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Center for Health Care Strategies

Expanding Access to Integrated Medicare-Medicaid Programs in Rural Communities

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TAKEAWAYS

- Of the 2.7 million individuals who are dually eligible for Medicare and Medicaid and live in rural areas, only about one in four have access to coverage options that meaningfully integrate their care and benefits — despite facing higher rates of chronic illness, mental health challenges, and social needs than their urban peers.
- Key factors impact state and health plan capacity to launch and sustain integrated care statewide, including lack of alignment among rural health stakeholders around prioritizing integration, limited managed care infrastructure, challenges in meeting network adequacy standards, and high start-up and operating costs.
- This brief identifies opportunities for implementing integrated models in rural communities — spanning partnership approaches, delivery flexibilities, and provider incentives — drawn from a literature review, interviews with state officials, health plans, providers, and community organizations, and a convening of Medicaid leaders from eight states.

Dually eligible individuals — people eligible for both Medicare and Medicaid due to age or disability *and* low income — make up one of the most complex and underserved populations in the U.S. health care system. Compared to people with Medicare only, they tend to have multiple chronic physical and behavioral health conditions and significant health-related social needs (HRSN).[1] While this population has Medicare and Medicaid coverage, these programs were not designed to work together, and as a result, dually eligible individuals often receive fragmented, uncoordinated care that can result in lower quality care, avoidable service use, and higher costs.[2]

To improve care for the nation's 13 million dually eligible individuals, federal and state policymakers, health plans including Medicaid managed care organizations (MCOs) and Medicare Advantage dual eligible special needs plans (D-SNPs), providers, and advocates have focused on better integrating the delivery, financing, and administration of Medicare

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and Medicaid services. For more than a decade, models like the Program of All-Inclusive Care for the Elderly (PACE),[3] Medicare-Medicaid plans operating under demonstrations in the federal Financial Alignment Initiative,[4] and D-SNPs[5] have proliferated in many areas of the country.[6] Despite these gains, states, health plans, and providers have had difficulty expanding integrated care programs into rural areas* where access to care challenges are particularly acute. Of the approximately 2.7 million dually eligible individuals who live in rural areas, only about one in four have access to meaningful integration options, compared to the nearly two-thirds of dually eligible people in more urban areas who have the choice to enroll in an integrated care plan.[7,8] This gap is concerning, as dually eligible individuals in rural areas have higher rates of chronic physical health conditions, mental health care needs, and HRSN than their urban peers — factors linked to worse health outcomes and higher all-cause mortality.[9,10,11]

Compounding these health risks are common rural challenges, including hospital closures, clinician and direct care worker shortages;[12,13,14,15] limited public transportation and long travel distances to reach care;[16] and inadequate broadband access that restricts telehealth and other virtual services.[17] Because these constraints make it harder for states and health plans to launch or scale integrated care models statewide, policymakers need to address rural-specific barriers for integration to reach all dually eligible individuals.[18]

Listening to Member Perspectives: *The People Say* Project

The People Say project is an online database that features first-hand insights from older adults and caregivers on the issues most important to them. One focus of the project is capturing the experiences of older adults who live in rural areas, including about the challenges of aging in these communities. For example, one individual noted: "[Getting older in a rural area] was a struggle because I was on my own. And being an old man by yourself, it was very lonely. There was a lot of depression, and my children didn't [visit]."

With support from The SCAN Foundation, the Center for Health Care Strategies (CHCS) sought to identify challenges that hinder the spread of integrated care in rural areas and potential solutions to overcome these barriers. CHCS examined how select states are advancing integration in rural areas and distilled lessons that other states can apply. The analysis builds on *The Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit* developed by Health Management Associates, which outlines how integrated care programs can address access-to-care barriers in rural communities.[19,20]

This brief explores the goals, barriers, and opportunities for implementing integrated care in rural communities. It is informed by findings from: (1) a literature review of rural dually eligible populations, their access to care and outcomes, and the systems that serve them; (2) key informant interviews with state Medicaid and rural health office officials, health

* Various definitions of "rural" are used by different government agencies, policies, and jurisdictions. The U.S. Census Bureau does not define "rural" but rather classifies rural areas as all geographic areas that are not classified as urban. For the purposes of this research, CHCS used the Census Bureau's expansive view of what constitutes a rural community.

plans, providers, and community-based organizations in **California**, **Idaho**, and **Pennsylvania** — three states advancing integration in large rural regions; and (3) a convening of Medicaid officials from eight states, including **California**, **Colorado**, **Idaho**, **Minnesota**, **New Mexico**, **North Carolina**, **Pennsylvania**, and **Tennessee**.

