The Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit

Raising Rural Voices from New Mexico, North Dakota, and Tennessee to Create Action

JANUARY 2023

Ellen Breslin • Samantha Di Paola • Susan McGeehan
Rebecca Kellenberg • Andrea Maresca
Health Management Associates

HMA

Contents

Executive Summary

The Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit: Raising Rural Voices from New Mexico, North Dakota, and Tennessee to Create Action provides a robust discussion of the access challenges facing dually eligible individuals in rural areas and offers a portfolio of actionable solutions to address these challenges.

Dually eligible individuals in rural areas reside at the intersection of a major public health crisis and a fragmented Medicaid and Medicare delivery system. They experience poor access to services and to integrated care programs (ICPs) to address their whole person needs. This is a perfect storm for this population, affecting both their life quality and life span.

An Imperative to Develop an Intentional Strategy for Dually Eligible Individuals in Rural Areas

We have a national imperative to solve the rural health crisis and to develop an intentional strategy to improve access to services and to integrated care for dually eligible individuals living in rural areas.

Approximately 1 in 20 individuals who are eligible for both Medicaid and Medicare live in rural America. They number only 2.6 million and represent only 5 percent of the total population living in rural, tribal, and geographically isolated communities. Their small size puts them at risk of falling through the cracks of the larger public health crisis.

As we reported in our 2021 brief, we know dually eligible individuals in rural areas "face uncertain access to health and behavioral health care, long-term services and supports, and social services."

Little information exists on the unique experiences of dually eligible individuals living in rural areas. Currently available reports and data do not describe their needs.

In response, we designed this toolkit to help policymakers address the access challenges facing dually eligible individuals in rural areas. For this population, addressing access must encompass access to a comprehensive Medicaid and Medicare services continuum that includes home- and community-based services (HCBS), as well as access to ICPs. State and rural variation in access to HCBS and to ICPs is uneven, however. This is very unfortunate, since HCBS and ICPs are such powerful solutions for states seeking to better serve dually eligible individuals in rural areas. Addressing these problems requires making equity the primary focus.[1]

A Toolkit to Bring Attention to the Unique Needs of Dually Eligible Individuals in Rural Areas

We must begin our work to improve access and reduce disparities for dually eligible individuals in rural areas by investing in these communities. We are pleased to share the HEARD Toolkit with federal and state policymakers and the community at-large. We are grateful to many people for their help in creating this toolkit.

In 2022, we convened stakeholder roundtables in three states—New Mexico, North Dakota, and Tennessee—hearing from 50 diverse voices, to enhance our understanding of the access barriers facing dually eligible individuals living in rural areas. We invited stakeholders to share their solutions to these challenges. We also convened a small review committee composed of four experts representing the Health Resources & Services Administration (HRSA), the Centers for Medicare & Medicaid Services (CMS), the disability community, and the special needs plans (SNPs) community.

Rural Americans are struggling to access services that meet their health and health-related service needs (HRSNs). They have poorer health outcomes and experience many health disparities, compared with urban residents.[2]

Acute workforce shortages in direct care workers and primary care and mental health providers, as well as hospital closures (183 since 2005), dominate the rural health crisis, worsened by other social, economic, and environmental factors such as limited transportation and a poor housing stock. There are no easy solutions to this public health crisis. Residents' needs and their corresponding demand for services outstrip the resource supply. These resources are constantly at risk as the public health crisis worsens. For instance, a change in one supply factor can have a domino effect on the entire community. One hospital closure can change the community's entire ecosystem and resident access to health care.[3]

Sadly, the public health crisis in rural America is disproportionately affecting dually eligible individuals, cutting thousands of lives short. Indeed, dually eligible individuals in rural areas pay a steep mortality penalty because of where they live.

Dually eligible individuals in rural areas must navigate a fragmented Medicaid and Medicare delivery system. They are a heterogenous population with unique and high needs. Unfortunately, they can't get what they need. They experience poor access to direct care workers for HCBS and to ICPs to address their whole person needs.

An Opportunity to Leverage the Federal Focus on Rural Health Access and Disparities

Given federal and state interest in improving access in rural America, we have an opportunity to do better. CMS's Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities outlines six priorities and several key supporting activities to respond to each community's unique needs.[4]

The federal government established Medicaid and Medicare as separate programs. They were not designed to work together. As a result, the two separate programs have produced three major pain points:

(1) A fragmented care delivery and poor outcomes for dually eligible individuals;

(2) Cost shifting between the two programs with no mechanism for Medicaid to share in Medicare savings that may result from Medicaid spending increases on HCBS; and

(3) State capacity burdens as states invest in developing Medicare expertise to create and manage new program models.

ICPs can take on many forms. Some states have a Medicaid fee-for-service model, while other states have a Medicaid managed care model. Under federal law, Medicare Advantage Dual Eligible SNPs (D-SNPs) are the most strategic means of leveraging the Medicare program to address the needs of dually eligible individuals receiving Medicaid services on a FFS basis or through a managed care plan. The problem is that dually eligible individuals in rural areas have limited access to ICPs.

Informed by our research and review processes, we developed the HEARD Toolkit to consider the actions that federal and state policymakers could take to improve access for dually eligible individuals in rural areas. The HEARD Toolkit contains eight actionable solutions housed within three domains. The toolkit provides guidance to federal and state policymakers on how to make solutions actionable. The federal government, for example, can provide technical assistance to states. States can also pass new laws, issue Executive Orders, set new Medicaid requirements, and leverage state Medicaid agency contracts (SMACs) with D-SNPs. Several toolkit solutions propose that state policymakers leverage their SMACs to advance ICPs.

We anticipate that policymakers will build upon this toolkit through continued dialogue with rural communities and that the federal government will make the necessary investments in rural communities to address the structural supply shortages in rural areas.

See **Appendix 1** for a list of acronyms used in this toolkit.

The Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit: Raising Rural Voices from New Mexico, North Dakota, and Tennessee to Create Action

JANUARY 2023

In 2022, HMA convened stakeholder roundtables in three states – including New Mexico, North Dakota, and New Mexico to identify the challenges facing dually eligible individuals living in rural areas and to propose solutions to these challenges. Informed by this process, HMA developed this toolkit.

The toolkit is structured around three domains used to organize eight solutions. For each solution, HMA provides a description of the rural access challenge, the proposed solution, and the proposed tool. Each tool is powered by some type of lever available to the federal and state government. We anticipate that policymakers will build upon this toolkit through continued dialogue with rural communities.

The HEARD Toolkit Framework

DOMAIN 1
Rural Community Planning

Goal: To strengthen the rural community's ability to optimize its assets, reduce racial and geographic disparities, support rural and Indigenous cultures, account for rural realities such as small populations and distance, and invest in transportation.

Actionable Solutions:

1.1. Create a Comprehensive Access and Rural Equity (CARE) Plan

1.2. Develop a Rural-Specific Databook Focused on Dually Eligible Individuals in Rural Areas

1.3. Establish Targeted Dual Eligible Special Needs Plan (D-SNP) Care Coordination Requirements

DOMAIN 2
Workforce Capacity

Goal: To increase access to direct care workers, community health workers, and providers for dually eligible individuals living in rural areas.

Actionable Solutions:

2.1. Expand Medicaid Coverage for Community Health Workers

2.2. Close Medicaid and Medicare Provider Network Gaps

2.3. Align Medicaid and Medicare Provider Networks

DOMAIN 3
Social Determinants of Health Needs

Goal: To address the SDOH needs and/or HRSNs of dually eligible individuals living in rural communities, prioritizing social isolation and loneliness, food, and housing.

Actionable Solutions:

3.1. Identify Community Resources to Address Social Isolation

3.2. Address Food and Housing Needs

Authors and Key Contributors

Authors: Ellen Breslin, Samantha Di Paola, Susan McGeehan

Key Contributors: Andrea Maresca, Rebecca Kellenberg

Ellen Breslin is a Principal at Health Management Associates (HMA). Previously Ms. Breslin was the Director for Medicaid Managed Care Payment and Analysis for the MassHealth program, a Principal at the Congressional Budget Office, and a Budget Analyst for the Massachusetts House Ways and Means Committee. She holds a Master's in Public Policy from the Sanford School of Public Policy at Duke University.

Samantha Di Paola is a Consultant at Health Management Associates (HMA). Previously Ms. Di Paola held positions at the Georgetown University Health Policy Institute Center for Children and Families, FASD United, and the United Kingdom Department of Health and Social Care. She holds a Master's in Health Administration from the Robert F. Wagner Graduate School of Public Service at New York University.

Susan McGeehan is a Senior Consultant at Health Management Associates (HMA). Previously Ms. McGeehan held different policy, clinical and operational leadership positions in Medicaid and dual-eligible programs administered by health plans. She holds a Master's in Gerontological Studies from Scripps Gerontology Center at Miami University and is a licensed social worker.

