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

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Executive Summary

Medicaid has grown significantly in its importance to rural health systems and communities; a higher proportion (22 percent) of rural residents was enrolled in Medicaid than Medicare (20 percent) in 2014. At the same time, the use of payment and delivery innovations has grown significantly, but varies across the U.S. As a result of expansions under ACA, Medicaid programs are crucial and growing sources of health insurance coverage and provider payments. For providers in rural areas, including hospitals, doctors, dentists, behavioral health providers, and a variety of institutional and community-based long-term services and supports (LTSS), Medicaid programs are key sources of financing and significant contributors to local economies. As Medicaid programs have grown, partly as a result of federal policy (including the ACA), new payment and delivery system models like shared savings programs (including accountable care organizations [ACOs], patient-centered medical homes [PCMHs], and health homes [HHs]) are being developed that depart significantly from the way providers have traditionally been paid. In this paper, the RUPRI Health Panel examines the implications of changes in the design of state Medicaid programs and in their adoption of new approaches to provider payments for rural Medicaid beneficiaries, and on the capacity required to build and sustain high performing rural health systems. The Panel offers the following recommendations which are discussed in detail in the full document.

1. Promote integrated and comprehensive primary care delivery.

Federal and state payment and delivery policies should encourage investments in the development of comprehensive primary care, including team-based care strategies and non-visit-based payment arrangements.

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

Rural providers need demonstration and technical assistance programs (1) to develop care integration models that encompass the full continuum of care, (2) to fund new health care worker training programs and provider payments to help rural providers transition financially to new shared savings payment and related arrangements, and (3) to ensure rural access to essential services through the development of telehealth and other initiatives.

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

New community partnerships among rural providers and community organizations representing the full continuum of care, together with corresponding governance models that align interests and responsibilities within these partnerships, are needed to enable rural providers and communities transition to accountable care arrangements. To support these partnerships and their care management functionality, the Panel recommends demonstrations, technical assistance, and/or payment incentives to support the development and use of population health data management platforms and skills, health information exchanges, and electronic health records.

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

   Measures of health care value used by Medicaid programs should incorporate specific common indicators relevant to rural providers and endorsed by the National Quality Forum. 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. 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.**

   Financial support through novel payment strategies may be necessary to encourage continuous care delivery and fiscal management innovation without risking access to essential local services. Medicaid programs should align payment policies (including managed care organization contracts) with new rural health delivery configurations to ensure essential services access for Medicaid enrollees.

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

   State Medicaid agencies should take advantage of demonstration, technical assistance, and other funding opportunities to facilitate shifts to new payment and delivery models for rural providers and health systems: 1) State Innovation Model (SIM) initiatives to support transitions from volume-based to value-based payments, especially for providers who care for a disproportionate share of Medicaid patients; 2) Enhanced Funding for Eligibility and Enrollment Systems (90/10) to support population health management and financial risk-management technologies and staff training; and 3) Medicaid Innovation Accelerator Program to support four function areas: payment modeling and financial simulations, data analytics, performance improvement, and quality measurement. States should work to find ways to utilize existing data sets to help rural providers develop the capacity to manage risk and 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, it is important to recognize both the desirability and shortcomings of new delivery system models for rural patients and providers. 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 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.

Introduction

The Medicaid program is a crucial source of health insurance coverage and provider payments for rural communities. The program grew dramatically between 2000 and 2014, nearly doubling the percentage of people covered, from 10.4 percent of the U.S. population[1] to 19.5 percent,[2] and is now the nation's largest public insurance provider. In rural areas, Medicaid provides essential, and otherwise unattainable, health insurance coverage for low-income households. The Patient Protection and Affordable Care Act of 2010 (ACA) expanded health care coverage, in part through the Medicaid program. In states that chose to expand their Medicaid program, 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., those with incomes up to 138 percent of the Federal Poverty Level [FPL]). For providers in rural areas, including hospitals, doctors, 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.

In addition to promoting significant growth in the number of people covered by Medicaid, the ACA has accelerated the pace of noteworthy Medicaid financing and delivery system reform initiatives. New payment and delivery system models like shared savings programs (including accountable care organizations [ACOs], patient-centered medical homes [PCMHs], and health homes [HHs]) depart significantly from the way providers have traditionally been paid. In response to these changes, rural providers and health systems are considering new delivery system models.

Previous work by the RUPRI Health Panel on the rural implications of delivery system reform 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 care systems with the capacity to respond effectively to the evolving design of state Medicaid programs.

