National Advisory Committee on Rural Health and Human Services

Rural Health Insurance Market Challenges

Policy Brief and Recommendations

AUGUST 2018

EDITORIAL NOTE

In April 2018, the National Advisory Committee on Rural Health and Human Services (hereinafter referred to as "the Committee") met in Saratoga Springs, New York. During this meeting, the Committee focused on the challenges faced by rural health insurance markets. While in Saratoga Springs, the Committee heard from federal and state health and human service officials, health economists, and local health care providers. While the focus was on health insurance markets in New York, many of the issues examined, and potential solutions, may also be applicable to rural areas in other states.

ACKNOWLEDGEMENTS

The Committee would like to give thanks and acknowledgement to those whose participation helped make this brief possible. The Committee thanks **Adirondack Health Institute**, **Adirondack Health**, **Chautauqua County Health Network**, **Citizen Advocates**, **Franklin County Office for the Aging**, **Glens Falls Hospital**, **Nascentia Health**, and **United Helpers** for sharing their experiences and thoughts about rural health insurance market challenges (see Appendix A). The Committee would also like to acknowledge the policy and economic background provided by **Donna Frescatore** (New York State Department of Health), **John Powell** (New York State Department of Financial Services), **Abigail Barker** (Washington University), **Timothy McBride** (Washington University), and **Normandy Brangan** (Federal Office of Rural Health Policy).

Special thanks to **Kate Rolf**, who served as the chair of the rural health insurance market challenges subcommittee. Other members of this subcommittee included **Ben Taylor**, **Kathleen Dalton**, **Kelley Evans**, **Chester Robinson**, and **Sallie Poepsel**.

Finally, we would like to acknowledge the work of **Victoria Maloch** on behalf of the Committee.

RECOMMENDATIONS

Availability of Insurance

1. The Committee recommends the Secretary require the alignment of insurance plan service areas with rating areas for insurance programs under HHS authority, utilizing models that integrate urban and rural areas in a region to increase risk pool size. Under this model, the Committee recommends requiring full participation across the rating/service area rather than allowing insurers to offer products to only a portion of the rating area.

2. The Committee recommends the Secretary require states have processes in place to streamline the transition from Medicaid to the individual market (or vice versa), reducing the churn between the two and minimizing lapses in insurance coverage.

Network Development and Adequacy

3. In order to encourage insurer participation in rural areas, the Committee recommends the Secretary allow more flexibility in network adequacy standards in rural areas when there are provider and/or plan shortages.

4. The Committee recommends simplifying the process for requesting and justifying network adequacy exemptions.

5. The Committee recommends that HHS provide technical assistance for under-resourced rural providers to enhance their ability to effectively negotiate with insurers.

Consumer and Provider Engagement

6. The Committee recommends the Secretary supports efforts to educate providers and consumers on the availability of insurance products for individuals and small employers to promote consumer engagement.

7. The Committee also recommends educating providers on insurance options to help inform their network participation decisions.

INTRODUCTION

One of the two topics the National Advisory Committee on Rural Health and Human Services focused on during the April 2018 meeting was how rural health insurance market challenges apply to public insurance programs under the authority of the Department of Health and Human Services (HHS) in keeping with its charge as an advisory committee to HHS. For the purposes of this policy brief, the Committee focused solely on assessing the challenges and providing recommendations related to Medicare Advantage, Medicare Part D, Medicaid Managed Care, and the Health Insurance Marketplace as these programs utilize private managed care organizations to provide health insurance. Because traditional fee-for-service models of insurance, such as original Medicare and some Medicaid programs, tend to pay for volume over value thereby putting the payer (e.g. Federal and/or State governments) at risk for high costs, the intent of using a managed care model for health insurance is to promote competition, control service use, and

ultimately lower costs. However, unique challenges in rural areas may actually inhibit competition, diminish coverage options, and increase costs. The Committee explored the challenges to rural insurance markets, which are often not accounted for in the way insurance markets are structured, and considered recommendations to better support the use of managed care in rural areas.

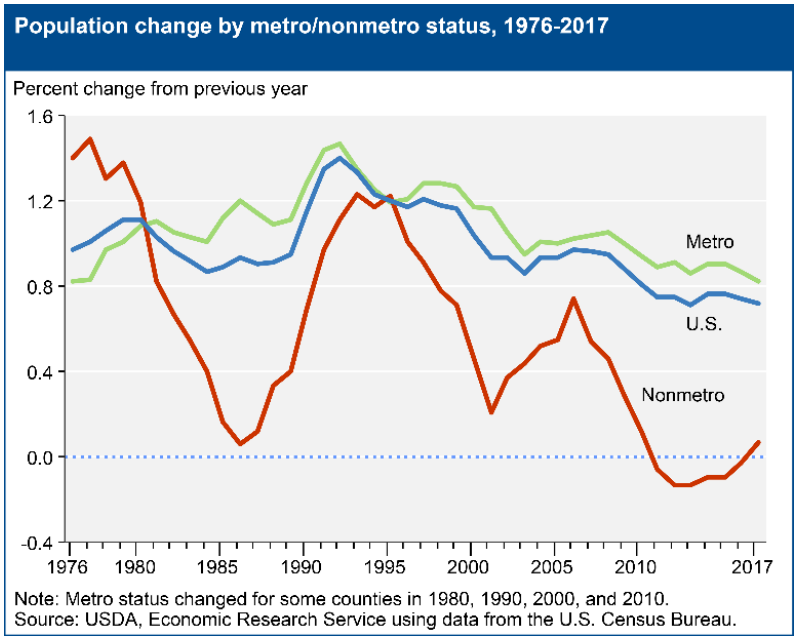
This topic is broader than many the Committee has focused on in the past. The authority to address many rural health insurance market challenges through regulation lies largely with the states and, through this brief, the Committee hopes to bring greater attention to this public policy challenge. At the same time, there are rural health insurance market challenges that fall under direct HHS authority, and these issues have been addressed through specific recommendations from the Committee.