Note that this research was conducted before passage of the 2025 budget reconciliation bill (H.R. 1). Therefore, neither the law's Medicaid- or rural health-related provisions, nor its potential impact on rural communities and efforts to expand integrated care, were included in CHCS' discussions with states and other stakeholders. However, the implications of H.R. 1 are considered later in this brief.

Challenges and Opportunities for Expanding Integrated Care to Rural Areas

1. Differing goals complicate efforts to advance statewide integration for dually eligible populations.

All Medicaid officials consulted said that maintaining or expanding integration statewide for dually eligible individuals, including in rural areas, was a goal for their agencies.

Other rural stakeholders, however, noted that they were focused on addressing access to care challenges for all rural populations, rather than explicitly considering the unique challenges faced by dually eligible individuals. In CHCS' interviews, health plans, providers, advocates, and rural health organizations spoke to the overall needs of rural populations, regardless of insurance status. The concerns of dually eligible populations were not considered unique; instead, rural stakeholders noted that most rural residents encountered challenges in accessing care. A rural health association representative in one state highlighted the lack of understanding among many rural stakeholders about dual eligibility and emphasized the need for basic education about this population.

Opportunities to Address this Challenge

- **Increase communication and collaboration**. Better alignment of goals could be achieved by increased communication and collaboration between Medicaid agencies and rural health associations. In interviews, both state Medicaid agency leaders and state rural health association staff acknowledged that, in the short term, states could prioritize disseminating information to all rural stakeholders that: (1) provide education on the unique barriers to care faced by dually eligible individuals and factors impeding the viability of integrated care programs and the levers to remove these barriers; and (2) elevate examples of partnerships between health plans, providers, and community-based organizations to demonstrate best and emerging practices in providing integrated care.

- **Establish a shared vision for rural health care**. Over the longer term, interviewees suggested that states could consider opportunities to develop a shared vision between state Medicaid agencies and rural stakeholders. Multisector plans for aging (MPAs), for example, are being used by states across the country to both advance integrated care,[21] as well as address the unique needs of rural communities.[22]

2. Capacity to offer integrated care statewide varies by states' managed care landscape.

States that have already expanded or that are planning to expand integrated care programs statewide noted that their managed care infrastructure gave them a foundation on which to advance their integration goals. They described using multiple policy levers to implement statewide integration models, including mandating that their Medicaid MCOs offer D-SNPs[†] and requiring that these D-SNPs operate statewide.

For these states, Medicaid managed care systems provided a clear pathway toward statewide integrated care. That said, states took different approaches to implementation. Some have been very hands-on and directive in working with their MCOs and D-SNPs to address rural challenges, while others have taken a more hands-off approach, encouraging plans to innovate to address rural challenges rather than providing specific state guidance.

In contrast, states with little or no Medicaid managed care infrastructure viewed statewide integrated care as an aspirational goal. These states described struggling to identify policy solutions to support Medicare-Medicaid integration overall, not just in rural areas.

Opportunities to Address this Challenge

- **Leverage existing models that have already proven to be valuable in rural contexts**. States with and without managed care saw the PACE model as a promising approach to bring integrated care to rural communities. However, states acknowledged that challenges related to serving rural areas — such as limited eligible PACE participants and provider shortages — also impact PACE organizations and can impede a PACE organization's viability. In addition to PACE, states without managed care delivery systems might also look to accountable care organizations or community care hubs as entities that could provide improved care coordination for rural dually eligible populations if full integration of Medicare and Medicaid services is not attainable.[23,24]

[†] D-SNPs are a type of Medicare Advantage plan that only enroll dually eligible individuals. D-SNPs were originally authorized by the U.S. Congress in 2003 and made a permanent part of Medicare Advantage in 2018. D-SNPs are required to hold contracts with the state Medicaid agency in each state in which they operate, and those contracts must contain at least certain minimum elements.