In this paper, we identify and discuss important rural considerations in changes to the design of state Medicaid programs and in their adoption of new approaches to provider payments. We examine these changes with a focus on the implications of different models and approaches for rural Medicaid beneficiaries, and on the capacity required to build and 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

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

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

state Medicaid programs are using, 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 United States, a 27 percent increase since the third quarter of 2013, shortly before the ACA's first open enrollment period.[3] Compared to their urban counterparts, rural populations tend to be older, poorer, and sicker[4] and have less access to employer-sponsored insurance plans.[5,6] 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.[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 has also grown. The ACA, as written, required states to expand Medicaid to cover all persons under 65 years of age with incomes of up to 138 percent (133 percent plus an income offset of 5 percent) of the FPL.[8] However, a 2012 Supreme Court decision ruled that the federal government could not withhold existing Medicaid funds from states that declined to expand the program (making expansion voluntary),[9] and as a result 19 states had decided not to expand Medicaid as of April 2016. An estimated 1.7 million people are in a "coverage gap" in these states, meaning they are ineligible both for Medicaid and for ACA subsidies to purchase coverage through a health insurance marketplace.[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.

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[3]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.
[4] Rowland D, Lyons B. Triple jeopardy: rural, poor, and uninsured*. Health Serv Res*. 1989;23(6): p. 975-1004.
[5] Barker AR, Londeree JK, McBride TD, Kemper, LM, Mueller K. *The Uninsured: An Analysis by Age, Income, and Geography.* Iowa City, IA: University of Iowa, RUPRI Center for Rural Health Policy Analysis; 2014. Rural Policy Brief 2014-2.
[6] Bull CN, Krout JA, Rathbone-McCuan E, Shreffler MJ. Access and issues of equity in remote/rural areas. *J Rural Health.* 2001;17(4):356-359.
[7] RUPRI Center for Rural Health Policy Analysis, computations based on the March 2015 Current Population Survey.
[8] Eligibility. Medicaid.gov Web site. Available at: http://medicaid.gov/affordablecareact/provisions/eligibility.html.
[9] The Henry J. Kaiser Family Foundation. A *Guide to the Supreme Court's Affordable Care Act Decision.* Menlo Park, CA: Henry J. Kaiser Family Foundation; 2012. Publication No. 8332. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8332.pdf.
[10] Bailey, JM. *Medicaid Expansion as a Rural Issue: Rural and Urban States and the Expansion Decision.* Lyons, NE: Center for Rural Affairs; 2013. Available at: http://www.cfra.org/sites/www.cfra.org/files/publications/Medicaid-Expansion-as-a-Rural-Issue-0514.pdf.

Doing so, however, is complicated by a lack of uniformity in the expansion of Medicaid. In the 32 states that had expanded Medicaid as of April 2016, Medicaid enrollment grew by 36.7 percent from July/September 2013 to January 2016. In contrast, Medicaid enrollment grew only 10.6 percent in the 19 states that had not expanded (Appendix 1, Table 1). States that have not expanded Medicaid have, on average, a higher proportion of the population that is rural (18.6 percent) than states that have expanded Medicaid (9.9 percent). Even within the expansion and non-expansion groups, the Medicaid growth rate varies considerably by state, in part because some states with proportionately larger rural populations also have large metropolitan areas (e.g., North Carolina, Tennessee).

The ACA also affected health insurance coverage in nonmetropolitan and metropolitan areas within Medicaid non-expansion and expansion states over the 2013-2014 period (Appendix 1, Table 2). In non-expansion states, the drop in uninsurance rates among the nonelderly living in nonmetropolitan areas was lower (-2.7 percent) than in metropolitan areas (-3.8 percent); in contrast, in expansion states, the drop in uninsurance rates was higher in nonmetropolitan areas (-3.2 percent) than in metropolitan areas (-3.0 percent).

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 percent of total state expenditures in 2009 to 27.4 percent in 2014, with substantial variation across states (Appendix 1, Table 3).