BACKGROUND

Rural areas face unique economic, demographic and population health challenges compared with urban areas (see **Appendix B** for definitions of 'rural'). For example, most Americans have access to some form of health insurance coverage, with employer-sponsored coverage making up the largest portion in 2016 at 49 percent, according to the Kaiser Family Foundation.[1] However, according to the U.S. Census Bureau, populations in nonmetropolitan statistical areas (rural) are more dependent on public health insurance programs (e.g. Medicare and/or Medicaid) for health insurance coverage than those living in metropolitan statistical areas (urban). Additionally, those living in nonmetro areas have a slightly higher uninsured rate than those living in metro areas. [2]

Population growth in nonmetro areas has declined significantly since 1976 (see **Figure 1**).[3] According to the USDA Economic Research Service and data from the U.S. Census Bureau, approximately 46 million people live in nonmetro counties, which are spread across 72 percent of the country's land area.

Figure 1 – Population Change by Metro/Nonmetro Status, 1976 – 2017



Nonmetro counties experienced a population decline of 200,000 people from 2010-2016, marking the first overall nonmetro population loss ever recorded. Notwithstanding, according to recent analysis of Census estimates, "Some long-declining small towns and farming and manufacturing counties are adding people as population growth in large cities cools." Many smaller rural counties, however, are continuing to see a decline, though at a slowed rate.[4] Persistent outmigration of younger people from rural areas, a nationwide trend of childbearing-age women having fewer children and increased mortality in working-age individuals have contributed to the rural population loss, as well as definitional changes resulting from the reclassification of non-metro counties to metro counties.[5]

People living in rural areas tend to have worse health outcomes than urban areas. On average, rural Americans are older and sicker than their urban counterparts and have higher rates of poverty, less access to health care services, and are less likely to have health insurance. They also have higher rates of cigarette smoking, high blood pressure, and obesity. Additionally, rural residents report less leisure-time physical activity and lower seatbelt use than their urban counterparts.[6] While the rate of drug use is lower in rural areas compared to urban areas, data through 2015 shows the overdose death rate has been higher in rural areas since 2006.[7]

Those in rural areas also tend to have less direct or local access to primary care physicians and specialists than their urban counterparts. There are approximately 55 primary care physicians per 100,000 rural residents while there are approximately 79 primary care physicians per 100,000 residents in urban areas. The rural-urban disparity in access to specialists is even greater. People in rural areas have access to 30 specialists per 100,000 residents and those in urban areas have access to 263 specialists per 100,000 residents.[8]

The physician shortage in rural areas, smaller patient populations, high rates of uninsured patients, and dwindling cash flows have all contributed to rural hospital closures. Since 2005, more than 120 rural hospitals have closed or ceased operations, with an accelerated rate beginning in 2010.[9]

INSURANCE PROGRAM OVERVIEW

Considering its role as an advisory committee to HHS, the Committee chose to focus on the following health insurance programs that fall to some degree under the jurisdiction of HHS. A basic overview of each program and/or market is provided below.

Marketplace

The Health Insurance Marketplace, (sometimes known as the Exchange) is an online shopping and enrollment service for individual and family health insurance created by the Affordable Care Act (ACA) in 2010. In most states, the federal government runs the Marketplace through HealthCare.gov. Some states run their own Marketplaces at different websites.[10] Data for 2016 showed health insurance marketplace premiums grew disproportionately in rural areas and fewer insurers offered coverage in rural areas compared to urban areas.[11] HHS oversees the federal Marketplace (HealthCare.gov), approval of ACA section 1332 waivers, delegation of authority to states, and overall compliance with the ACA. States not using the federal platform (i.e. state-based exchanges) oversee administration and operations of their marketplaces with federal oversight.

Medicaid Managed Care

According to Medicaid.gov, Medicaid managed care "provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services."[12] In order to provide services through managed care contracts, states must submit applications to the Centers for Medicare & Medicaid Services (CMS) to waive some of the requirements of Medicaid law, specifically state-wideness, comparability of services, and freedom of choice. HHS and the states jointly oversee the Medicaid program. The federal government provides payment, regulatory guidance, and waiver approval to states, and states are responsible for operating and administering the program to meet local and state needs, such as through innovation, oversight of managed care plans, and payment.

Medicare Advantage

The Medicare Advantage program is an alternative to traditional Medicare that allows beneficiaries to receive all Part A and Part B benefits through private insurance plans that contract with CMS. Most Medicare Advantage plans also offer prescription drug coverage.[13] Since the 1970s, Medicare beneficiaries have been able to enroll in a private plan option. The Balanced Budget Act of 1997 gave this program the name "Medicare+Choice" and the Medicare Modernization Act of 2003 renamed it "Medicare Advantage." While Health Maintenance Organizations (HMOs) with limited networks of providers are the predominant type of Medicare Advantage plan, according to the Kaiser Family Foundation, "Regional Preferred Provider Organizations (PPOs) were established to provide rural beneficiaries greater access to Medicare Advantage plans, and cover entire statewide or multi-state regions." These PPOs accounted for 7 percent of Medicare Advantage enrollees in 2017.[14] Approximately 22 percent of rural Medicare enrollees are enrolled in a Medicare Advantage plan.[15] HHS oversees the administration and operations of Medicare Advantage as well as all regulatory guidance.