3. Provider network requirements can limit expansion into rural areas.

Current integrated care models have federal requirements for provider network adequacy (42 CFR 422.116 for D-SNPs) or care team composition (42 CFR 460.102 for PACE organizations) set by the Centers for Medicare & Medicaid Services (CMS). CMS uses maximum travel time and distance standards for Medicare Advantage plans that vary by five geographic designations: Counties with Extreme Access Considerations (CEAC), rural, micropolitan, metropolitan, and large metropolitan.[25] In general, CMS permits longer travel times and distances between plan enrollees and providers in increasingly rural counties.[26] Despite CMS' allowances for rural areas, however, several states reported that their D-SNPs still have difficulty meeting provider network adequacy requirements.

Relatedly, one MCO mentioned that the distances between enrollee residences in rural areas also make it difficult for the plan to provide care and services in enrollees' homes in a cost-effective way. For example, if care managers need to make in-person assessments of enrollees' needs, they must drive long distances to reach enrollees' homes. As a result, care manager-to-enrollee ratios need to be lower in rural areas to adequately meet the needs of rural populations, but this increases the plan's care management costs. Similarly, health plans have higher expenses to provide other in-home services, such as home health and personal care, or to deliver medical equipment and supplies in rural areas compared to more urban areas.

Opportunities to Address this Challenge

- **Work with D-SNPs to address provider shortages**. At CHCS' convening, several states described varied approaches to help plans address challenges with provider network requirements. One state shared that it takes a proactive approach — working closely with its plans — to address provider network challenges, including providing education and awareness about how D-SNPs can request Medicare Advantage provider network exemptions from CMS. Another state mentioned a more hands-off approach with plans, encouraging D-SNPs to develop creative approaches and determine the actions needed to address provider network challenges. Yet another state said that it encourages D-SNPs with non-overlapping service areas to work together to identify opportunities to address provider network challenges.

- **Encourage D-SNPs and Medicaid MCOs to work with local entities to identify community-based solutions**. States also mentioned encouraging D-SNPs and MCOs to collaborate with local entities in rural areas to identify resources and capacity supports that would help these plans to meet federal and state provider network, care management, and interdisciplinary care team requirements.

Key collaborations with local entities — such as with community- and faith-based organizations, larger hospital systems, and federally qualified health centers — enable plans to leverage these partners' local insights and expertise with rural communities and extend plans' provider network reach and capacity. For example, one MCO mentioned that it has created a workforce development program to support rural provider organizations and their efforts to increase provider staffing. Under the program, the MCO and provider organizations offered matching bonuses to incentivize new physicians to join the rural provider organizations.

- **Support D-SNP and Medicaid MCO use of community health workers (CHWs) to improve outreach and engagement for rural enrollees**. Several D-SNP and MCO interviewees mentioned using CHW programs to support outreach and engagement. CHWs are public health workers who have deep connections to the communities they serve. Health plans can employ CHWs to connect dually eligible enrollees with health and social care, as well as to improve the cultural competence of delivered services. One D-SNP noted that its CHW program made it possible to help meet the needs of rural communities. The CHWs helped fill workforce gaps that impact dually eligible individuals in rural areas, such as connecting enrollees to services that address food, housing, and transportation needs.

- **Continue to invest in broadband access to support telemedicine**. Several stakeholders noted that telemedicine is a promising area of innovation to overcome a lack of providers in rural areas. The COVID-19 pandemic demonstrated the potential of telehealth to make care more accessible, particularly where in-person visits are not feasible. During the pandemic, telemedicine offered an efficient, convenient, and often cost-effective way to deliver care, especially for routine and non-emergency services.[27] State interviewees and one D-SNP mentioned interest in using telehealth for improving access to behavioral health care. It is important to note, however, that many rural communities still struggle with internet connectivity, which can hinder telehealth services.