States design their Medicaid programs

Since its inception, states have had discretion in the design of their Medicaid programs. While states must meet minimum requirements set by federal law, they have flexibility above those levels to set eligibility requirements and payment rates, and may also offer a more comprehensive program that includes 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 grappling simultaneously with whether and how to implement eligibility expansions and with finding new ways to organize and deliver Medicaid services. With pressure to address rising Medicaid costs in an era of fiscal austerity, states are turning to new methods of purchasing Medicaid services, including the use of managed care organizations (MCOs), accountable care organizations (ACOs), and other value-based purchasing arrangements. Table 4 in Appendix 1 presents data on the role of the most developed of the alternative payment schemes—comprehensive Managed Care Organizations (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

[11]http://www.nasbo.org/publications-data/state-expenditure-report/state-expenditure-report-fiscal-2013-2015-data. National Association of State Budget Officers. *State Expenditure Report: Examining Fiscal 2013-2015 State Spending.* Washington, DC: National Association of State Budget Officers; 2015. Available at: http://www.nasbo.org/publications-data/state-expenditure-report/state-expenditure-report-fiscal-2013-2015-data.

considerably, as Table 4 shows. For example, 11 states enroll more than 80 percent of their Medicaid population in a comprehensive MCO, while another 11 states enroll less than one percent.

Efforts to reform the health care delivery system are gaining momentum among all payers and within the Medicaid program 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 need of LTSS,[12] those populations are significantly different from 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 Medicaid service delivery while slowing the growth of program costs.

Medicaid Payment and Delivery System Reform Strategies

Just as federal policymakers are pursuing value-based payment reforms to drive quality and cost improvements in health care delivery in the Medicare program, state policymakers are employing a variety of alternate payment models and contracting mechanisms to drive improvements in care delivery, cost, and outcomes in the Medicaid program. Such reforms may be implemented statewide or in specific geographic areas. Some reforms, especially those linked to expanding eligibility to the limits provided in the ACA, are increasingly implemented statewide. 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 to closure of health care facilities, if losses are high enough. For many rural providers, particularly Critical Access Hospitals and Rural Health Clinics, 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, making 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, which no longer fit the needs of contemporary rural communities given changes in how people use the health care system. Developing new systems requires changing the way care is

[12] Reaves EL, Musumeci M. *Medicaid and Long-Term Services and Supports: A Primer.* Menlo Park, CA: The Henry J. Kaiser Family Foundation; 2015. Publication No. 8617-02. Available at: http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

organized and delivered, resulting in care that is less costly and is focused on services (such as preventive and primary care) that truly create 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, pay for services outside clinic walls, reward individual providers or networks of providers who take steps to improve practice quality and efficiency across the care continuum, and reward investment in infrastructure may enable rural providers to be involved in 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 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, 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. Policymakers should consider the role of Medicaid reform in achieving the high-performing rural health care delivery system of the future for two compelling reasons:

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.

Provider Payment Systems

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

- **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-

[13] MacKinney AC, Vaughn T, Zhu X, Mueller K, Ullrich F. *Accountable Care Organizations in Rural America.* Iowa City, IA: University of Iowa, RUPRI Center for Rural Health Policy Analysis; 2013. Rural Policy Brief 2013-7.
[14] FAQ on Accountable Care Organizations. American Academy of Family Physicians Web site. Available at: http://www.aafp.org/practice-management/payment/acos/faq.html.

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 LTSS. Currently, nine state Medicaid programs utilize ACO arrangements as either demonstration projects or as the payment arrangement for providers. Payment arrangements to ACOs vary, but generally continue 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 up-front 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, 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)**
  HHs provide integrated and coordinated care to Medicaid populations with chronic care needs. Under Section 2703 of the ACA, states may opt to enroll Medicaid beneficiaries in a Health Home if they have two or more chronic conditions (including mental health, substance abuse, asthma, diabetes, heart disease, and being overweight). The HH consists of a provider or providers who integrate and coordinate all primary, acute, behavioral health, and even LTSS for this population.[21]

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[15] Gady M. A Closer Look at ACOs. Putting the Accountability in Accountable Care Organizations: Payment and Quality Measurements. New York: Families USA; 2012. Available at: http://familiesusa.org/sites/default/files/product_documents/ACOs-Payment-and-Quality-Measurements.pdf.

[16] Integrated Health Partnerships (IHP) Overview. Minnesota Department of Human Services Web site. Available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441.

[17] Ibid.

[18] McGinnis T, Houston R. *An Overview of Emerging State Health Care Purchasing Trends.* 2015 Medicaid Health Care Purchasing Compendium. Washington, DC: National Governors Association; 2016.

[19] Ibid.

[20] Coordinated care: the Oregon difference. Oregon Health Policy Board. Oregon.gov Web site. Available at: http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx.

[21] Health Homes. Medicaid.gov Web site. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html.