Andrea Maresca is a Principal at Health Management Associates (HMA). Previously Ms. Maresca was the Legislative Director for Policy and Strategy for the National Association of Medicaid Directors and the Legislative Director for Health at the National Governors Association. She holds a Master's in Public Health from the Milken Institute School of Public Health at the George Washington University.

Rebecca Kellenberg is a Principal at Health Management Associates (HMA). Previously Ms. Kellenberg was Director of Member Services and Policy for the Georgia Department of Community Health's Medicaid program and Georgia's CHIP Director. She holds a Master's in Public Policy from The Irving B. Harris School of Public Policy at the University of Chicago.

Acknowledgments

The authors would like to thank **Arnold Ventures** for supporting this work and Amy Abdnor, Anisha Agrawal, and Arielle Mir for their guidance and support throughout the project.

We express our gratitude to many individuals and organizations for sharing their time, expertise, and valuable insights. We are grateful to our stakeholder participants from **New Mexico**, **North Dakota**, and **Tennessee**. **Appendix 2** provides a list of participating organizations.

We also want to express our appreciation to our state Medicaid program leaders from New Mexico, North Dakota, and Tennessee: **Tallie P. Tolen**, Long-Term Services and Supports Bureau Chief, Human Services Department, Medicaid (New Mexico); **Katie Evans Moss**, Chief of LTSS, Division of TennCare (Tennessee), and **Patti Killingsworth**, former Chief of LTSS; and **Krista Fremming**, Interim Director, Medical Services at North Dakota Department of Health and Human Services, and **Caprice Knapp**, former Director, Medical Services at North Dakota Department of Health and Human Services. We also wish to thank other state Medicaid programs including **Paul Saucier** and **Joseph Zamboni** from Maine and **Andrew Bean** from Indiana for providing state contracts.

We are grateful to our external expert reviewers of this toolkit and for helping to shape this final document.

Craig Caplan, MA, Senior Advisor, Federal Office of Rural Health Policy, Health Resources & Services Administration (HRSA)

Tim Engelhardt, MHS, Director, Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office

Dennis Heaphy, MPH, MEd, MDiv, Health Justice Advocate and Researcher with the Massachusetts Disability Policy Consortium, Co-Chair of the One Care Implementation Council, a One Care member, and MACPAC Commissioner

Pamela J. Parker, MPA, Medicare-Medicaid Integration Consultant, SNP Alliance

We are grateful to our HMA colleagues who leant their expertise to this project, including **Diane Schneidman**, Quality Control Editor; **Suzanne Daub** and **Sarah Oachs** for supporting the roundtables; and **Rachel Deadmon** and **Leslie Ramirez** for helping with the research.

Finally, we are grateful to **Maria Gallagher** and **Kieran Daly** of Winking Fish for designing the report.

Background: Dually Eligible Individuals Living in Rural Areas

As Health Management Associates (HMA) wrote in *Health Affairs*, the rural health crisis is disproportionately affecting dually eligible individuals living in these areas.

HMA estimates that 1 in 20 dually eligible individuals live in rural areas and account for 5 percent of the total rural population. See Figure 1. These numbers assume that: (1) 2.6 million dually eligible individuals live in rural areas, accounting for 21 percent of all dually eligible individuals in the US; and, (2) the total rural population ranges between 46 and 61 million people.

Given the small number and dispersion across many counties, dually eligible individuals living in rural areas are at risk of escalating into crisis without an intentional plan to address their needs.

FIGURE 1.

Dually Eligible Individuals as a Percentage of Total Rural Population.

Dually eligible individuals lack access to adequate medical, behavioral health, home- and community-based services (HCBS) and other social services. People living in rural areas face even steeper challenges. Because dually eligible individuals are among the poorest of all individuals covered under Medicare, they are at significant risk of paying a steep rural mortality penalty.

A recent study indicates that the age-adjusted gap in death rates between urban and rural dually eligible individuals ages 65 and older more than doubled from 9.7 per 1,000 to 19.9 per 1,000 from 2004 to 2017, based on the authors' calculations. This situation is unacceptable, cutting thousands of lives short.

Dually eligible individuals are a heterogeneous population. They have diversity in age, as well as chronic conditions and disabilities. The population has a high percentage of people with mental health or substance use disorder (SUD) needs and face health care inequities resulting from the intersectionality of poverty, race, disability, and geographic location.

The complexity of the population and the challenges being faced also present opportunities for innovation for the dually eligible population living in rural communities. The US can reverse the mortality-disparity rate trajectory. Public and private entities are interested in revitalizing rural America, confronting the rural health crisis, and harnessing the power of rural communities. Investment in the rural health care sector is essential, given it is a major economic driver of rural communities.

Federal and state leaders must carefully account for the needs of rural dually eligible individuals. Flexible integrated care or whole-person, person-centered models, grounded in independent living (IL) principles and the recovery model, effectively address dually eligible individuals' needs. These models can improve community tenure by providing the right supports at the right time to prevent acute-care events and hospitalizations. Effective care models include comprehensive care assessments, planning, and coordination to integrate services across the continuum and drive access to in-home care and support innovations.

Most dually eligible individuals cannot participate in an integrated care program (ICP) that can help them navigate the often confusing, complicated, and fragmented care systems and supports across Medicare and Medicaid. HMA's 2020 brief reported that ICP enrollment for dually eligible individuals never rose above 10 percent between calendar years (CYs) 2014 and 2019.

Due to many factors, including population size and plans' financials, fewer ICPs are available to dually eligible individuals in rural areas. Urban residents have greater access to these types of programs. Many rural residents do not have the option to enroll in a Medicare Advantage (MA) plan. As of March 2022, the urban-rural enrollment rate difference was nearly 10 percentage points. This gap leaves dually eligible individuals without the potential for care coordination and the opportunity to receive integrated care. Another problem is that other rural residents lack access to MA plans because they leave MA plans for traditional Medicare. This is due to limited benefits and restrictive provider networks.

Introduction

The Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit builds on an earlier HMA issue brief, finding that dually eligible individuals living in rural areas "face uncertain access to health and behavioral health care, long-term services and supports, and social services."[5]

Dually eligible individuals in rural areas live at the intersection of a major public health crisis, and a fragmented Medicaid and Medicare care delivery system. They have poor access to direct care workers and service providers, as well as ICPs that address their whole person needs. Rural dually eligible individuals experience poorer health outcomes than their urban counterparts and pay a rural mortality penalty.

See Figure 2 for a few key facts about the rural public health crisis for context, and **Appendix 3** for additional information.

FIGURE 2.

Rural Public Health Crisis Key Facts

1 in 5 people live in rural, tribal, and geographically isolated communities across the US	**Rural residents have higher rates of poverty, and higher rates of chronic conditions than urban residents**	**66 percent of federally designated HPSAs are in rural areas, affecting access to primary care and mental health care**	**183 hospital closures since 2005**

The Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit

In recognition of the access needs for dually eligible individuals living in rural areas, HMA convened representatives from diverse stakeholders in three state roundtables, in New Mexico, North Dakota, and Tennessee.

States were selected based on the state's share of rural residents, poverty rates, race, ethnicity, ICP experience and enrollment, broadband internet access, HPSAs, and the state Medicaid program's willingness and capacity to engage in the roundtable.

HMA asked stakeholders to describe the challenges facing dually eligible individuals in rural areas and propose solutions to address their needs. Stakeholders shared that individuals covered under Medicaid and Medicare lack adequate access to direct care workers, providers, services, and ICPs.

Informed by these state roundtables, HMA developed the *Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit* to provide policymakers with actionable solutions to improve access to services and ICPs.

The HEARD toolkit contains eight actionable solutions, structured around three domains. The toolkit's solutions illustrate the range of rural access challenges and actions that federal and state policymakers can take to improve access to services and ICPs for dually eligible individuals in rural areas.

Stakeholders in New Mexico, North Dakota, and Tennessee are struggling to develop solutions for rural dually eligible individuals against the backdrop of a larger public health crisis and related workforce shortages, affecting all rural residents. Stakeholders' experiences and stories underscored the national imperative to improve access for dually eligible individuals living in rural areas.

For this reason, the toolkit's very first solution creates a national imperative for the federal and state governments to invest in a local infrastructure across rural communities, with the capacity to engage diverse stakeholders and prepare a *Comprehensive Access and Rural Equity (CARE) Plan*.

HMA will house the *HEARD Toolkit* on its website. See Figure 3 for key terms used in this toolkit. Rural communities are encouraged to tailor the solutions to each community's culture, based on a robust stakeholder process.

FIGURE 3.

Key Terms Used in the HEARD Toolkit

We use the terms **dually eligible individual** or **the dual eligible population** to mean full-benefit, dually eligible individuals. However, federal and state policymakers must consider the needs of all dually eligible individuals as they work with communities to improve access.

We define **integrated care programs (ICPs)** as financing and care delivery organizing entities or programs that coordinate and integrate Medicare and Medicaid-covered services and supports for dually eligible individuals.

We use the terms **rural area** and **rural community** generally.