Medicare Part D

The Medicare Part D program helps beneficiaries pay for prescription drugs.[16] This program was enacted through the Medicare Modernization Act of 2003 and was officially implemented in 2006.[17] It is administered, operated, and regulated by HHS. Over time, Medicare Part D has played a role in the reduction of geographic disparities in prescription coverage. Both rural and urban areas achieved prescription drug coverage rates of over 90 percent by 2009.[18]

RURAL HEALTH INSURANCE MARKETS

The economic, demographic, and population health characteristics of rural areas pose challenges for rural health insurance markets that undermine conditions for competitive insurance markets. In a perfectly competitive market, economists assume:

- There are a large number of buyers and sellers and these buyers and sellers are price takers (meaning they have no control or influence over price).
- There is free entry and exit of firms in the market.
- Everyone has access to the same information (known as perfect information).
- Goods or services offered are identical and cannot be differentiated from other goods and services in the market on any basis.[19]

At best, due to imperfect information, health insurance markets do not function as perfectly competitive markets because any degree of departure from any of these conditions leads to a corresponding decrease in market efficiency, or, in extreme situations, to market collapse. The departure from perfect competition is more severe in rural areas than in urban areas due to factors largely beyond their control and unique to the reality of rural demographics. As rural markets have relatively few buyers (consumers) and sellers (insurers) of health insurance, market power can shift to sellers leading to higher prices (premiums).[20] According to economists, this situation is an example of market failure, wherein the individually rational behavior of setting higher prices when market power allows it does not lead to an efficient outcome for society.[21] In general, market failure occurs when individuals or companies make the correct decision for themselves, but those decisions prove to be suboptimal decisions for the group (or for society). Additionally, the relatively small number of health service providers in rural areas may confer a certain amount of perceived "monopoly power" upon them.[22] In this situation, insurers may have very few alternative providers with whom they can negotiate to create networks at acceptable rates, while rural providers may perceive they cannot afford to take the rate offered by insurers. In both cases, rural markets are left in a situation where buyers and sellers cannot agree, and the result is a market with few or no insurance offerings.

The potential for economies of scale may also create situations in which insurance companies are more likely to enter urban areas than rural areas. Economies of scale arise because of the inverse relationship between the quantity produced and per-unit fixed costs; i.e. the greater the quantity of a good produced, the lower the per-unit fixed cost because these costs are spread out over a larger number of goods. Economies of scale may also reduce variable costs per unit because of operational efficiencies and synergies.[23] In urban areas, the larger number of patients, health care providers, hospitals, etc. allow for fixed costs associated with providing health care services to be spread across a higher volume of services delivered. In rural areas, however, the fixed costs remain relatively high due to lower volume of services delivered. This may put rural markets at a disadvantage because insurance companies are sometimes less willing to negotiate lower premiums in markets with lower patient volumes and higher costs of providing care. Additionally, with fewer opportunities to disperse fixed costs, making investments in new technology, equipment, or facilities often does not make sense and creates a barrier to new health care providers and/or insurers entering rural markets.

The Committee notes there may be a disconnect in how insurers and rural providers account for these economy-of-scale issues when they enter into negotiations. Broadly speaking, in urban markets, insurers may offer a discounted rate with the expectation that providers can make up the revenue reductions through increased volume. In underserved rural areas, however, that sort of rate-volume tradeoff may not be possible, and the discounted provider payments simply represent lower provider income. The Committee received testimony from several witnesses suggesting that at the same time, this narrative can be reversed by rural providers who may use a perceived monopoly position to reject a legitimate negotiated market rate from an insurer who has no other option to reach beneficiaries in a given area.

Overall, these challenges are inherent to rural markets and, combined with the demographics and health of the rural population, may contribute to higher insurance premiums and relatively few choices of insurers in many rural areas. During the Committee's site visit and discussions with policymakers, researchers and state officials, members received repeated testimonies regarding the broad inherent challenges in the rural market that are a result of structural factors beyond their control such as low population density, a limited provider infrastructure, and higher poverty and socioeconomic challenges. The result for rural communities is less choice and competition, limited local coverage, challenging negotiations between providers and insurers, and higher individual premiums. At the same time, because

HHS plays a unique role in the administration, funding and/or oversight of several of the largest insurance programs, the Committee believes there are areas of opportunity for regulatory reform that can improve rural health insurance.

CHALLENGES

In background research, meeting presentations, and site visit discussions, many challenges emerged. Considering the inherent nature of rural markets and the authorities under which HHS administers its federal insurance programs, the Committee identified the following three areas upon which to further examine these challenges and make recommendations.

Availability of Insurance

As previously detailed in this policy brief, people in rural areas tend to be older and poorer. Therefore, Medicaid and Medicare are important to insuring rural populations.[24] However, there are several rural insurance market challenges related to the availability of insurance. According to presentations by Dr. Timothy McBride and Dr. Abigail Barker of Washington University at the Committee meeting, "modern health insurance is intended to serve two functions. It is a mechanism for sharing risk, and it is a means of access to a range of providers who help manage the enrollee's health." They shared that current market-based insurance programs fall short of fulfilling these functions in rural areas.

Insurance markets are defined by rating areas, which are geographic areas for which premiums and plan offerings are determined. For Medicare Advantage, the rating area is a county. For the Marketplace, rating areas vary by state and can range from a single county to an entire state. Because rating areas with rural counties tend to have smaller populations and population density, insurers are less able to spread risk and there may be fewer health care providers with whom to contract.[25] Additionally, plans can be offered in services areas, which may be independent of rating areas and not necessarily the same as rating areas. Insurers can create service areas where products are only offered in more populous portions of a rating area, or not offer plans in a rating area. According to the Kaiser Family Foundation based on 2016 Marketplace participation, counties with a single insurer offering plans were particularly concentrated in rural states.[26] With fewer choices of insurance providers, and those offering coverage having higher premiums and deductibles in many cases, rural consumers may have few or no choices for health insurance coverage.