HH 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 HH payment programs that include rural providers. HHs are financed by a 90 percent enhanced Federal Medical Assistance Percentage (FMAP) for HH services (eight quarters only, with potential for extension) and 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 initiative based on a PCMH model that provides intensive care coordination and care management and addresses social determinants of health for a medically complex Medicaid population.[23]

- **PCMHs**
  Like HHs, PCMH initiatives 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 statewide primary care practices. Arkansas's PCMH 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

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[22] Department of Health and Human Services, Office of the Secretary. *Interim Report to Congress on the Medicaid Health Home State Plan Option*. Available at: 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.

[23] MO HealthNet Primary Care Health Home Initiative. Missouri Department of Social Services Web site. Available at: http://dss.mo.gov/mhd/cs/health-homes/.

[24] Takach M. About half of the states are implementing patient-centered medical homes for their Medicaid populations. *Health Affairs.* 2012;31(11):2432:-2440.

[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. Available at: http://healthaffairs.org/blog/2014/05/20/patient-centered-medical-homes-in-arkansas/.

community health. Local healthcare organizations connected to, and complementary of, the contributions of others nearby can facilitate collaboration to address both clinical care and health-related social 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 adopted by 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 ACH 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]

Managed Care Models

In use for decades for specific Medicaid populations or covered benefits (i.e., mental health services), managed care arrangements are becoming increasingly common as a way for states to deliver the entire range of Medicaid covered benefits at a predictable, contracted cost.

- **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.[29] 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.

- **Managed Care Organizations (MCOs)**
  States that contract with MCOs pay a capitated amount for delivery of Medicaid health benefits and additional services, such as nonemergency medical transportation, expanded care coordination services, and health education classes, with the objectives of reducing program costs and improving care quality.[30] In 37 states, MCO contracts are used for eligible Medicaid clients, regardless of rural/urban residence. Many states are using their MCO contracts to implement value-based delivery system reform initiatives, including those that align payment incentives with performance

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[26] Center for Community Health and Evaluation. *Building the Foundation for Regional Health Improvement: Evaluating Washington's Accountable Communities of Health*. Seattle, WA: Group Health Research Institute; 2016. Available at: http://www.hca.wa.gov/hw/Documents/ach_evalreport_year_1.pdf.

[27] Tipirneni R, Vickery KD, Ehlinger EP. Accountable Communities for Health: Moving from providing accountable care to creating health. *Annals of Family Medicine*. 2015;13(4):367-369.

[28] About SPCC. Southern Prairie Community Care Web site. Available at: http://www.southernprairie.org/?page=about_us_spcc.

[29] Verdier JM, Byrd V, Stone C. *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States.* Hamilton, NJ: Center for Health Care Strategies, Inc.; 2009.

[30] Managed Care. Medicaid.gov Web site. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html.

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 to pursue 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 link a percentage of provider payment 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 multipayer value-based payment alignment initiative (Tennessee); and requiring MCOs to launch value-based pilot projects approved by the state (New Mexico, Minnesota).[31] More than 59 percent of all Medicaid enrollees are served through comprehensive managed care delivery systems.[32]

Waivers

In addition to the delivery system reform models discussed above, the Centers for Medicare & Medicaid Services (CMS) encourages continuous innovation through other means, such as waivers, and through projects sponsored by the Center for Medicare & 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.

- **Section 1115 Waivers**
  Under section 1115 of the Social Security Act, states can apply to participate in experimental Medicaid demonstrations with a waiver from CMS. 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 CMS approves a waiver application, 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 section 1115 waiver to implement some aspect of the Medicaid program.[35] Although section 1115 waivers have been used to expand services to additional populations, they have also been used recently to test new program models as part of Medicaid expansions.[36] Under section 1115 waivers, states also receive payment from CMS through Delivery System Reform Incentive Payments (DSRIPs). These payments are tied to performance in the context

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[31] Leddy T, McGinnis T, Howe G. *Value-Based Payments I Medicaid Managed Care: An Overview of State Approaches.* Hamilton, NJ: Center for Health Care Strategies, Inc.; 2016.

[32] Centers for Medicare & Medicaid Services. *Medicaid Managed Care Enrollment and Program Characteristics, 2013.* Princeton, NJ: Mathematica Policy Research. Winter 2015 (revised). Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-managed-care-enrollment-report.pdf.

[33] 42 CFR Part 431(I)(a)(1)

[34] Section 1115 Demonstrations. Medicaid.gov Web site. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html.

[35] Demonstrations & Waivers. Medicaid.gov Web site. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html.