Of note, the definition of rural varies across government agencies, policies, and jurisdictions. The US Department of Health and Human Services and its Centers for Medicare & Medicaid Services (CMS) define rural areas according to the Census Bureau of the US Department of Commerce and Office of Management and Budget (OMB).

The Census Bureau defines rural as any population, housing, or territory outside an urban area. The Census defines urban as urbanized areas (UAs) of 50,000 or more people and urban clusters (UCs) of 2,500–49,999 people.

The OMB defines counties as metropolitan (metro), micropolitan (micro), or neither based on population size. Metro areas are considered not rural; they contain an urban core of 50,000 or more people. Micro areas are considered rural but contain at least an urban core of 10,000–49,999 people. Counties outside of metro or micro areas are considered rural.

The National Imperative to Advance Health Equity in Rural Areas

The nation has an imperative to advance health equity in rural areas. Over the last few years, the federal and state governments have increased their focus on the rural public health crisis affecting people in rural, tribal, and geographically isolated communities. More recently, President Biden declared November 17, 2022, National Rural Health Day (see Figure 4).

In recognition of this day, CMS's OMH released the CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities. CMS's new framework for advancing health care focuses on six priorities over the coming years and outlines key activities within each priority. CMS's priorities and activities hold promise for dually eligible individuals in rural areas.

CMS's six priorities are:

- **Apply a community-informed geographic lens to CMS programs and policies**
- **Increase collection and use of standardized data to improve health care for rural, tribal, and geographically isolated communities**
- **Strengthen and support health care professionals in rural, tribal, and geographically isolated communities**
- **Optimize medical and communication technology for rural, tribal, and geographically isolated communities**
- **Expand access to comprehensive health care coverage, benefits, and services and supports for individuals in rural, tribal, and geographically isolated communities**
- **Drive innovation and value-based care in rural, tribal, and geographically isolated communities.**

We anticipate that CMS's framework and activities will bolster state and community capacity to develop and implement actionable solutions in the HEARD Toolkit for dually eligible individuals in rural areas.

CMS's framework examines issues affecting individuals who are dually eligible for Medicare and Medicaid programs, including those residing in rural areas. CMS is also collaborating with states and other organizations to increase access to integrated care for individuals in rural areas who are dually eligible for Medicare and Medicaid. CMS is requiring that these entities assess certain social risk factors.

FIGURE 4.

President Biden Declares National Rural Health Day

President Biden declared November 17, 2022, National Rural Health Day. The proclamation stated, "We recommit to delivering quality, affordable health care to every zip code in America by making insurance and prescription drugs more affordable, expanding mental health and substance use disorder services, and by keeping rural facilities open and staffed with dedicated doctors, nurses, and other health professionals."[6]

According to the Health Resources & Services Administration (HRSA), "Since 2010, the National Organization of State Offices of Rural Health set aside the third Thursday of every November to celebrate National Rural Health Day. National Rural Health Day is an opportunity to celebrate the 'power of rural' by "honoring the selfless, community-minded spirit that prevails in rural America." We use this day to highlight the unique health care challenges that rural people face. Then, we show how our programs and policies, and the efforts of our partners and stakeholders, help address and reduce health care disparities in rural communities."[7]

Medicaid and Medicare Pain Points Present Barriers to Integrated Care

To improve access for dually eligible individuals living in rural areas, we must address the pain points between the Medicaid and Medicare program. In the coming years, rural communities will need federal and state legislative and regulatory support to remove artificial barriers impeding dually eligible individuals' access to ICPs.

The federal government established Medicaid and Medicare as separate programs. They were not designed to work together. As a result, the two separate programs have produced three major pain points:

- **Fragmented care delivery and poor outcomes** for dually eligible individuals
- **Cost shifting** between the two programs with no mechanism for Medicaid to share in Medicare savings that may result from Medicaid spending increases on HCBS
- **State capacity burdens** as states invest in developing Medicare expertise to create and manage new program models [8]

Federal policymakers have long recognized these pain points by changing laws and regulations to provide states with opportunities to align Medicaid and Medicare financing and integrate Medicaid and Medicare services. The Affordable Care Act established CMS's Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office (MMCO), "to make sure dually eligible individuals have full access to seamless, high-quality health care and to make the system as cost-effective as possible. The MMCO works with the Medicaid and Medicare programs across federal agencies, states, and stakeholders to align and coordinate benefits between the two programs effectively and efficiently."[9]

CMS's CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F) furthers federal efforts and state opportunities to improve Medicaid and Medicare integration.[10] The rule "revises regulations for D-SNPs [Dual Eligible Special Needs Plans], and in some cases, other special needs plans related to enrollee advisory committees, health risk assessments, and ways to improve integration of Medicare and Medicaid. Many finalized policies are based on lessons learned from the Medicare-Medicaid Financial Alignment Initiative." Of note, officials at CMS plan to end the Financial Alignment Initiative (FAI) by the end of 2025.

FIGURE 5.

Key Pain Point Between the Medicaid and Medicare Programs: Separate Medical Loss Ratios (MLRs).

With CMS ending the FAI capitated model, some states will experience a major set back with the re-introduction of separate Medicaid and Medicare MLRs.

CMS and state Medicaid programs must address the state's financial risks related to having misaligned federal and state MLR methodologies that apply to Medicaid and MA plans. When ICPs have two different MLRs, an MLR for Medicare and another MLR for Medicaid, both programs are at risk for cost shifting.[11]

From a Medicaid perspective, state Medicaid programs are at high risk of cost shifting from Medicare to Medicaid. Cost shifting is an important budget concern to state Medicaid programs that pay for HCBS and other LTSS. Without a current mechanism to capture Medicare's acute care savings, state Medicaid budgets could increase as Medicaid LTSS costs increase, while Medicare costs decrease.

Given this situation, state Medicaid programs must be able to leverage the SMAC to set MLR remittance requirements for D-SNPs. States should tie remittance requirements to plan gains. They should also require that plans reinvest any gains above the MLR into plan benefits for dually eligible individuals.

In addition to CMS, the Medicaid CHIP and Payment and Access Commission (MACPAC) has focused on ways to increase the availability of, and enrollment in, integrated care models. According to MACPAC, integrated care has the "potential to improve the health of these individuals and reduce federal and state spending on their care."

In its June 2021 report to Congress, MACPAC offered states ways to "use their contracts with Medicare Advantage D-SNPs to promote greater integration and increase enrollment in integrated plans." In its June 2022 report, MACPAC recommended that all states develop an integrated care strategy.[12] See MACPAC's prepared language for Congress.

In addition to CMS and MACPAC, the Bipartisan Policy Center[13] and the Dual Eligible Coalition[14] support integrated care for dually eligible individuals. Both organizations have developed separate proposals to create a unified program for dually eligible individuals, and address Medicaid and Medicare pain points. Both proposals would require policymakers to reconcile differences in how the Medicaid and Medicare programs work around administration and financing, as MACPAC has noted.[15]

Some policymakers are interested in a unified program. In 2022, a bipartisan congressional proposal recommended that states have the option to fully integrate Medicaid and Medicare financing and services to deliver a comprehensive benefit package that meets dually eligible individuals' medical and non-medical needs.[16]

As federal and state policymakers continue to consider the best ways to increase dually eligible individuals' access to integrated care, they need to understand and recognize the circumstances facing rural communities. Policymakers must consider extending additional Medicaid and Medicare flexibilities for rural communities to ensure that solutions are grounded in rural and Indigenous cultures, community values, and the realities of the rural landscape, such as small populations and distance from health care facilities and supply shortages.

Additional Medicaid and Medicare flexibilities would allow policymakers to consider many options. Conceptually, rural areas could benefit from a single state-administered contract or plan specific to dually eligible individuals.

Another option would be to move forward with a unified program exclusively for dually eligible rural individuals to improve access to services, care coordination, and ICPs. A unified program for rural communities might provide states with greater ability to leverage total Medicaid and Medicare spending, or "dual spend," on dually eligible individuals in rural areas to increase access to ICPs under a Medicaid fee-for-service (FFS) or capitated model, and tailor care delivery around their person-centered needs.

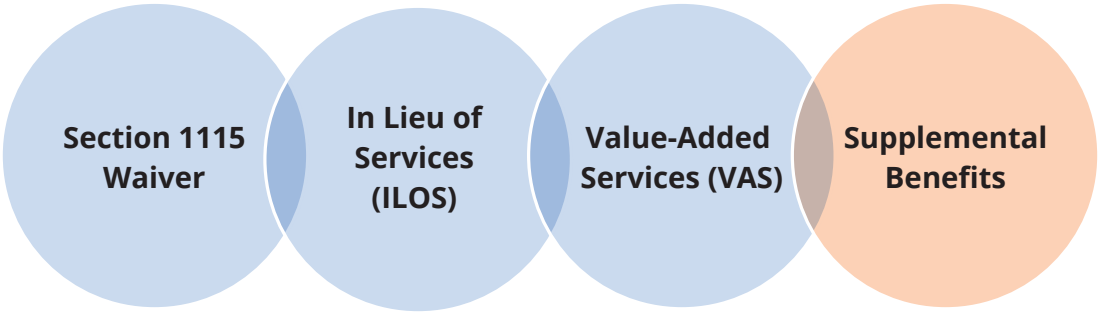
A unified program offering states control over dual spending could simplify many processes for rural communities. Rural communities might find it easier to develop CARE

plans that optimize rural assets and streamline the community's approach to addressing health-related social needs (HRSNs).

