Policy Brief   June 2016

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

Keith J. Mueller, PhD; Charles Alfero, MA; Andrew Coburn, PhD; Jennifer Lundblad, PhD, MBA; A. Clinton MacKinney, MD, MS; Timothy McBride, PhD; Guest Author, Paula Weigel, PhD

State Medicaid programs grew dramatically between 2000 and 2014, nearly doubling the percentage of people covered, from 10.4 percent of the U.S. population to 19.5 percent (roughly 72.4 million people), and, as a result of expansions under ACA, Medicaid is now the nation's largest public insurance provider. Medicaid enrollment has increased 27 percent since the third quarter of 2013, shortly before the ACA's first open enrollment period.[1] In rural areas, Medicaid provides essential, and otherwise unattainable, coverage for low-income households. For providers in rural areas, including hospitals, doctors, behavioral health providers, dentists, and a variety of institutional and community-based long-term services and supports (LTSS), the Medicaid program is a key source of financing and a significant contributor to local economies with an ever growing impact on local health care delivery system design.

Compared to their urban counterparts, rural populations tend to be older, poorer, and sicker and have less access to employer-sponsored insurance plans. Consequently, a higher proportion of rural people are potentially eligible for Medicaid. Indeed, as of 2014, 22 percent of rural residents were enrolled in Medicaid while 20 percent were enrolled in Medicare, signifying that Medicaid has surpassed Medicare as the largest source of public health coverage in rural areas, and is second in coverage only to employer-sponsored insurance plans. Finally, as a percentage of total state spending, Medicaid consumes a significant portion of state resources, 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.

Thus, Medicaid and its associated state variations in payments and delivery incentives, has grown significantly in its importance. Its influence in determining the conditions impacting a high-performance system has also grown. The federal government supports flexibility in state Medicaid program structures through waivers under sections 1115 and 1915 of the Social Security Act and section 1332 of the ACA.

RUPRI offers the following recommendations related to Medicaid programming moving forward. They are discussed in detail in a companion paper.

1. **Promote integrated and comprehensive primary care delivery.**

   A. *Expand the development of integrated and comprehensive primary care.*
      Start-up grants, cooperative agreements (i.e., funding from State Innovation Model awards), technical assistance programs (i.e., Practice Transformation Network under the Transforming Clinical Practice Initiative awarded by CMMI), and payment policies that support primary care practice transformation and expansion are necessary to meet the goals of patient-centered and

---

[1]Centers for Medicare & Medicaid Services. *Medicaid & CHIP: January 2016 Monthly Applications, Eligibility Determinations and Enrollment Report*, *April 13.* Baltimore, MD: Centers for Medicare & Medicaid Services, Department of Health and Human Services; 2016.

comprehensive health care, delivered and coordinated by primary care providers. In these federally funded programs, states play a critical role in defining project scopes, managing projects, and supporting successful innovations.

B. ***Develop team-based care strategies.***
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 SIM) and Teaching Health Centers and Area Health Education Center programs that provide training and practice in interdisciplinary settings based in primary care.

C. ***Support non-visit-based care strategies.***
Medicaid programs should actively support demonstrations and or payment policy changes that recognize new health care visit alternatives such as group visits, email or other nonvisual electronic communications, chat room management, telehealth consultations, and virtual office visits with primary care providers.

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

A. ***Integrate care across settings.***
 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, for example, coordinating prenatal services across settings that include clinical and social services.

B. ***Develop a new healthcare workforce to serve the continuum of care.***
Although developing the relationships to effectively utilize new health care 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 to fund new health care worker training programs and direct compensation are needed to help transition rural providers until new payment systems produce cost savings (e.g., shared savings).

C. ***Design Medicaid network adequacy policies to ensure access to essential rural health care services.***
When such services are not available locally, 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 given models and facilitation expertise to move toward new shared and collaborative decision-making arrangements that strengthen community-based systems of care. Changing governance structures can be challenging, yet

there are examples where the Medicaid program is a key force in driving these new arrangements.

> B. ***Support the development and implementation of population health data management platforms and skills, health information exchanges, and electronic health records.***
> 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 (EHRs) that help integrate care providers, and to offer the staff training and skill development needed to effectively use this technology.

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

> A. ***Develop rural appropriate health care value measures.***
> Measures of health care value used by Medicaid should incorporate specific common indicators relevant to rural providers and endorsed by the National Quality Forum. Measures pertinent to health care delivered by rural providers should recognize the statistical reliability challenge of low-volume rural situations.

> 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. Medicaid programs should align Medicaid performance measures with other payers and facilitate data acquisition and dissemination through health information exchanges.

> 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.

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

> A. ***Recognize the challenge of low volumes in payment design.***
> Additional financial support through novel payment strategies may be 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.

> 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 in prioritizing essential rural health care services, but require multipayer participation for success.

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

    A. *Provide technical assistance for transitions to value-based care.*
        i.   Medicaid policies should align with federal grant programs (e.g. Health Resources and Services Administration and CMMI) providing technical assistance to rural providers ready to transition to new payment systems.
        ii. 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.[2]
        iii. 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.[3]

    B. *Help identify and disseminate proven population health and financial risk-management strategies.*
        States should work to find ways to utilize existing data sets to manage risk and to 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.

In summary, this brief, and companion paper, considers the policy implications of Medicaid delivery system reform in the context of rural providers and patients. While acknowledging the unique needs of rural populations, it is also important to recognize both the potentials and shortfalls of new delivery system models. While both national and state policymakers shape Medicaid reform, state-level policies have the potential to encourage a broader statewide 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.

---

[2] Centers for Medicare & Medicaid Services. *Medicaid and CHIP FAQs: Enhanced Funding for Eligibility and Enrollment Systems (90/10).* Baltimore, MD: Center for Medicare and CHIP Services. Centers for Medicare & Medicaid Services, Department of Health and Human Services; 2012. Available at: 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.

[3] IAP Functional Areas: Targeted Technical Support for State Medicaid Agencies. Medicaid.gov Web site. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/iap-functional-areas.html.