Additionally, those in rural areas are more likely than those in urban areas to transition back and forth between periods of eligibility and ineligibility for expanded Medicaid (also known as "churning") as rural residents are more likely than their urban counterparts to be poor or near-poor.[27] According to the Center on Budget and Policy Priorities, when beneficiaries churn back and forth between Medicaid and the Marketplace, coverage gaps and disruptions in care may occur. This churning is also costly for state Medicaid agencies, Marketplaces, and health plans.[28]

Network Development and Adequacy

The patient-to-primary care physician ratio in rural areas is 55 physicians per 100,000 people, compared to 79 physicians per 100,000 in urban areas.[29] With fewer providers and specialists to contract with, network development in rural areas can be a challenge for insurance companies. Network adequacy can be defined simply as, "the ability of health plan provider networks to deliver the right care, at the right time, without enrollees having to travel too far."[30] Network adequacy standards can make network development hard in some rural areas because they may be more difficult to meet, and states have

varying levels of flexibility regarding network adequacy standards for rural areas.[31] When networks are developed that do not offer patients adequate options of contracted providers from whom they may receive in-network services, rural residents may have to resort to receiving services outside of network resulting in higher costs, or they may forgo care altogether.[32]

Network adequacy can also play a role in network development, which can be seen particularly with the Marketplace and Medicare Advantage. While network adequacy standards could be seen as a strategy to place limits on the time or distance rural patients would have travel to see providers, strict standards without flexibility can also diminish the willingness of insurers to enter rural markets.[33] According to presentations at the meeting, the current market-based models encourage marginal thinking and can incentivize insurers to pressure providers that are needed for network adequacy purposes to accept lower rates or to omit providers who cannot accept lower rates and are not needed for network adequacy purposes.[34] A 2017 study of five geographically diverse states with significant rural populations reported that all of the state insurance department representatives interviewed reported network adequacy challenges related to lack of providers and a need for flexibility in network adequacy standards when it comes to rural areas.[35]

Consumer and Provider Engagement

Lack of consumer engagement may also create challenges for rural health insurance markets by hampering consumers' ability to find and understand coverage options and possible subsidies. Studies indicate the rural population has lower health literacy rates,[36] which may negatively impact consumer participation in rural insurance markets. Barriers such as transportation and lack of internet or cell phone connectivity can also impact consumers' access to resources to shop for insurance or seek guidance on coverage options.[37] Based on presentations during the meeting and discussions at the site visit, the Committee learned some providers were unaware of insurance options and therefore did not participate in the networks.

POLICY RECOMMENDATIONS

Taking into consideration the challenges outlined above, as well as the Committee's charge as an advisory committee to HHS on how its programs serve rural communities, the Committee makes the following recommendations.

Availability of Insurance

To ensure accessibility and availability of insurance in rural markets, the Committee believes there must be a way to expand the risk pool and expand access to providers in rural networks. Additionally, given the higher rates of poverty and uninsured in rural areas, the Committee believes it would be beneficial to have processes in place to help minimize churn between insurance programs.

> **Recommendation 1:** The Committee recommends the Secretary require the alignment of insurance plan service areas with rating areas for insurance programs under HHS authority, utilizing models that integrate urban and rural areas in a region to increase risk pool size. Under this model, the Committee recommends requiring full participation across the rating/service area rather than allowing insurers to offer products to only a portion of the rating area.

Recommendation 2: The Committee recommends the Secretary require states have processes in place to streamline the transition from Medicaid to the individual market (or vice versa), reducing the churn between the two and minimizing lapses in insurance coverage.

Network Development and Adequacy

Given the difficulty of forming networks of rural providers, the Committee believes strategic flexibility in network adequacy requirements (i.e., when provider and/or plan shortages exist) may encourage full insurer participation across rating areas. Additionally, since rural providers are at risk of being undercut by larger providers during the negotiation process, the Committee believes providing technical assistance to providers specifically related to contract negotiations with insurers will be beneficial in improving provider participation in networks.

Recommendation 3: In order to encourage insurer participation in rural areas, the Committee recommends the Secretary allow more flexibility in network adequacy standards in rural areas when there are provider and/or plan shortages.

Recommendation 4: The Committee recommends simplifying the process for requesting and justifying network adequacy exemptions.

Recommendation 5: The Committee recommends that HHS provide technical assistance for under-resourced rural providers to enhance their ability to effectively negotiate with insurers.

Consumer and Provider Engagement

The Committee believes improving rural consumer engagement could lead to increased enrollment in insurance markets thereby increasing the risk pool. Educating both consumers and providers on the variety of plans available, e.g. Medicaid and Medicare may offer multiple plans in an area, is a useful step to improving participation and engagement and creating a better functioning rural insurance market.

Recommendation 6: The Committee recommends the Secretary supports efforts to educate consumers on the availability of insurance products for individuals and small employers to promote consumer engagement.

Recommendation 7: The Committee also recommends educating providers on insurance options to help inform their network participation decisions.

POLICY CONSIDERATIONS

While hearing from federal and state health and human service officials and participating in discussions with various health care professionals during our site visit, many different challenges were brought to the Committee's attention. As noted earlier, the Committee has chosen to address and provide recommendations to the Secretary only for those challenges that relate directly to the specific markets and/or programs outlined previously. However, the Committee would like to spotlight other challenges that are not directly under the jurisdiction of HHS that merit acknowledgement and/or further consideration from policy makers.

Expanding Medicaid

There are many decisions regarding Medicaid that could have outsized impacts in rural areas, such as whether a state chooses to expand Medicaid to those with incomes up to 138 percent of the Federal Poverty Level. As detailed earlier in this paper, those in rural areas are more reliant on Medicaid due to the higher rates of poverty. As of May 2018, 19 states[i] have either not expanded Medicaid or have not yet implemented expansion after voting to do so.[38] At the same time, a 2014 paper reported nearly two-thirds of the rural uninsured population live in states that have not expanded Medicaid.[39] According to a recent analysis by the Kaiser Family Foundation, Medicaid expansion has resulted in "disproportionately positive coverage impacts in rural areas in expansion states" and expansion was associated with "improved hospital financial performance and significant reductions in the probability of hospital closure, especially in rural areas and areas with higher pre-ACA uninsured rates."[40] The Committee believes encouraging Medicaid expansion in all states would prove very beneficial to the rural population. As more states look to expand and/or modify their Medicaid programs, the Committee would urge states and CMS to take into consideration the particular challenges faced by those living in rural areas or on Native American reservations and ensure these individuals have fair access to the expanded coverage.