For example, Medicaid and Medicare currently design their approaches to addressing dually eligible individuals' HRSNs through separate vehicles. Medicaid uses a combination of Section 1115 demonstration waivers, in-lieu-of services (ILOS), and value-added services (VAS). Medicare relies on supplemental benefits. A unified program could bring a more integrated approach to addressing HRSNs and partnering with community-based organizations (CBOs). See Figure 6 for a depiction of the four key vehicles used by Medicaid and Medicare to cover HRSNs.

FIGURE 6.

Key Medicaid and Medicare Vehicles to Covering Dually Eligible Individuals' SDOH Needs.



ICPs would align Medicaid and Medicare approaches to address SDOH and/or HRSN needs.

State control over "dual spend" also would help state Medicaid programs to determine the baseline spending adequacy for dually eligible individuals in rural areas. Stakeholders, including D-SNP plans, have expressed concern that Medicaid and Medicare spending in rural areas may be inadequate to improve access and outcomes.

In one study, researchers found evidence that Medicare risk scores for urban MA enrollees were higher than scores for rural MA enrollees, despite more favorable outcomes for urban enrollees. This researchers' finding could be the result of urban-rural capacity differences.

Depending on the program design, a unified approach could introduce a significant shift in how the Medicaid and Medicare programs finance services for dually eligible individuals. An innovative design for rural areas could break down agency silos to provide the

plan(s) with a single, risk-adjusted capitation rate held to a single Medical Loss Ratio (MLR) and provide Medicaid with authority to reinvest savings for dually eligible individuals.[17]

Needless to say, any type of unified program raises many policy questions about future federal and state Medicaid and Medicare administration and financing, all of which require thoughtful deliberation to avert unforeseen and adverse consequences on dually eligible individuals in rural areas.

FIGURE 7.

MACPAC's Approach to Measuring State Integrated Care Level for Dually Eligible Individuals.

It is possible to measure the level of integration among states in many ways. MACPAC's June 2022 report to Congress suggests measuring states based on the level of integration offered through D-SNPs. MACPAC sorted states by those with no integration or minimal, low, moderate, high, or full integration. In this report, MACPAC defines "a state with full integration," as one in which "all D-SNPs in the state are either FIDE SNPs or HIDE SNPs that operate with exclusively aligned enrollment."[18]

The HEARD Toolkit: Raising Rural Voices

The Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit provides actionable solutions for policymakers, organized around three domains to improve rural access to services and ICPs for dually eligible individuals living in rural areas.

Methodology

HMA used the following methodology to develop the toolkit.

Step 1. Conduct a literature review.

HMA conducted a literature review to identify the key access issues affecting dually eligible individuals living in rural areas. We found scant information specific to accessible services, care coordination, and ICPs for dually eligible individuals in rural communities. However, many articles and reports focus on the public health crisis facing rural communities. See Figure 8 for more information about rural resources. Based on this review, HMA developed a set of research findings to shape an agenda for the roundtables. See **Appendix 4** for key findings from our literature review.

FIGURE 8.

HMA's Rural Health Resource Library.

HMA created a library to house existing rural resources and toolkits to address rural access challenges identified during our research process. See **Appendix 5**.

Step 2. Hold state roundtables.

HMA conducted virtual roundtables with stakeholders in New Mexico, North Dakota, and Tennessee. Across the three states, we engaged 50 representatives of diverse stakeholders. Each session ran approximately three hours. Stakeholders included dually eligible individuals living in rural areas; CBOs; state agencies including Medicaid, Aging, and Tribal Liaisons; state-based rural health organizations; consumer advocacy organizations; health plans; providers; and Program of All-Inclusive Care for the Elderly (PACE) providers. See **Appendix 2** for a list of stakeholder participants and state "fast facts."

The roundtable included opportunities for small breakout sessions to determine key access challenges and solutions and large group reports. In advance of the roundtables, we provided stakeholders with educational decks to level the playing field for everyone. We focused the agenda on generating solutions for the workforce and service needs. We paid dually eligible individuals a stipend for their time to meet before the roundtable sessions and to participate in the discussion. See **Appendix 4** for key findings from state roundtables.

Step 3. Seek external expert review.

To determine the toolkit's value, HMA selected four experts from different vantage points in Medicaid and Medicare policy and rural health policy. We asked our experts to review two iterations of the solutions recommended in our toolkit to help us answer remaining questions. Informed by our research phases and stakeholder session notes, we developed an initial set of domains and actionable solutions, which we shared with our reviewers for comment. We also shared our stakeholder meeting notes for context. We met as a group to receive the reviewers' initial comments and to discuss their perspectives on each solution. We also shared our first full draft of the toolkit for reviewers' comments. We received valuable feedback from our reviewers.

Limitations

The toolkit is representative of the stakeholders attending the roundtables. However, HMA experienced limited availability and access to dually eligible individuals with lived experience of mental illness and SUD conditions, mental health and SUD providers, HCBS providers, and CILs. Hence, our findings do not fully reflect these perspectives. HMA also experienced another limitation. Stakeholders were focused on solving for the social determinants of health (SDOH) needs of dually eligible individuals. All stakeholder groups ranked SDOH needs as more relevant than access to traditional health care services, care coordination, and ICPs. Our research limitations underscore the significant poverty circumstances dually eligible individuals are confronting during this rural public health crisis.

Toolkit Framework

Informed by our research findings, HMA developed a framework with three domains and eight actionable solutions. In the toolkit's narrative section, we describe the rural access challenge, the actionable solution, and the tool and lever for each solution.

The following figures are designed to help readers use the toolkit.

Figure 9 presents the toolkit's framework, including its three domains.

Figure 10 provides a summary list of the eight actionable solutions contained within each domain. This list also notes the lever(s) used to make each solution actionable. The levers are sorted into two categories. Category 1 includes broad types of federal and state levers, such as executive orders. Category 2 includes specific Medicaid program levers, such as Medicaid managed care (MMC) contracts or SMACs.

Figure 11 provides two tables to guide readers in understanding the range of levers used in this toolkit to create actionable solutions. These levers may be applied differently across the state.

FIGURE 9.

The HEARD Toolkit Framework.

DOMAIN 1 **Rural Community Planning**	DOMAIN 2 **Workforce Capacity**	DOMAIN 3 **Social Determinants of Health Needs**
Goal: To strengthen the rural community's ability to optimize its assets, reduce racial and geographic disparities, support rural and Indigenous cultures, account for rural realities such as small populations and distance, and invest in transportation. **Actionable Solutions:** three (3).	**Goal:** To increase access to direct care workers, community health workers, and providers for dually eligible individuals living in rural areas. **Actionable Solutions:** three (3).	**Goal:** To address the SDOH needs and/or HRSNs of dually eligible individuals living in rural communities, prioritizing social isolation and loneliness, food, and housing. **Actionable Solutions:** two (2).

FIGURE 10.

The HEARD Toolkit Summary

Domain	Actionable Solutions	Tools	Broad Federal and State Levers	State-Specific Medicaid Levers
Domain 1. Rural Community Planning				
1.1	Create a Comprehensive Access and Rural Equity (CARE) Plan	Tool 1. Create a CARE Pan	State executive order Federal and/or state technical assistance (TA)	
1.2	Develop a Rural-Specific Databook	Tool 2. Develop a Rural-Specific Data Book		
1.3	Establish Targeted D-SNP Care Coordination Requirements	Tool 3. Establish Targeted D-SNP Care Coordination Requirements		SMAC
Domain 2. Workforce Capacity				
2.1	Expand Medicaid Coverage for CHWs	Tool 4. Expand Medicaid Coverage for CHWs		SPA
2.2	Close Medicaid and Medicare Provider Network Gaps	Tool 5. Close Medicaid and Medicare Provider Network Gaps		SMAC
2.3	Align Medicaid and Medicare Provider Networks	Tool 6. Align Medicaid and Medicare Provider Networks		MMC Contract SMAC
Domain 3. Social Determinants of Health Needs				
3.1	Identify Community Resources to Address Social Isolation	Tool 7. Identify Community Resources to Address Social Isolation	CARE Plan	SMAC
3.2	Address Food and Housing Needs	Tool 8. Address Food and Housing Needs		Section 1115 Demonstration Waiver MMC Contract SMAC

FIGURE 11A.