[36] Rudowitz R, Musumeci, M. *The ACA and Medicaid Expansion Waivers.* Menlo Park, CA: The Henry J. Kaiser Family Foundation; 2015. Issue Brief 8551-04. Available at: http://kff.org/report-section/the-aca-and-medicaid-expansion-waivers-issue-brief/.

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 undertake delivery system reform while pursuing CMS's goals of value-based purchasing.

- **Section 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 section 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 budget neutrality.[41] Currently, Rhode Island, California, Hawaii, Minnesota, New Mexico, and Arkansas have expressed interest in the section 1332 waiver.[42] Each of these states is considering the section 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]

- **Section 1915(b) Waivers**
  Waivers under section 1915(b) of the Social Security Act are also known as Managed Care Waivers. As with the section 1115 waivers, use of section 1915(b) waivers precedes ACA implementation. A Section 1915(b) waiver may be used in four ways to implement Medicaid managed care: (1) to implement a delivery system that will limit the types of providers a Medicaid beneficiary may see, (2) to allow local governments to assist beneficiaries in choosing providers, (3) to redirect program savings to provide additional services to beneficiaries, or (4) to restrict how many or which providers can provide Medicaid services. [44] These waivers are distinct from section 1115 or section 1332

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[37] Gates A, Rudowitz R, Guyer J. *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers.* Menlo Park, CA: The Henry J. Kaiser Family Foundation; 2014. Available at: http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/.
[38] Delivery System Reform Incentive Payment (DSRIP) Pool. KanCare.KS.gov Web site. Available at: http://www.kancare.ks.gov/download/Delivery_System_Reform_Incentive_Payment_Overview.pdf.
[39] Howard H, Benshoof G. Section 1332 waivers and the future of state health reform. *Health Affairs* Blog. December 2014. Available at: http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/.
[40] Ibid.
[41] 45 CFR Part 155, Waivers for State Innovation: Guidance.
[42] Howard H, Benshoof G. Section 1332 waiver activity heating up in states (Update: New CMS Hub). *Health Affairs* Blog. June 2015. Available at: http://healthaffairs.org/blog/2015/06/24/section-1332-waiver-activity-heating-up-in-states/.
[43] National Governors Association. *Medicaid Health Care Purchasing Compendium*. Washington, DC: National Governors Association; 2015. Available at: http://www.nga.org/files/live/sites/NGA/files/pdf/2016/1601NGAMedicaidCompendium.pdf.
[44] 1915(b) Managed Care Waivers. Medicaid.gov Web site. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/managed-care-1915-b-waivers.html.

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]

- **State Innovation Models (SIMs)**
  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 initiative stresses the importance of flexible systems that support state-specific populations, geographic areas (including rural), providers, health care organizations, and transformation readiness.[47] SIM encourages grantees to lower costs associated with Medicaid, Medicare, and CHIP; improve patient care by convening public and private stakeholders to enhance collaborative/collective efforts; improve the state's health information technology infrastructure; and develop a comprehensive plan specific to the state's population. For example, Minnesota is using its SIM award to implement and test both HHs and Medicaid ACOs.[48] Their approach is an ACH model that strives to fill gaps in the health care 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, 3 territories, and the District of Columbia.[49]

- **Medicaid Innovation Accelerator Program (IAP)**
  The Medicaid IAP 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 integration, community integration of LTSS, 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.

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[45] McCarthy R, Schafermeyer K. *Introduction to Health Care Delivery: A Primer for Pharmacists.* 4th ed. Burlington, MA: Jones & Bartlett Publishers; 200. Page 475.
[46] Van Vleet A, Paradise J. *The State Innovation Models (SIM) Program: An Overview.* Menlo Park, CA: The Kaiser Family Foundation; 2014. Available at: http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/.
[47] The Kaiser Commission on Medicaid and the Uninsured. *The State Innovation Models (SIM) Program: A look at Round 2 Grantees.* Menlo Park, CA: The Henry J. Kaiser Family Foundation; 2015. Available at: http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-a-look-at-round-2-grantees/.
[48] CMS State Innovation Model (SIM) Test Award – Minnesota. Patient-Centered Primary Care Collaborative Web site. Available at: www.pcpcc.org/initiative/cms-state-innovation-model-sim-test-award-minnesota.
[49] State Innovation Models Initiative: General Information. Centers for Medicare & Medicaid Services. CMS.gov Web site. Available at: https://innovation.cms.gov/initiatives/state-innovations/.
[50] Medicaid Innovation Accelerator Program (IAP). Medicaid.gov Web site. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/innovation-accelerator-program.html.
[51] Innovation Accelerator Program News and Activity. Medicaid.gov Web site. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/news-and-activity/news-and-activity.html.