Innovation

Site visit panelists communicated that allowing flexibility in rural areas to create opportunities for innovation was a very important component to the future success of rural health care and rural health insurance markets. Potential approaches the Committee identified in research and from expert speakers include: creating incentives for rural providers and plans to find innovative solutions to improve access to care, improve quality, and reduce costs; supporting rural-based demonstrations and value-based payment pilots that provide enhanced flexibility to test and implement innovative solutions for insurers and providers; and systematically reviewing and rationalizing federal and state regulations that may inhibit innovation and competition (e.g., credentialing, clinical trials, prescription drug import regulations).[ii] The Committee believes these approaches align with the Secretary's recently announced areas of focus he believes are vital in the process of transforming our health care system to a value-based system.[41]

CONCLUSION

The Committee is concerned that rural areas continue to be at a disadvantage by the way many of the public and private insurance markets are constructed, and these areas, in effect, are penalized for geographic and demographic factors beyond their control. The Committee recognizes there is no perfect way to correct this. However, there are steps HHS can take to mitigate some of these challenges and the recommendations included in this policy brief are some immediate steps to consider. When speaking with state officials and local providers in New York, it was clear that New York chose a strong regulatory approach to setting up its markets, building on its experience with Medicaid Managed Care. This approach has led to their insurance markets having insurance providers, often multiple, in every county. At the same time, we acknowledge each state is different and may prefer more flexibility in its regulatory approach to insurance markets. While the Committee is primarily focused on recommendations to HHS, we think other public policy makers can do more to level the playing field for rural markets, and the Committee urges

[i] Maine and Virginia have voted to expand Medicaid, but have not yet implemented the expansion.

[ii] See "A Bipartisan Blueprint for Improving Our Nation's Health System Performance." Available at: <https://www.governor.pa.gov/wp-content/uploads/2018/02/23.02.2018-Bipartisan-Health-Care-Blueprint.pdf>.

states to focus on ways to aggregate rural places together to better pool risk. Policymakers need to think more proactively about the unique challenges faced by rural markets and account for those in setting regulations and policy with a goal of ensuring the same range of choice and costs for rural consumers as for those in urban areas. The Committee hopes HHS will lead the way by acting upon these recommendations and others will take similar approaches, when appropriate, with insurance programs and decisions outside of HHS authority.

APPENDIX A: SITE VISIT PROFILES

While the Committee's site visit was hosted by Adirondack Health Institute, several other health care providers, offices, and networks were invited to participate in the discussion. Thirteen representatives from eight different organizations were present. The primary focus was rural health insurance market challenges, but many of the individuals we spoke with at the site visit mentioned other challenges they face practicing in rural areas. Highlights of those discussions are included below.

Adirondack Health Institute

Adirondack Health Institute (AHI) is located in Glens Falls, New York. It is a joint venture of Adirondack Health, Glens Falls Hospital, Hudson Headwaters Health Network, St. Lawrence Health System and The University of Vermont Health Network – Champlain Valley Physicians Hospital. They serve patients in Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, St. Lawrence, Warren, and Washington Counties. AHI operates a program to assist individuals, families, and small business owners with enrolling in health insurance coverage. This program, called the Enrollment Assistance Services and Education (EASE) program, provides a unique insight into rural health insurance challenges in the counties they serve. The director of AHI's EASE program shared that access to providers is the number one issue they see. The director said that just because their program enrolled people in insurance does not guarantee they truly have good coverage because many patients have to travel too far to see providers or many in-network providers do not accept new patients. Other reported challenges include access to resources, connecting people to those resources, and education of consumers regarding what insurance and services are available to them. As they continue to assist people in signing up for insurance, the director said there are a surprising number of people who sign up who previously never had insurance. Many of these individuals either could not afford insurance, had always been healthy, were seasonal employees or worked in areas such as construction, or were transient across states.

Adirondack Health

Adirondack Health is located in Saranac Lake, New York. They are the largest provider of health care and largest private employer within the Adirondack Park. They employ 60 physicians and are the official hospital of the Lake Placid U.S. Olympic Training Center. Additionally, they have a 4-star facility rating and a 5-star home health care rating from CMS. Lack of negotiating leverage with payers was expressed to be a large challenge they face related to rural insurance markets. They also noted a perceived shift in tone when dealing with payers over the last year with a reported attitude of "either take what you got last year, or we are cutting rates." They shared that workforce is a problem for them, particularly when it comes to homecare services. They also face challenges with care coordination from a distance and said that while there is great promise in services such as telehealth, lack of broadband and cell phone coverage in the Adirondack Park makes it very difficult. Panelists shared that they believe rural environments can teach us many things about innovative approaches, but they have to be given the resources, flexibility, and commitment to develop these innovative solutions. They shared that they felt like "providers are asked to be flexible, but HHS and programs are not flexible and they do not give providers flexibility." They also expressed desire to have the stability to learn lessons and tweak issues in developing new approaches to address rural challenges without risking closure. The value-based approach has been difficult for them as a low cost provider. They told us that because they already removed excess costs before accountable care came in, it is hard for them to do anything else to push down costs past a certain point.

Chautauqua County Health Network

Chautauqua County Health Network is located in Jamestown, New York and comprised of the four hospital organizations, including their governing boards and medical staff, in Chautauqua County. They were one of the first four rural Medicare shared savings programs in the country. They shared that they were unsure of the sustainability of the ACO model, however, and that the challenge is not a rural issue, but a program design issue. They feel that at a certain point, it is hard to continue finding places to cut and find savings while continuing to provide quality care. The majority of their patients are covered by regional, not-for-profit plans. Regarding shared savings, they feel like CMS has a "one policy fits all" approach and that it does not work well for rural areas. They think a regional approach is better but would like to see a special model for rural areas. Additionally, they would like to see an opportunity for rural providers to be able to come together to negotiate with large insurers to provide them better negotiating leverage.