Navigational Guides

Guide 1. Federal and State Levers to Create Action and Access Improvements for Dually Eligible Individuals Living in Rural Areas	
Broad Federal and State Levers	**Major Executive and Legislative Levers:** • Laws passed by Congress or the state legislature • Executive orders from the president or governor (Note: An EO or declaration carries the force of law and does not require Congress or the state legislature to act; the legislature cannot overturn.) **Federal and State Administrative Levers that Apply to All States:** • Regulatory • Technical assistance (TA) • Methodologies, innovations, best practices, other

Specific Medicaid Program Levers	**Federal Medicaid authorities for all states**
	• **State Plan Authorities**
	• **State Plan Amendments (SPAs)** may be used to cover optional state plan services
	• **Section 1115 Waiver Demonstrations** may be used to address health-related social needs such as food, housing, and other SDOH
	• **Other Medicaid Authorities** may be used to increase access
	
	Medicaid Contracts for Many States
	• **Medicaid Managed Care (MMC) Contract**
	  • States with MMC contracts may use this lever to leverage Medicaid managed care flexibilities, such as in lieu of services (ILOS) and value-added services to address needs. An MMC contract can also be called a Medicaid Managed Long-Term Services and Supports (MLTSS) contract when they cover LTSS.
	• **State Medicaid Agency Contract**
	  • A SMAC is a "State Medicaid Agency Contract" (SMAC). It is also known as a MIPPA (Medicare Improvement for Patients and Providers Act) contract. D-SNPs must have a SMAC with states (with or without Medicaid managed care) to improve access to care, access to care coordination, and integrated care.
	  • The SMAC identifies the requirements that MA plans must follow when serving dually eligible individuals.
	  • States with D-SNPs may use this lever and augment CMS base requirements for D-SNPs to coordinate with Medicaid programs.

FIGURE 11B.

Navigational Guides

Guide 2. State Examples to Illustrate the Integrated Care Continuum for Dually Eligible Individuals Visit the Integrated Care Resource Center (ICRC) to learn more about D-SNPs				
	State Example 1. **Medicaid FFS + No D-SNP**	**State Example 2.** **Medicaid FFS or MMC Contract + CO D-SNP**	**State Example 3.** **MMC Contract + HIDE SNP**	**State Example 4.** **MMC Contract + FIDE SNP**
State Integration Level	State has a Medicaid fee-for-service (FFS) program and no MA D-SNP. Note: The state has an MMC contract for the Affordable Care Act (ACA) Medicaid expansion population.[19] [20]	State has minimal integration, with either a Medicaid FFS or an MMC program and coordination-only (CO) D-SNP. CO D-SNP models have no risk for LTSS or behavioral health (BH).	State has a moderate level of integration, with an MMC program and a Highly Integrated Dual Eligible (HIDE) SNP, a type of D-SNP. D-SNP organization has Medicaid risk for LTSS or BH. The MMC includes LTSS or BH.	State has a high level of integration, with an MMC program and a FIDE SNP. D-SNP legal entity has Medicaid risk for LTSS and BH. The MMC includes LTSS and BH. Note: Many states deliver LTSS through capitated Medicaid managed care programs, referred to as MLTSS.[21]
State Example(s), Roundtable State*	North Dakota*	Maine, Michigan, Indiana, South Dakota, and Wyoming	New Mexico* and Kansas	Tennessee* Minnesota, Arizona, and Idaho.
Medicaid FFS	Yes	Maine's dually eligible individuals receive Medicaid services via FFS.	Yes	Yes
Medicaid Managed Care	No	Michigan excludes certain services from the MMC contracts.	New Mexico includes all services in the MMC contracts. HIDEs must cover BH and LTSS in NM.	Tennessee includes all services in the MMC contracts. FIDEs must cover BH and LTSS.
Medicare FFS	Traditional Medicare or Medicare FFS is available to dually eligible individuals in all counties across all states.			
Medicare D-SNP	The state has no D-SNPs.	State has D-SNPs, but they may not serve rural areas. D-SNP access varies by state.		
PACE	32 states have PACE programs, including all three roundtable states: New Mexico, North Dakota, and Tennessee			

DOMAIN 1:

Rural Community Planning

1.1 Create a Comprehensive Access and Rural Equity (CARE) Plan.

Lever(s)	Executive Order

Rural Access Challenge

Dually eligible individuals living in rural areas need access to ICPs to address their whole person needs and coordinate care across the care continuum. Because of the dually eligible population's complexity, ICPs must address medical, behavioral health, HCBS, other LTSS, and HRSNs, including but not limited to food, housing, transportation, and internet services.

ICPs include many notable features, including care coordination. Care coordination is critical to health and well-being, managing chronic conditions, and supporting dually eligible individuals' independent living (IL) and recovery goals.[22] [23] See **Appendix 6** for a description and summary of states' level of integration.

However, many dually eligible individuals in rural areas lack access to ICPs to address their whole person needs.[24] They are part of a larger public health crisis, complicated by demographic, economic, environmental, and social factors,[25] as well as an opioid crisis in rural America.[26] The small size of the dual-eligible population spread across distant rural areas puts them at risk of falling through the cracks of the crisis.

Given the evidence, we have reason to be concerned about dually eligible individuals in rural areas. Compared with their urban counterparts, dually eligible individuals living in rural areas have higher mortality and morbidity rates. They pay a rural mortality penalty.

In general, negative health outcomes often are related to weak care coordination for dually eligible individuals. For dually eligible individuals in rural areas, poor health outcomes are also heavily related to no services. Like other people living in rural areas facing supply shortages and infrastructure problems, the dual-eligible population may be more affected than most, stemming from complex conditions and high needs.

People living in rural areas face acute supply shortages—from direct care and provider shortages in primary care and mental health to hospital and nursing facility closures—and infrastructure problems, such as inadequate transportation and limited access to broadband internet. The nation's shortage of direct care workers for in-home care is more acute and immediate in rural areas, worsened by low wages, unpaved roads, and limited transportation.

Dually eligible individuals cannot get to the grocery store for fresh and nutritious foods. The housing stock is old, and they are unable to locate accessible and barrier-free housing. Individuals living in unsuitable housing must face nursing home care. Many dually eligible individuals living in rural areas also experience social isolation, given that they have less access to social activities than their urban counterparts due to distance, lack of transportation, and other factors.

As one participant said,

"Affordable housing is a major problem, and there is a lack of inventory. There is no real estate investment because the community is not seen as investing in other major infrastructure."

Rural dually eligible individuals' access barriers stemming from supply shortages and infrastructure constraints may have potentially distorted and artificially lowered Medicaid and Medicare spending. If this is the case, policymakers must work with actuaries to determine if dual spending levels in rural areas are adequate to support IL and recovery goals, create a level playing field, and support ICP expansion.

FIGURE 12.

How Did Stakeholders Describe Rural Access Challenges?

State roundtable participants emphasized the difficulties dually eligible individuals face when navigating the Medicaid and Medicare programs, services, and sectors. They noted that dually eligible individuals' needs span many federal and state agencies, including Medicaid, Medicare, Aging, Development Services, Department of Health, Insurance, Transportation, and Economic Development and Commerce.

Many stakeholders raised concerns that Medicaid and Medicare policies and programs do not account for rural values, Indigenous culture, and the effects of remote living. Stakeholders expressed a desire for the federal government to fund efforts that would loosen restrictive Medicare and Medicaid policies that have created barriers to services and ICPs. They see flexibility in Medicare and Medicaid program design as necessary to resolve the large supply-side challenges. They support payment methodologies that favor replicable programs over scalable programs. They want Medicaid and Medicare to compensate direct care workers (DCWs) with higher wages and with coverage for day care and transportation costs. In particular, North Dakota's stakeholders shared many initiatives the state has adopted to support the direct workforce and caregivers, as outlined by the National Academy of State Health Policy.

Stakeholders also want federal and state officials to appreciate rural cultures, which frequently revolve around personal relationships and trust. Many dually eligible individuals in rural areas live far from grocery stores and hours away from health care facilities. Neighbors help each other. Word of mouth is a powerful communications tool in rural areas. Many residents are skeptical about government programs, preferring to get information from neighbors or local support groups.

Across the states, we heard many perspectives on rural access challenges and culture:

"People look to each other to solve problems, provide resources, not to government funding."

"In rural areas, the basis for access to care are non-traditional, non-health entities. The church, for example, could serve as a first step

towards resource integration. They may have a knowledge base, and people look to churches for information."

"Small communities operate on the basis of word of mouth. There is a distrust of larger communities. You are going to rely on grandmothers and family rather than a broker."

One stakeholder shared an important goal: "Bring the care to them instead of expecting them to go to the care."

Stakeholders want dually eligible individuals to gain access to a robust service continuum and care coordination supported by an ICP. Many believe that a state leader needs to support a decentralized and stakeholder engagement effort across rural communities to develop a rural-specific strategy for implementation. The strategy must focus on new and innovative ways to optimize rural community assets, recognizing unique rural realities and aligning with rural and Indigenous culture to advance health equity.

Actionable Solution

Federal and state policymakers must partner with rural communities to help build and fund a local infrastructure at the county level to develop a CARE Plan that prioritizes dually eligible individuals' needs. The CARE Plan development and implementation process will benefit from a local infrastructure with staffing at the county level (or community level) to engage diverse stakeholders, develop supply-side solutions, and coordinate with larger federal and state efforts to address barriers to access to health care, HRSNs, and social services, resulting from supply shortages and capacity issues in rural areas.