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

A number of assumptions 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, there must first 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 the workforce must have the skills needed to assume the new roles of care integrators, care coordinators, case managers, and social workers that are integral to PCMHs/HHs, and ACOs. Third, rural providers and systems must 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 measurable 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. 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 statewide focus on population health by connecting Medicaid to other important state-level resources, such as human and social support services and public health.

More broadly, however, if provider participation in these changing delivery systems is to be encouraged, reform policies must strike a balance between incentivizing change and limiting the adverse effects and unintended consequences of these changes on rural providers. 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.

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

The transition in Medicare payment policies from volume to value is already producing widespread delivery system changes.[52] 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 under 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.

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 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 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. In these federally funded programs, states play a critical role in defining project scopes, managing projects, and supporting successful innovations. Medicaid programs should actively participate in the new CPC Plus initiative (a five-year model beginning January 2017 that builds

[52] RUPRI Health Panel. *Medicare Value-based Payment Reform: Priorities for Transforming Rural Health Systems.* Iowa City, IA: University of Iowa, Rural Policy Research Institute; 2015. Available at: 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.* Princeton, NJ: Mathematica Policy Research; 2015. Available at: https://innovation.cms.gov/files/reports/cpci-evalrpt1.pdf.

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. Participation should include special efforts to incorporate rural practices in ways that address challenges described earlier.

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 SIM) 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. Incentives should be used to encourage developing the local workforce in rural communities.

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 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. Payment policy changes are needed to sustain efforts that may have been started in rural places with grant funding.

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. Similarly, services in the Early Periodic Screening Diagnosis and Treatment program include social and clinical services that benefit from integration. The integration of behavioral health services into primary care has received considerable attention in recent years with multiple effective models. Care integration is also fostered by 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, models for expanding and integrating end-of-life services such as hospice are needed to achieve the goals of payment and delivery system reform.

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[54] Comprehensive Primary Care Plus. CMS.gov Web site. Available at: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus.

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

Payment and policies like those provided through SIM grants should support the provision of comprehensive, integrated care management services for Medicaid beneficiaries. New expectations of lower cost and improved population health will require new types of health professional such as health coaches, community health workers, care coordinators, and community paramedics. 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.

Medicaid programs should ensure access to essential health services locally, including public and preventive health, emergency medical services, and primary care. Rehabilitative care, dental care, and LTSS may also be included. In rural areas, the full continuum of health care and human services may not always be local. 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. 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 multicounty 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 multisector stakeholders to ensure the success of SPCC's mission and initiatives, a second, complementary organization (Southern Prairie Center for Community Health Improvement [CCHI]) 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.[55]

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, 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 (EHRs) that help integrate care providers, and to offer the staff training and skill development 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 EHR technology by certain Medicaid providers.[56] States can help coordinate or consolidate multiple sources of support such as those from public health, social and human services, and economic development via US Department of Agriculture (USDA) loans.

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 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 health care services.

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

[55] Southern Prairie Community Care. *Introduction to Southern Prairie.* Marshall, MN: Southern Prairie Community Care. Available at: http://c.ymcdn.com/sites/www.southernprairie.org/resource/resmgr/Docs/SPCC-Leave-Behind_%28006%29.pdf.

[56] *Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers.* Baltimore, MD: Department of Health and Human Services, Centers for Medicare & Medicaid Services; February 29, 2016. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf.

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. Payment for health care value requires measurement of the various components of health care value—simplified within the framework of better care, better health, and smarter spending. Consistent, valid, and reliable health care 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.[57] 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, health care providers must demonstrate the delivery of value-based care, which 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.[58]

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.

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.

New payment policies that shift financial risk to providers will prove especially challenging to

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

[58] 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. Available at: http://healthaffairs.org/blog/2014/05/20/patient-centered-medical-homes-in-arkansas/.

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 be, and many do not want to be, exempt from new value-based payment policies. Therefore, 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. Payment designs should incorporate incentives for providing high-quality preventive and primary care (i.e., fee-for-service payments for primary care) and value-based payments linked to desired outcomes. Such designs 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 in prioritizing essential rural health care services, but require multipayer participation 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.[59] Under the hub-and-spoke pilot program, four regional hospitals (hubs) would direct patients to the facility providing the most appropriate care, to help relieve 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.