Citizen Advocates

Citizen Advocates is located in Malone, New York and is a certified community behavioral health center and downstream provider in New York State's Medicaid Health Home program. They have two primary clinics and 15 satellite locations, primarily serving residents of Franklin, Clinton, Essex, Hamilton, and St. Lawrence counties. They employ approximately 775 people and serve nearly 6,500 individuals each year. Workforce was expressed as a big challenge they face, including overall recruitment as well as recruitment of specific types of licensed professionals. They specifically mentioned having to use Licensed Mental Health Counselors (LMHC) instead of other types of licensed professionals in some cases, but that LMHCs are not able to bill Medicare, which poses a financial challenge. One recruitment strategy that has been effective that they hope to see continued/expanded is loan forgiveness for health care professionals that work in high need areas. They also mentioned consumer engagement as a challenge. They feel like key stakeholders, such as providers, have been left out of the process when it comes to education on new types of insurance plans, and that some providers won't accept some plans because they don't understand it. They believe providers have to be engaged and educated on insurance and other various programs. Another challenge highlighted was regarding value-based payments for those working in behavioral health. Panelists shared that it can be hard to attribute quality gains to behavioral health and this can lead to skewed value payments. This, along with other financial challenges faced in rural markets, makes it hard for rural providers to invest in technology, such as more costly complex electronic medical record systems, that would both improve their billing and reporting efficiency and enhance patient care.

Franklin County Office for the Aging

Franklin County Office for the Aging is located in Malone, New York. Currently, New York is the third eldest state in the country. The Franklin County Office for the Aging provides assistance for individuals that are not Medicaid eligible. They also assist with transportation, adult protective services, and are a SNAP-Ed provider. Additionally, they are involved with crisis intervention for individuals that use the first response system. They feel that capacity is one of the largest issues they are seeing. They reported that even though people might have coverage, there are not enough people to provide services. This has also been a challenge as they have seen an increase in Advantage plans, but experience capacity issues related to the number of providers in the area. To address the challenges working with elderly patients in a rural area, they would like to see an enhanced rural mileage rate for home health.

Glens Falls Hospital

Glens Falls Hospital (GFH) is the largest hospital between Albany, NY and Montreal, Canada and maintains a service area that spans 6,000 square miles across 5 diverse counties. Founded in 1897, GFH today operates an advanced health care delivery system featuring 23 regional facilities including 9 specialty

practices and 10 medical centers. GFH is a not-for-profit organization and the largest employer in New York's Adirondack region, with over 2,700 staff, including more than 175 employed providers and a medical staff composed of over 575 providers. As the healthcare industry continues to rapidly evolve, hospitals are faced with complex issues and uncertainties. GFH noted that a challenge facing their community is the management of a high-need, high-risk patient population. While GFH operates a successful community care coordination service, including intensive case management, a health home, and case management for the inpatient population, additional resources to support and expand this work is still needed to keep up with the patient demand. GFH continues to leverage any additional funding available outside of the reimbursement model to support this most vulnerable population.

Nascentia Health

Nascentia Health is located in Syracuse, New York. They are a home and community-based care system with services spanning 48 counties. They care for approximately 6,500 patients a day. Network adequacy and transportation were challenges they mentioned facing. They also shared that they feel the rules, regulations, and payments models are antiquated and not paying for innovation in rural areas. Regarding network adequacy standards, they believed that while well-intentioned, network adequacy standards actually made it harder for them in rural areas. When expanding, they shared that meeting the network requirements in new counties can make it hard to get providers to sign a Medicaid contract. They have had to create their own transportation department and own nine vehicles because they have struggled finding contractors that would go to rural areas. They expressed a desire for more alignment of goals between insurers and providers and more cross-sector efforts to work together addressing social determinants of health.

United Helpers

United Helpers is located in Ogdensburg, New York and serves patients in St. Lawrence County (the largest county in New York) and Jefferson County. They are a post-acute care and community based organization with over 1000 employees. Their view, simply put, is that "The rural battle is always uphill." They expressed a desire for transparency with payers so they can plan for the future. Currently, they do not feel they have this transparency. They also do not believe they have enough data to bring to the table with payers. Additionally, they believe there is a need to put payers, practitioners, and those involved in policy together in an effort to come up with a mode of care coordination that will work in rural areas. Issues they mentioned include workforce, the potential for flexible operating certificates, reimbursement, conditions of participation, and potentially creating accepted regional costs. One big challenge they are facing relates to the increasing presence of managed care and timeliness of payment. As they have seen more managed care, their accounts receivables have gone up significantly and lag time has increased from 60 to 90 days.

APPENDIX B: DEFINITIONS

Rural: The federal government uses two main definitions of rural, a definition from the U.S. Census Bureau and one from the Office of Management and Budget. The Federal Office of Rural Health Policy uses components of each in determining their definition of rural.[42] With the various sources of data cited in this paper, "rural" can be defined by one of the following definitions depending on the source and the definition they use in data collection and analysis.