FIGURE 13.

CARE Plans Must Be Connected to Larger Federal and State Solutions.

An underlying assumption of this toolkit is that the CARE Plan will bring forth solutions to improve access to services and ICPs for dually eligible individuals living in rural areas. These plans must leverage larger national and state efforts and solutions to remove key barriers in rural areas, including provider and direct care shortages, transportation barriers, and telehealth and broadband limitations.

A robust stakeholder engagement process should adopt the function and feel of a collaborative, bringing a range of people and entities together. Engagement processes must include dually eligible individuals, Tribal Nations, Medicaid and Medicare officials, providers and plans, CBOs including Area Agencies on Aging (AAAs) and CILs; food, housing, transportation, and social service organizations (SSOs); workforce associations, and other community assets.

It is important to recognize two critical issues:

- **States and counties will face a heavy lift in developing and implementing CARE Plans.** For this reason, states and counties must determine a reasonable and sustainable approach to creating county-level CARE Plans. States and counties, for example, might choose to create CARE Plans that cover contiguous counties or similarly situated counties based on demand and supply-side factors and economic realities.
- **Every state is unique.** States and counties must be able to drive solutions to fit their environment and culture. State Medicaid programs' HCBS coverage varies extensively. State Medicaid preferences for integrating care also vary. On the one hand, Maine and Washington have shown a preference for integrating care using Medicaid FFS.[27] New Mexico and Tennessee, on the other hand, have shown a preference for creating ICPs via managed care programs.

Federal and state policymakers will need to connect county CARE plans to larger, potentially more resourced state and federal efforts to respond to dually eligible individuals' needs. However, it is critical that federal, state, and rural planners coordinate to prevent duplication and burnout among participants in planning processes. States may be able to leverage other processes such as state processes used to develop aging plans, which also focus on addressing supply-side factors such as rural workforce shortages, internet and broadband barriers, and transportation limitations.

FIGURE 14.

The Importance of Transportation to Dually Eligible Individuals in Rural Areas.

Rural communities must make access to medical and non-medical transportation for dually eligible individuals, as well as DCWs and CHWs, a central component of CARE plans.

Stakeholder participants emphasized many important needs for dually eligible individuals including transportation. Participants shared the following rural access challenges on the topic of transportation.

"Rural access means transportation challenges. We have challenges with companies because they do not have enough individuals to transport. Some of our tribal communities also have challenges. The roads are not paved, they can't get to where they need to be for medical services. This is a huge need."

"Ground transportation is a challenge when the hospital is three hours away."

"You don't have public transport. You don't have Ubers or Lyfts. They are not readily available."

At the national level, the concept of a CARE Plan aligns well with MACPAC's recommendation to Congress that all states develop an integrated care strategy. The CARE Plan also aligns with other federal efforts such as CMS's 2022 commitment to advance health equity in rural, tribal, and geographically isolated communities[28] and HHS's 2020 Rural Action Plan to enhance its focus on rural communities.

At the state level, CARE Plans would align with state agency efforts to develop plans that bring focus to important challenges. In 2019, California Gov. Gavin Newsome issued an Executive Order for a Master Plan for Aging (MPA). (The authors do not endorse the use of the term "Master.") The directive included seven major elements and serves as a model for other states. Subsequently, the SCAN Foundation reported on key elements of an MPA. States have taken different approaches, with governors and legislatures playing different leadership roles in advancing MPAs. Similarly, states and their rural counties should apply and tailor this concept to develop a plan to address rural residents' needs.

States could start the process by putting a state official in charge of a "rural hub" with accountability for helping rural communities to create CARE Plans. From there, the official should partner with counties and rural communities. The rural hub should be

prepared to provide TA to launch the effort, facilitate data collection and analysis, and craft a local infrastructure plan.

States and rural communities must also consider leveraging rural state planning processes and state rural research entities to support the planning process. For example, North Dakota's state leader may want to engage the Center for Rural Health (CRH) at the University of North Dakota.[29] CRH, which participated in North Dakota's roundtable, is designated as the State Office of Rural Health (SORH).[30] Each state has a SOHR[31] and a State Rural Health Plan.[32] State leaders must engage rural communities and experts to inform policy recommendations.

The CARE Plan must make dually eligible individuals a priority, accounting for both demand-side and supply-side factors based on consideration of dually eligible individuals' needs; culture; health disparities; workforce capacity across direct care, primary care, and behavioral health; and gaps in access to care coordination and ICPs.

FIGURE 15.

The Plan for Aging.

In 2019, California's governor issued Executive Order N-14-19, calling for an MPA. The Executive Order directed the Secretary of the California Health and Human Services Agency and related committees to deliver: (1) a March 2020 report from the Long-Term Care Subcommittee, focusing on the growth, stability, and sustainability of the long-term care infrastructure; access to and quality of long-term care programs; system financing; and workforce capacity; and (2) a final plan submitted by October 1, 2020, to the governor.

As a result of this process, the California Department of Aging created a playbook for developing an aging plan that includes seven major moves, including: (1) use the governor's blueprint to engage local leaders; (2) explore local data; (3) review local age-friendly models; (4) select initiatives for local implementation; (5) build an action plan; (6) evaluate the age friendly community program; and (7) stay connected.

In 2019, the SCAN Foundation urged every state to follow California's lead in developing and implementing a plan for aging. The blueprint includes planning for 10 years or more, is often led by a governor with other executive and legislative leaders and is developed to guide the restructuring of state and local policy, programs, and funding toward aging well in the community. The SCAN Foundation contracted with the Center for Health Care Strategies in 2021 to develop a Getting Started with a [Master] Plan for Aging tool.[33] To

date, several states have an aging plan or are in the process of developing one with a combination of executive and legislative support.[34]

Finally, the National Conference of State Legislatures characterizes an aging plan as a document that "aims to transform care for older adults and refers to a comprehensive planning process that delves deep into policy issues and solutions, calling out proposed investments and connections ranging across housing, transportation, workforce, health care, LTSS, economic security and safety, among others."[35]

Tool 1. Create a Comprehensive Access and Rural Equity (CARE) Plan

This tool provides foundational language for governors to issue an executive order to develop CARE Plans. States are free to tailor the language to meet their specific needs. We modeled the following language on California's executive order.

EXECUTIVE DEPARTMENT

STATE NAME

Executive Order [#-#-#]

WHEREAS, STATE NAME values the health and well-being of all individuals in STATE NAME and is committed to addressing the challenges of living in rural areas by creating a CARE Plan so that all state residents can experience improved access to Medicare and Medicaid services, social services and services, food, housing, and transportation, supported by integrated care programs (ICPs).

WHEREAS, all dually eligible individuals living in rural areas in STATE NAME should have access to whole-person, person-centered care, care coordination, and ICPs so that all state residents can live in the community with dignity and independence; and

WHEREAS, STATE NAME'S total population is [NUMBER], the dual eligible population is [NUMBER] in 2023, and the dual eligible population living in rural areas is [NUMBER]; and

WHEREAS, the dual eligible population living in rural areas is racially and ethnically diverse, has higher mortality and morbidity rates, lower incomes and higher needs, poor access to many Medicare and Medicaid services, limited opportunities for care coordination, and limited access to ICPs than their counterparts residing in urban areas; and

WHEREAS, dually eligible individuals including those with complex chronic conditions, physical disabilities, intellectual and development disabilities, and mental health and substance use conditions, should be able to choose to remain in their communities, and whereas meaningful choice requires access to a broad range of public and private programs, resources, and supports, including health, home and community-based services, food and nutrition, human services, housing, and transportation; and

WHEREAS, dually eligible individuals contribute to our communities in numerous ways by mentoring and training STATE NAME residents; and

WHEREAS, dually eligible individuals are severely affected by the rural public health crisis; and

WHEREAS, STATE NAME has long been a leader in supporting [EXAMPLES: a wide range of home- and community-based services] to support dually eligible individuals living independently; and

WHEREAS, STATE NAME is home of many innovators and has tremendous opportunities to design and promote policies to advance independent living and recovery for dually eligible individuals of all disability types; and

WHEREAS, any policy recommendations should build on STATE NAME'S work supporting dually eligible individuals living independently and reflect the principle of "Nothing About Us Without Us" and "About Us, By Us."

NOW, THEREFORE, I, GOVERNOR NAME, Governor of the State of STATE NAME, by virtue of the power and authority vested in me by the Constitution and statutes of the State of STATE NAME, do hereby issue this order to become effective immediately.

IT IS HEREBY ORDERED that the health and well-being of dually eligible residents residing in rural areas in STATE NAME residents be a priority of the State of STATE NAME.

IT IS FURTHER ORDERED that by [DATE] the county-level CARE Plans be developed and issued to serve as a blueprint for state government, local government, private sector, and philanthropy to implement strategies and partnerships around the CARE Plans' key objectives. The CARE Plan must make the needs of dually eligible individuals living in rural areas the primary objective of the CARE Plan.