  Targeted investments in broadband infrastructure are essential to realize the benefits of telemedicine in rural areas. One MCO mentioned that it covers the cost of broadband services for rural enrollees, as well as offers remote devices to help monitor health status, such as blood pressure. The investment in broadband infrastructure not only includes expanding broadband access, but also ensuring that residents have the devices and digital literacy to engage with telehealth platforms. In another example, a D-SNP interviewee mentioned exploring tele-therapy in combination with CHWs working with enrollees as a possible hybrid model to improve access to services.

4. Financial risk deters investment in integrated care expansion.

Significant upfront investments are needed to implement or expand a D-SNP or PACE organization.[28] For these entities, entering rural service areas with no guarantee that enrollment will be sufficient to yield a return on investment in the foreseeable future is financially risky. For example, one MCO interviewed estimated that it would take approximately seven years for its soon-to-launch rural D-SNP to no longer operate at a loss. Plans also expressed concerns — reinforced by recent evidence — about financial barriers for rural providers to invest in the technologies needed to improve their information and data exchange capabilities in support of care management.[29]

Opportunities to Address this Challenge

- **Implement state policies to encourage enrollment in integrated care options**. To operate in rural areas, integrated care plans need a sufficient enrollee base to offset the higher operational and administrative expenses associated with providing coverage in rural areas. Representatives from Medicaid MCOs that also offer affiliated D-SNPs in the same state noted that state policies encouraging enrollment in integrated care plans can help improve health plans' financial viability in rural areas. While states cannot require dually eligible individuals to enroll in a D-SNP, they can implement default enrollment — the process by which a member of an MCO is automatically enrolled into an affiliated D-SNP when the member becomes eligible for Medicare.[30] Default enrollment can allow D-SNPs to steadily build enrollment over time. One MCO that had an affiliated D-SNP believed that default enrollment would help the plan grow enrollment in rural areas, but the state in which it operated does not permit this enrollment mechanism.

- **Consider rural-specific payment policies**. Interviewed MCOs noted that Medicaid payment-rate flexibilities for health plans operating in rural areas would be helpful in expanding and maintaining statewide integrated care programs. States could, for example, establish rural-specific capitation rates that provide enhanced payments to rural-based providers. This might help encourage providers to participate in plans' provider networks. Additionally, states could consider specific risk corridors in rural areas that encourage plans to enter and stay in rural markets that have low enrollment, which may, in turn, ensure the continued presence of aligned D-SNPs and MCOs in these areas.

Looking Ahead

Expanding integrated care programs into rural communities is a policy goal for many state Medicaid agencies. A focus on innovation, regulatory collaboration, and cross-sector partnerships is needed at the national, state, and local levels to not only address the integrated care needs of dually eligible individuals in rural areas, but also the broader care needs of all people living in these communities.

CMS and states have opportunities to advance innovative solutions that meet the unique needs of dually eligible individuals in rural communities. Recent actions by federal policymakers could signal a willingness to encourage innovation. In the last several months, both CMS and Congress have focused on rural health issues. For example, CMS has announced the addition of more hospitals to the Rural Community Hospital Demonstration Program that tests a cost-based payment methodology for inpatient services.[31] And, in January 2025, the Health Resources & Services Administration announced a grant funding opportunity to support the expansion of PACE into rural communities.[32]

While these supports could help strengthen the infrastructure needed to provide integrated care in rural communities, the passage of 2025 H.R. 1 could make it more difficult to improve rural health care access and infrastructure in many states, given the array of Medicaid funding cuts contained within the law.[33] While the legislation includes a new Rural Health Transformation Program designed to mitigate potential negative impacts on rural communities,[34] whether this funding will be sufficient to offset other cuts will vary by state.[35]

Continued bipartisan support for Medicare-Medicaid integration, along with renewed attention to issues affecting rural communities, offers a pathway for states across the country to expand access to integrated care programs. Leveraging the opportunities outlined in this brief may be challenging for states, health plans, and other stakeholders, given the current policy environment and competing state priorities for their Medicaid programs. However, a focus on rural populations is necessary to offer Medicare-Medicaid integrated care programs to dually eligible individuals in all communities.

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