U.S. Census Bureau: The Census Bureau identifies two types of urban areas: Urbanized Areas (UAs) of 50,000 or more people and Urban Clusters (UCs) of at least 2,500 and less than 50,000 people. "Rural" encompasses all population, housing, and territory not included within an urban area.[43]

Office of Management and Budget: The Office of Management and Budget (OMB) designates counties as Metropolitan, Micropolitan, or Neither. A Metro area contains a core urban area of 50,000 or more population, and a Micro area contains an urban core of at least 10,000 (but less than 50,000) population. All counties that are not part of a Metropolitan Statistical Area (MSA) are considered rural. Micropolitan counties are considered non-Metropolitan or rural along with all counties that are not classified as either Metro or Micro.[44]

Federal Office of Rural Health Policy: The FORHP accepts all non-Metro counties as rural and uses an additional method of determining rurality called the Rural-Urban Commuting Area (RUCA) codes. Like the MSAs, these are based on Census data that is used to assign a code to each Census Tract. Tracts inside Metropolitan counties with the codes 4-10 are considered rural. While use of the RUCA codes has allowed identification of rural census tracts in Metropolitan counties, among the more than 70,000 tracts in the U.S. there are some that are extremely large. In these larger tracts, use of RUCA codes alone fails to account for distance to services and sparse population. In response to these concerns, FORHP has designated 132 large area census tracts with RUCA codes 2 or 3 as rural. These tracts are at least 400 square miles in area with a population density of no more than 35 people.[45]

REFERENCES

[1] "Health Insurance Coverage of the Total Population | The Henry J. Kaiser Family Foundation." *Kaiser Family Foundation - Health Policy Research, Analysis, Polling, Facts, Data and Journalism*. 2016. Web. <http://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

[2] Barnett, Jessica C. and Edward R. Berchick. "Health Insurance Coverage in the United States: 2016." *Census.gov.* United States Census Bureau, Sep 2017. Web. <http://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf>.

[3] "USDA ERS - Population & Migration." *USDA ERS - Home.* United States Department of Agriculture, 26 Apr 2018. Web. <http://www.ers.usda.gov/topics/rural-economy-population/population-migration.aspx>.

[4] Henderson, Tim. "Rural Counties Are Making a Comeback, Census Data Shows." *The Pew Charitable Trusts.* 22 Mar 2018. Web. <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/03/22/rural-counties-are-making-a-comeback-census-data-shows>.

[5] "Rural America At A Glance." *USDA ERS.* United States Department of Agriculture, Nov 2017. Web. <http://www.ers.usda.gov/webdocs/publications/85740/eib-182.pdf?v=43054>.

[6] "About Rural Health | CSELS | OPHSS | CDC." *Centers for Disease Control and Prevention*. 2 Aug 2017. Web. <http://www.cdc.gov/ruralhealth/about.html>.

[7] "Preventing Opioid Overdoses in Rural America." *Centers for Disease Control and Prevention.* Web. Mar 2018. <http://www.cdc.gov/ruralhealth/drug-overdose/pdf/Policy-Brief_Opioiod-Overdoses-H.pdf>.

[8] Warshaw, Robin. "Health Disparities Affect Millions in Rural U.S. Communities." *AAMCNews*. 31 Oct 2017. Web. <http://news.aamc.org/patient-care/article/health-disparities-affect-millions-rural-us-commun/>.

[9] "Hospital Closings Likely to Increase." *U.S. Health Resources & Services Administration*. Oct 2017. Web. <http://www.hrsa.gov/enews/past-issues/2017/october-19/hospitals-closing-increase.html>.

[10] "Marketplace." *Health Insurance Marketplace | HealthCare.gov*. U.S. Centers for Medicare & Medicaid Services, Web. Mar 2018. <http://www.healthcare.gov/glossary/marketplace/>.

[11] Barker, Abigail R., Leah M. Kemper, Timothy D. McBride and Keith J. Mueller. "Health Insurance Marketplaces: Premium Trends in Rural Areas." *University of Iowa College of Public Health.* RUPRI Center for Rural Health Policy Analysis, May 2016. Web. <http://cph.uiowa.edu/rupri/publications/policybriefs/2016/HIMs%20rural%20premium%20trends.pdf>.

[12] "Managed Care." *Medicaid.gov*. Centers for Medicare & Medicaid Services, Web. Mar 2018. <http://www.medicaid.gov/medicaid/managed-care/index.html>.

[13] "Medicare Advantage (Medicare Part C)." *HealthCare.gov*. U.S. Centers for Medicare & Medicaid Services, Web. Mar 2018. <http://www.healthcare.gov/glossary/medicare-advantage-medicare-part-c/>.

[14] "Medicare Advantage." *Kaiser Family Foundation*. 10 Oct 2017. Web. <http://www.kff.org/medicare/fact-sheet/medicare-advantage/>.

[15] Ullrich, Fred and Keith Mueller. "Medicare Advantage Enrollment Update 2016." *University of Iowa College of Public Health.* RUPRI Center for Rural Health Policy Analysis, Sep 2016. Web. <http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2016/Medicare%20Advantage%20Enrollment%20Update%202016.pdf>.

[16] "Medicare Part D." HealthCare.gov. *U.S. Centers for Medicare & Medicaid Services*, Web. Mar 2018. <http://www.healthcare.gov/glossary/medicare-part-d/>.

[17] "History." *CMS.gov*. U.S. Centers for Medicare & Medicaid Services, 3 May 2018. Web. <http://www.cms.gov/About-CMS/Agency-information/History/>.

[18] Jonk, Yvonne, Heidi O'Connor, Michelle Casey and Ira Moscovice. "Comparing Rural and Urban Medicare Part D Enrollment Patterns and Prescription Drug Coverage Rates." *Rural Health Research Gateway*. University of Minnesota Rural Health Research Center, May 2013. Web. <http://www.ruralhealthresearch.org/publications/878>.