IT IS FURTHER ORDERED that the Secretary of the STATE AGENCY convene a Cabinet-level Work-group for Rural Access to advise the Secretary in developing and issuing county-level CARE Plans for dually eligible individuals living in rural areas.

IT IS FURTHER ORDERED that the CARE Plans include key data indicators, with 10-year targets, to support the implementation of the CARE Plans.

IT IS FURTHER ORDERED that the CARE Plans include recommendations to better coordinate federal, state, and local government programs and services to serve dually eligible individuals' needs.

IT IS FURTHER ORDERED that the STATE NAME Health and Human Services Agency, in consultation with other state agencies, convene a CARE Plan Stakeholder Advisory Committee, which would include a Research Subcommittee and a Medicaid and Medicare Subcommittee representing a broad array of STATE NAME residents with an interest in expanding access to coordinated and integrated care in rural communities, such as individuals with disabilities covered under Medicare and Medicaid, healthcare providers, health plans, community-based organizations, foundations, rural research centers, to provide advice and input to the Administration on the development of the CARE Plans.

IT IS FURTHER ORDERED that the Medicare and Medicaid Subcommittee report to the Governor by DATE on, but not limited to the following:

- An assessment of the demand for and supply of services for dually eligible individuals in rural areas.
- Recommendations to optimize rural assets, request Medicaid and Medicare flexibilities, modify the Medicaid and Medicare benefits to reflect rural culture and values, and leverage total Medicare and Medicaid spending on dually eligible individuals ("dual spending") as a foundation for implementing the CARE Plans.

IT IS FURTHER ORDERED that agencies under my direct executive authority cooperate in the implementation of this Order, and it is requested that entities of State government not under my direct executive authority assist in its implementation.

IT IS FURTHER ORDERED that as soon as hereafter possible, this Order shall be filed with the Office of the Secretary of State and that widespread publicity and notice shall be given to this Order.

This Order is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of STATE NAME, its departments, agencies, or other entities, its officers or employees, or any other person.

In Witness Whereof:

I have hereunto set my hand and caused the Great Seal of the State of [State Name] to be affixed this **day** of [Month Year].

Signature

Name

Governor of [State Name]

ATTEST:

Name

Secretary of State

1.2 Develop a Rural-Specific Data Book.

Lever(s)	Technical Assistance

Rural Access Challenge

Few data resources comprehensively measure the need for, use of, or spending on care for dually eligible individuals.[36] Federal and state policymakers have yet to invest in the infrastructure to support this work.[37] [38]

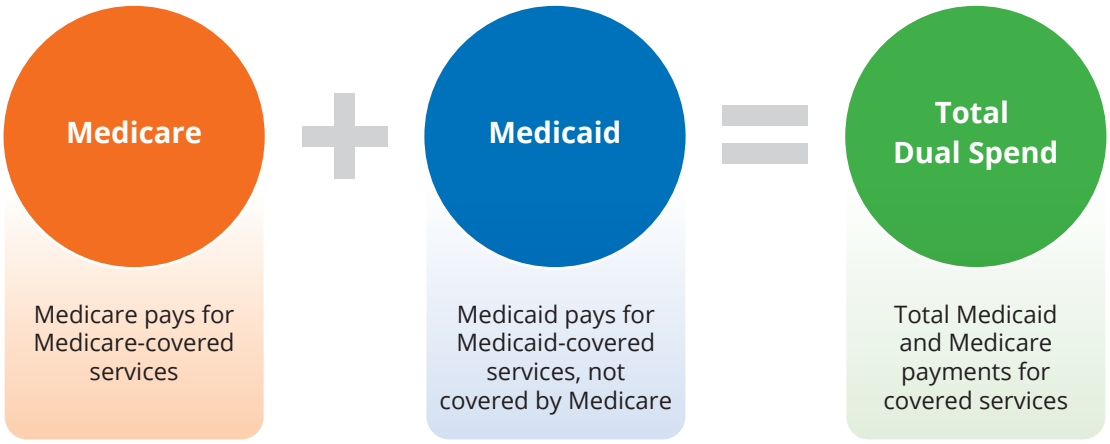
However, rural communities need federal and state data reports to support the evolution of the Medicare and Medicaid programs for dually eligible individuals in rural areas. Data investment is essential to answer stakeholder questions and to guide policy and program development, especially for dually eligible individuals.

Data books on the dual-eligible population often serve discrete purposes, such as setting capitation rates, measuring quality, or tracking spending (see example). Data books and dashboards are less frequently developed to track access to whole-person, person-centered services, and ICPs to address their needs. Data book are needed to track patterns of care delivery, health disparities, unmet HCBS needs, and opportunities to reduce inpatient and emergency department use.

To understand access and equity for dually eligible individuals in rural areas, policymakers and stakeholders need a transparent account of Medicaid and Medicare use and spending among dually eligible individuals living in rural areas. For example, every state should have access to the data to compare total dual spend on dually eligible individuals in rural areas compared to urban areas.

FIGURE 16.

Total "Dual Spend" Equals the Sum of Medicare and Medicaid Spending.



Dually eligible individuals are people enrolled in both Medicare and Medicaid. They are eligible by virtue of their age or disability and low incomes. Medicare is the primary payer for acute and post-acute care services. Medicaid wraps around Medicare. Medicaid assists with Medicare premiums and cost sharing; and covers services that Medicare does not cover, such as HCBS and other LTSS. The two programs cover many of the same services, but Medicare pays first for the Medicare-covered services that are also covered by Medicaid. Medicaid covers services that Medicare does not cover. (Source: Dually Eligible Beneficiaries.)

Note: This basic depiction does not highlight any other spending that does not count as Medicaid and Medicare spending, such as plan spending on value-added services or other services not covered by Medicaid.

As we learned from roundtable discussions and other research, current data books, while helpful, do not provide what rural communities need. See **Appendix 7** to learn more about national and state data resources, which include dually eligible individuals.

At the national level, CMS has produced data profiles on dually eligible populations and their use of Medicare and Medicaid services to support interest in the FAI demonstration program. Since 2013, MACPAC and the Medicare Payment Advisory Commission (MedPAC) have produced a data book that offers a clear picture of the dual-eligible population.[39] The data book presents a high-level overview of the population and related expenditures, utilization, and trends.

At the state level, many Medicaid programs assess the data for budgetary purposes and examine data on the dual-eligible population receiving services. However, many states do not focus on measuring dually eligible individuals' unmet needs, health disparities, and IL and recovery goals. States with MLTSS programs and companion Medicare programs, PACE programs, or FFS and capitated FAI demonstrations tend to produce comprehensive data books to support integrated care procurements. States in this category also collect data, such as financial and quality performance reports, from managed and integrated care plans. Few state Medicaid programs have produced comprehensive data books to facilitate planning and to support the design and development of ICPs.

Although these federal and state data book examples have served various audiences well, the CARE Plan development process with a focus on dually eligible individuals living in rural areas requires a more comprehensive resource, with equal attention to the demand for services and the supply of services.

Federal and state policymakers do not publish these data books. Consequently, federal, state, and rural community policymakers, planners, and stakeholders lack a transparent account of dually eligible individuals' experiences in rural areas, their care gaps and disparities in access to health and human services, and available resources to address their person-centered needs and goals.

Stakeholders participating in the three state roundtables expressed concern about the lack of information to answer fundamental questions about dually eligible individuals' needs, their use of health and social services, and their unmet challenges. Stakeholders asked for a comprehensive account of Medicaid and Medicare data on the dually eligible population, resource utilization, and spending. They also expressed concerns related to the lack of information to answer questions about the community's health care workforce and capacity to address dually eligible individuals' needs.

Many stakeholders would like to see a robust data section focused on the supply side of the equation, with data on the workforce capacity, local market wages, child-care facilities, and transportation options. They see pay, child-care costs, and transportation as inextricably linked components to building a strong, skilled, and engaged workforce.

Other stakeholders discussed additional needs for data on the availability of health care facilities, community resources including grocery stores, food banks, churches, and other CBOs, such as food and housing organizations, social services and supports, community centers, AAAs, CILs, and other rural assets to assess a community's capacity to meet the needs of dually eligible individuals.

Actionable Solution

Rural communities and stakeholders must have a transparent account of dually eligible individuals' experiences around care access, health disparities, and community resource gaps to create a baseline that rural communities can use to track their progress.

Federal and state governments must partner with rural communities and stakeholders to define and create a comprehensive, rural-specific data book on dually eligible individuals to support community-wide discussion, planning, and decision making. The data book should address the community's needs and the supply of available services, as well as support the development of options to increase the workforce.

FIGURE 17.

Federal Resources Needed to Help State Medicaid Programs Produce Data Books.

As one state Medicaid program commented, many states need funding to add new data analysis efforts. Federal officials must dedicate resources and staff with expertise in working with integrated Medicaid and Medicare administrative data to leverage administrative data to create data sets and to use surveys and other tools to collect additional demand-side and supply-side data.