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.
Value-based care and management strategies (including population health management and

[59] Rural Hospital Stabilization Committee. Georgia Department of Community Health Web site. Available at: https://dch.georgia.gov/rural-hospital-stabilization-committee.

financial risk management) will require new health care organization 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 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 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 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.[60]
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.[61]

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 claims and 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.[62] 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.[63] 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.

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[60] 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.

[61] 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.

[62] Byrd V, Nysenbaum J, Lipson D. *Encounter Data Toolkit.* Princeton, NJ: Mathematica Policy Research; 2013. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-encounter-data-toolkit.pdf.

[63] Ibid.

Summary

In this paper, we consider the policy implications of Medicaid delivery system reform for rural providers and health systems and their patients. In implementing policies that promote delivery system reform, it is important to consider how certain models may either enhance access for rural populations or diminish it. New delivery system models offer both opportunities and challenges. For example, the post-ACA section 1115 waiver system has recently been criticized as providing a method for decreasing benefits or imposing additional restrictions on access to the Medicaid program.[64] On the other hand, the section 1115 program has been used to provide states with the flexibility to create new delivery systems such as Oregon's Coordinated Care Organization model—an innovative approach to integrated and coordinated care. State-level Medicaid policies have the potential to encourage a broader statewide focus on population health by connecting Medicaid to other important state-level resources, like 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.

[64] Watson SD. Out of the black box into the light: using section 1115 Medicaid waivers to implement the Affordable Care Act's Medicaid expansion. *Yale J Health Policy, Law, & Ethics.* 2015;15(1).

Appendix 1

Table 1. Rural Population, Uninsurance Rates, and Medicaid enrollment by state, 2013-2016

State	Percent of Population that is		Total Enrolled In Medicaid in:		
	Rural*	Nonelderly Uninsured**	July/ September, 2013	January 2016	Percent Growth
STATES NOT EXPANDING MEDICAID					
OVERALL	**18.6%**	**16.8%**	**19,143,366**	**21,180,651**	**10.6%**
Maine	61.3%	12.3%	--	--	--
Mississippi	50.7%	16.8%	637,229	698,977	9.7%
South Dakota	43.3%	11.4%	115,501	118,568	2.7%
Alabama	41.0%	14.2%	799,176	885,444	10.8%
Wyoming	35.2%	13.7%	67,518	64,130	-5.0%
North Carolina	33.9%	15.2%	1,595,952	1,941,209	21.6%
Oklahoma	33.8%	17.8%	790,051	789,536	-0.1%
South Carolina	33.7%	16.0%	889,744	939,344	5.6%
Tennessee	33.6%	14.1%	1,244,516	1,571,644	26.3%
Wisconsin	29.8%	8.6%	985,531	1,045,752	6.1%
Missouri	29.6%	13.7%	846,084	951,734	12.5%
Idaho	29.4%	15.7%	238,150	280,753	17.9%
Nebraska	26.9%	11.2%	244,600	231,355	-5.4%
Kansas	25.8%	11.8%	378,160	398,272	5.3%
Georgia	24.9%	17.9%	1,535,090	1,750,551	14.0%
Virginia	24.5%	12.5%	935,434	953,599	1.9%
Texas	15.3%	21.3%	4,441,605	4,679,156	5.3%
Utah	9.4%	13.8%	294,029	303,684	3.3%
Florida	8.8%	20.1%	3,104,996	3,576,943	15.2%
STATES EXPANDING MEDICAID					
OVERALL	**9.9%**	**12.7%**	**37,248,644**	**50,937,288**	**36.7%**
Vermont	61.1%	5.9%	161,081	190,532	18.3%
West Virginia	51.3%	10.4%	354,544	548,197	54.6%
Montana	44.1%	16.9%	148,974	208,754	40.1%
Arkansas	43.8%	13.9%	556,851	850,426	52.7%
Kentucky	41.6%	9.8%	606,805	1,182,852	94.9%
North Dakota	40.1%	9.0%	69,980	89,639	28.1%
New Hampshire	39.7%	10.8%	127,082	186,603	46.8%
Iowa	36.0%	7.2%	493,515	605,467	22.7%
Alaska	34.0%	18.8%	121,867	135,967	11.6%
Indiana	27.6%	13.8%	1,120,674	1,443,494	28.8%
Louisiana	26.8%	17.0%	1,019,787	1,074,896	5.4%