[19] "9.1 Perfect Competition: A Model | Principles of Economics." *Open Textbooks · University of Minnesota Libraries*. University of Minnesota, Web. Mar 2018. <http://open.lib.umn.edu/principleseconomics/chapter/9-1-perfect-competition-a-model/>.
[20] "OECD Glossary of Statistical Terms - Market power Definition." *OECD*. 2002. Web. <http://stats.oecd.org/glossary/detail.asp?ID=3256>.
[21] "Market Failure." *Investopedia*. Web. Mar 2018. <http://www.investopedia.com/terms/m/marketfailure.asp>.
[22] "Monopoly Power." *Business Dictionary*. Mar 2018. Web. <http://www.businessdictionary.com/definition/monopoly-power.html>.
[23] "Economies of Scale." *Investopedia*. Web. Mar 2018. <http://www.investopedia.com/terms/e/economiesofscale.asp>.
[24] Foutz, Julia, Samantha Artiga, and Rachel Garfield. "The Role of Medicaid in Rural America." *Kaiser Family Foundation*. Apr 2017. Web. <http://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>.
[25] McBride, Timothy D., and Abigail R. Barker. "The Market Mechanism: Challenges and Solutions for Rural Health Insurance Access." *National Advisory Committee on Rural Health and Human Services Meeting*. 16 Apr 2018, Saratoga Springs, New York.
[26] Cox, Cynthia and Ashley Semanskee. "Preliminary Data on Insurer Exits and Entrants in 2017 Affordable Care Act Marketplaces." *Kaiser Family Foundation*. 28 Aug 2016. Web. <http://www.kff.org/health-reform/issue-brief/preliminary-data-on-insurer-exits-and-entrants-in-2017-affordable-care-act-marketplaces/>.
[27] Ziller, Erika, Deborah Thayer, and Jennifer Lenardson. "Medicaid Income Eligibility Transitions among Rural Adults." *Rural Health Research Gateway.* Maine Rural Health Research Center, Aug 2018. Web.
[28] Rosenbaum, Dottie. "Lessons Churned: Measuring the Impact of Churn in Health and Human Services Programs on Participants and State and Local Agencies." *The Center on Budget and Policy Priorities.* 20 Mar 2015. Web. < https://www.cbpp.org/research/lessons-churned-measuring-the-impact-of-churn-in-health-and-human-services-programs-on>.
[29] Warshaw, Robin. "Health Disparities Affect Millions in Rural U.S. Communities." *AAMCNews*. 31 Oct 2017. Web. <http://news.aamc.org/patient-care/article/health-disparities-affect-millions-rural-us-commun/>.
[30] "Network Adequacy 101: An Explainer." *Families USA: The Voice for Health Care Consumers*. Oct 2014. Web. <http://familiesusa.org/product/network-adequacy-101-explainer>.
[31] Casey, Michelle, Carrie Henning-Smith, Jean Abraham and Ira Moscovice. "Regulating Network Adequacy for Rural Populations: Perspectives of Five States." *The University of Minnesota Rural Health Research Center*. Aug 2017. Web. <http://rhrc.umn.edu/wp-content/files_mf/1502732117UMRHRCNetworkAdequacy.pdf>.
[32] "Network Adequacy 101: An Explainer." *Families USA: The Voice for Health Care Consumers*. Oct 2014. Web. <http://familiesusa.org/product/network-adequacy-101-explainer>.
[33] Talbot, Jean A., Andrew Coburn, Zach Croll and Erika Ziller. "Rural Considerations in Establishing Network Adequacy Standards for Qualified Health Plans in State and Regional Health Insurance Exchanges." *Wiley Online Library*. The Journal of Rural Health, 22 Feb 2013. Web. <http://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12012>.
[34] McBride, Timothy D., and Abigail R. Barker. "The Market Mechanism: Challenges and Solutions for Rural Health Insurance Access." *National Advisory Committee on Rural Health and Human Services Meeting*. 16 Apr 2018, Saratoga Springs, New York.
[35] Casey, Michelle, Carrie Henning-Smith, Jean Abraham and Ira Moscovice. "Regulating Network Adequacy for Rural Populations: Perspectives of Five States." *The University of Minnesota Rural Health Research Center*. Aug 2017. Web. <http://rhrc.umn.edu/wp-content/files_mf/1502732117UMRHRCNetworkAdequacy.pdf>.
[36] Zahnd, WE, SL Scaife and ML Francis. "Health literacy skills in rural and urban populations. - PubMed - NCBI." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 2009. Web. <http://www.ncbi.nlm.nih.gov/pubmed/19296745>.
[37] "Serving Special Populations: Rural Areas Fast Facts for Assisters." *Marketplace.CMS.Gov*. U.S. Department of Health and Human Services, Web. Mar 2018. <http://marketplace.cms.gov/outreach-and-education/rural-areas-fast-facts.pdf>.
[38] "Where States Stand on Medicaid Expansion Decisions." *NASHP - National Academy for State Health Policy*. 11 May 2018. Web. <http://nashp.org/states-stand-medicaid-expansion-decisions/>.

[39] "The Affordable Care Act and Insurance Coverage in Rural Areas | The Henry J. Kaiser Family Foundation." *Kaiser Family Foundation*. 29 May 2014. Web. <http://www.kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/>.
[40] Rudowitz, Robin and Larisa Antonisse. "Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence." *Kaiser Family Foundation*. 16 May 2018. Web. <http://www.kff.org/medicaid/issue-brief/implications-of-the-aca-medicaid-expansion-a-look-at-the-data-and-evidence>.
[41] Azar II, Alex M. "Remarks on Value-Based Transformation to the Federation of American Hospitals." *HHS.gov*. 5 Mar 2018. Web. <http://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html>.
[42] "Defining Rural Population." *U.S. Health Resources & Services Administration*. Jan 2017. Web. <http://www.hrsa.gov/rural-health/about-us/definition/index.html>.
[43] "Urban and Rural." *Census.gov*. United States Census Bureau, Web. Mar 2018. <http://www.census.gov/geo/reference/urban-rural.html>.
[44] "Defining Rural Population." *U.S. Health Resources & Services Administration.* Jan 2017. Web. <http://www.hrsa.gov/rural-health/about-us/definition/index.html>.
[45] "Defining Rural Population." *U.S. Health Resources & Services Administration.* Jan 2017. Web. <http://www.hrsa.gov/rural-health/about-us/definition/index.html>.