/geo/reference/ua/urban-rural-2010.html

Rural Definition: http://www.ers.usda.gov/datafiles/Rural_Definitions/StateLevel_Maps/(insertstateabreviation).pdf

ACO: http://www.chcs.org/media/ACO-Fact-Sheet-032116.pdf

Health Homes: http://www.nashp.org/state-delivery-system-payment-reform-map/
Michigan - http://www.nashp.org/state-delivery-system-payment-reform-map/
http://www.ers.usda.gov/datafiles/Rural_Definitions/StateLevel_Maps/MI.pdf
New Jersey - http://www.ers.usda.gov/datafiles/Rural_Definitions/StateLevel_Maps/NJ.pdf
New Mexico - http://www.nashp.org/state-delivery-system-payment-reform-map/
http://www.ers.usda.gov/datafiles/Rural_Definitions/StateLevel_Maps/NM.pdf
Ohio - http://www.nashp.org/state-delivery-system-payment-reform-map/
http://www.ers.usda.gov/datafiles/Rural_Definitions/StateLevel_Maps/OH.pdf
Vermont - https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/downloads/vt/vt-13-0071.pdf
Washington - https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/washington-spa.pdf
West Virginia - http://www.dhhr.wv.gov/bms/BMSPUB/Documents/WVHealthHomes_final.pdf
Wisconsin - https://aspe.hhs.gov/sites/default/files/pdf/137856/HHOption2-WI.pdf

Medical Homes: http://www.nashp.org/state-delivery-system-payment-reform-map/

MCO:
Kaiser: http://kff.org/other/state-indicator/total-medicaid-mco-enrollment/
Medicaid Profiles: https://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html
California http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf
Colorado: https://www.healthcolorado.net/Choose-a-Plan.shtml
Illinois: http://www.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf
Nevada: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/LTSS/MCE/MCE_NoDate.pdf
http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/MCO%20FAQ'S%20letterhead.pdf
Oregon: http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx
Pennsylvania: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_171248.pdf
South Carolina: https://www.scchoices.com/Documents/SC1/HealthPlanComparisonChartEnglish.PDF
Virginia: http://www.virginiamanagedcare.com/English/pdfs/CVA.pdf