State	Percent of Population that is		Total Enrolled In Medicaid in:		
	Rural*	Nonelderly Uninsured**	July/ September, 2013	January 2016	Percent Growth
Minnesota	26.7%	6.8%	873,040	1,068,706	22.4%
Michigan	25.4%	10.0%	1,912,009	2,339,419	22.4%
New Mexico	22.6%	16.8%	457,678	737,850	61.2%
Ohio	22.1%	9.8%	2,341,481	2,907,193	24.2%
Pennsylvania	21.3%	10.0%	2,386,046	2,754,296	15.4%
Oregon	19.0%	11.5%	626,356	1,040,426	66.1%
Delaware	16.7%	9.2%	223,324	243,750	9.1%
Washington	16.0%	10.6%	1,117,576	1,771,605	58.5%
Colorado	13.8%	11.6%	783,420	1,324,193	69.0%
Maryland	12.8%	8.9%	856,297	1,159,510	35.4%
New York	12.1%	10.0%	5,678,417	6,431,583	13.3%
Connecticut	12.0%	8.0%	--	756,725	--
Illinois	11.5%	11.1%	2,626,943	3,103,597	18.1%
Arizona	10.2%	16.0%	1,201,770	1,670,422	39.0%
Rhode Island	9.3%	8.7%	190,833	278,062	45.7%
Hawaii	8.1%	6.1%	288,357	340,949	18.2%
Massachusetts	8.0%	3.8%	1,296,359	1,662,800	28.3%
Nevada	5.8%	17.4%	332,560	600,854	80.7%
New Jersey	5.3%	12.6%	1,283,851	1,703,107	32.7%
California	5.0%	14.0%	7,755,381	12,259,866	58.1%
DC	0.0%	5.8%	235,786	265,548	12.6%

Source: U.S. Bureau of the Census (*2010 Census: http://cber.cba.ua.edu/edata/census2010/Urban%20Rural%20by%20State%202010%20short%20ver.xls, **2014 data, from: U.S. Census Bureau, Current Population Reports, P60-253, *Health Insurance Coverage in the United States: 2014*, U.S. Government Printing Office, Washington, DC, 2015.); Centers for Medicare & Medicaid Services. *Medicaid & CHIP: January 2016 Monthly Applications, Eligibility Determinations and Enrollment Report.* Baltimore, MD: Centers for Medicare & Medicaid Services, Department of Health and Human Services; 2016. Available at: https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/january-2016-enrollment-report.pdf.

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

	Medicaid Non-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%*

Note: *Difference is significant at the 95-percent level.

Source: Timothy McBride, Washington University, RUPRI Center for Rural Health Policy Analysis, unpublished memorandum, “Analysis of uninsurance rates, 2013 and 2014, using CPS,” November 27, 2015.

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%

Source:
2009: Medicaid and total state expenditures. Available at: https://www.nasbo.org/publications-data/state-expenditure-report/state-expenditure-report-2009-fiscal-2008-2010-data
2014: Total Medicaid expenditures. Available at: http://kff.org/medicaid/state-indicator/total-medicaid-spending/
2014: Total state expenditures. Available at: 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: Centers for Medicare & Medicaid Services. *Medicaid Managed Care Enrollment and Program Characteristics.* Baltimore, MD: Centers for Medicare & Medicaid Services, Department of Health and Human Services; 2014. Available at: 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 summary of Medicaid delivery system and contracting arrangements

Population Percent Rural[1]		ACO[2]		Health Homes[3]		Medical Homes[4]		Comprehensive MCO[5]	
		Year Started	Rural	Year Started	Rural	Year Started	Rural	Year Started	Rural
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	✓
New Mexico	22.57			2016	✓	2013	✓	2010	✓
New York	12.13			2012	✓	2009	✓	1997	✓
North Carolina	33.91			2011	✓	1983	✓		

Population Percent Rural[1]		ACO[2]		Health Homes[3]		Medical Homes[4]		Comprehensive MCO[5]	
		Year Started	Rural	Year Started	Rural	Year Started	Rural	Year Started	Rural
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 1, 2016. Sources for Health Homes and Medical Home information were drawn from the National Association of State Health Policy. The ACO information source is the Center for Health Care Strategies; MCO data utilized 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 a state's managed care was not indicated to have a statewide expansion, the state government website was utilized. Counties were defined as metro (urban)/non metro (rural) using the Office of Management and Budget rural definitions.

Sources:
[1]*Population Percent Rural:*
https://www.census.gov/geo/reference/ua/urban-rural-2010.html
[2]*ACO*:
http://www.chcs.org/media/ACO-Fact-Sheet-032116.pdf
[3]*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

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

[5]*Comprehensive 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

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