A comprehensive data book would provide rural communities with a powerful tool to:

- **Establish a baseline for measuring and tracking disparities in outcomes and ICP access**
- **Identify unmet needs across the service continuum including SDOH and HCBS needs**
- **Develop opportunities for improving care delivery through care coordination and integration**
- **Compare patterns and trends between rural and urban communities**
- **Promote independent living and recovery**

For data books to be useful, they must stratify the information in ways that account for the diversity of dually eligible individuals across age, race, ethnicity, language, and disability (RELD), and sexual orientation, gender identity, and expression (SOGIE), and chronic conditions.

The federal government can play a meaningful role in facilitating access to data. CMS's State Data Resource Center, created in 2011, provides states with access to Medicare data. For states that have yet to access Medicare data, the federal government should

produce the base data by linking Medicare and Medicaid data at the state, county, and rural community level while being mindful of small population sizes.

States need an integrated data file to support whole-person care delivery. CMS should work with states to link the Medicare enrollment data from Enrollment Database and Common Medicare Environment (CME) files; Medicare Part A, Part B, and Part D claims from Common Working File and Part D Prescription Drug Event data; Medicare Part C payment data from MA Prescription Drug files; Medicaid enrollment and claims data from Transformed Medicaid Statistical Information System (T-MSIS) files; and other data sources.

To support policy and program decision making and CARE Plans, states should collaborate with rural communities to augment the Medicare and Medicaid data with cross-sector data from Tribal Nations, AAAs, CILs, and CBOs, including food and housing organizations.[40] Cross-sector data are critical to attaining an accurate understanding of each community's resources.

Rural communities and other stakeholders must help to define and prioritize the relevant and applicable policy questions, data collection methods, and data analyses, including benchmark comparisons to other rural areas and urban areas across access, use, quality, and integration measures meaningful to rural and Indigenous culture and values.

Federal and state governments may be able to build upon existing data books and methodologies as they help to make data accessible to communities. They also may want to engage other federal and state partners in these efforts. Every state has a SORH.[41] Rural health research centers (see the following box) located throughout this country also might be interested in supporting these efforts by offering analyses to stakeholder engagement efforts. To date, many of these research organizations are interested in dually eligible individuals' needs, but the research tends to focus on their Medicare claims data.[42]

FIGURE 18.

The List of Rural Health Research Centers.

Maine Rural Health Research Center, North Carolina Rural Health Research Center, RUPRI Center for Rural Health Policy Analysis, Rural Health and Minority Research Center (formerly South Carolina Rural Health Research Center), Rural and Underserved Health Research Center, Rural Health Equity Research Center, Rural Telehealth Evaluation Center, Southwest Rural Health Research Center, University of Minnesota Rural Health Research Center, and the WWAMI Rural Health Research Center.[43] WWAMI stands for the states that the UW (University of Washington) School of Medicine serves: Washington, Wyoming, Alaska, Montana and Idaho.[44]

Tool 2. Develop a Rural-Specific Data Book.

Rural communities need access to a range of data books and dashboards. Washington State's "Healthier Washington Dashboard" focuses on the Medicaid population, and serves as a model dashboard because it is easy to use and understand.

Tool 2, which has three sections, provides information about the data needed to support policy and program decision making.

- Section 1 provides general guidance to stakeholders to start on the data process.
- Section 2 provides frameworks to use or modify when stratifying and analyzing data.
- Section 3 provides considerations in using the Medicaid and Medicare data.

See "Databook Tool."

1.3 Establish Targeted D-SNP Care Coordination Requirements.

Lever(s)	SMAC

Rural Access Challenge

Care coordination is critically important for dually eligible individuals with a range of health and social needs to help navigate a fragmented care delivery system.[45] Care coordination has the potential to improve individuals' outcomes by addressing the disconnects between Medicare and Medicaid and to other entities, such as AAAs and CILs.

The term "care coordination" can take on many definitions.[46] In this instance, the term "care coordination" refers broadly to activities to coordinate and manage services for dually eligible individuals, across and between Medicaid and Medicare providers and the larger ecosystem of services and supports.

Many dually eligible individuals lack access to care coordination.[47] This situation is problematic for dually eligible individuals who require access to whole-person, person-centered, and coordinated care across the continuum of medical, behavioral health, LTSS and social services' needs. Participants in the three state roundtables emphasized that dually eligible individuals living in rural areas need care coordination to navigate the care continuum. In rural areas, care coordinators must play a vital role in connecting individuals with health and human service programs. Care coordinators may make referrals,

develop an individualized care plan, and manage the exchange of information between providers and other human services organizations.[48]

Care coordination is critical for dually eligible individuals in rural areas who have higher mortality rates than their urban counterparts and face significant supply-side challenges. As CMS underscores in *Advancing Rural Health Equity: Fiscal Year 2022 Year in Review*, "many people living in rural, tribal, and geographically isolated areas experience barriers to economic opportunities and important services such as health care and internet."[49] Rural areas face acute provider shortages, facility closures, and less available housing, transportation, social services, and nutrition.

Federal and state policymakers have focused on building care coordination expectations and requirements into ICPs for dually eligible individuals. For example, care coordination is a core component of ICPs such as FIDE-SNPs, the FAI demonstration, and PACE. ICPs have helped to reduce potentially preventable inpatient and emergency department use and expand access to LTSS and behavioral health services to support independent living and recovery goals. Under the FAI demonstration, for example, Massachusetts created the Long-Term Services and Support (LTS) Coordinator to strengthen LTSS coordination and advance IL and recovery goals.[50]

Many state Medicaid programs leverage D-SNPs to advance Medicaid and Medicare integration and complement the state's Medicaid approach to providing Medicaid services to dually eligible individuals. Washington's Medicaid FFS program and New Mexico's Medicaid managed care program rely on D-SNPs.

CMS's Model of Care (MOC) makes care coordination a core requirement of D-SNPs. The MOC must describe the plan for delivering coordinated care and care management services to D-SNP enrollees. CMS requires every SNP to have a MOC approved by the National Committee for Quality Assurance.[51] According to CMS, "The MOC is a vital quality improvement tool and integral component for ensuring that the SNP identifies each enrollee's unique needs and addresses the needs through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes."[52]

However, CMS MOC requirements do not require D-SNPs to address Medicaid services for dually eligible individuals.[53] Many state Medicaid programs leverage the SMAC to set and operationalize state expectations and requirements for D-SNPs around care coordination.

CMS requires every D-SNP to have a SMAC with the state Medicaid program and to document at least eight elements in these state contracts. For the contract element, "Coordinating the Delivery of Medicare and Medicaid Benefits and Services," CMS offers the following "foundational language" for state to use:

"The Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and [Medicaid program name], including when Medicaid benefits are delivered via [Medicaid program name] fee-for-service [insert if applicable: and/or managed care providers]. The Contractor is responsible for coordinating the enrollee's Medicare and Medicaid benefits, including, but not limited to discharge planning, disease management, and care management."[54]

States can use the SMAC to define the process between D-SNPs and Medicaid FFS providers or Medicaid managed care plans or AAAs. Many state Medicaid programs require D-SNPs to exceed CMS's minimum requirements. Policymakers appreciate that care coordination is a key component of providing whole-person care for individuals enrolled in both Medicare and Medicaid who integrated care models serve.[55]

A 2019 HMA report on care coordination for MACPAC found that states with the most detailed care coordination requirements also are the most experienced in providing Medicaid managed care. The report also highlights several emerging areas of focus in care coordination requirements: "transitions of care between acute and non-acute settings; information technology, data requirements, and reporting; health risk assessment integration and information sharing; family and other caregiver involvement and assessment; and SDOH."[56]

Actionable Solution

State Medicaid programs can use the SMAC to establish and enhance care coordination requirements including processes for D-SNPs. Indiana's and Maine's requirements cover dually eligible individuals in rural areas. They represent complementary approaches to increasing the value of care coordination for dually eligible individuals and conveying state care coordination expectations for D-SNPs.

Most of Indiana's dually eligible individuals in rural areas receive services through Medicaid FFS today. Approximately one in five dually eligible Indiana residents live in rural areas. Starting in 2024, however, Indiana's dually eligible individuals will have access to a new statewide Medicaid LTSS program. The state's goals include rebalancing the LTSS system and integrating Medicaid and Medicare. The state's new MLTSS program requires all plans to establish a D-SNP, which means coverage for all state counties and all dually eligible individuals in rural areas.

Indiana's approach for leveraging the SMAC has evolved over time, beginning in 2021 with a requirement for D-SNPs to share information on high-risk members in waiver programs, in 2022 with a requirement to make proactive referrals to AAAs for non-waiver members, and in 2023 to require D-SNPs to use a SDOH assessment tool. Indiana's 2023 SMAC brings the state's expectations together, focusing on care coordination, transitions of care, and coordination with the state's AAAs.[57] Indiana's strategy for integrating care

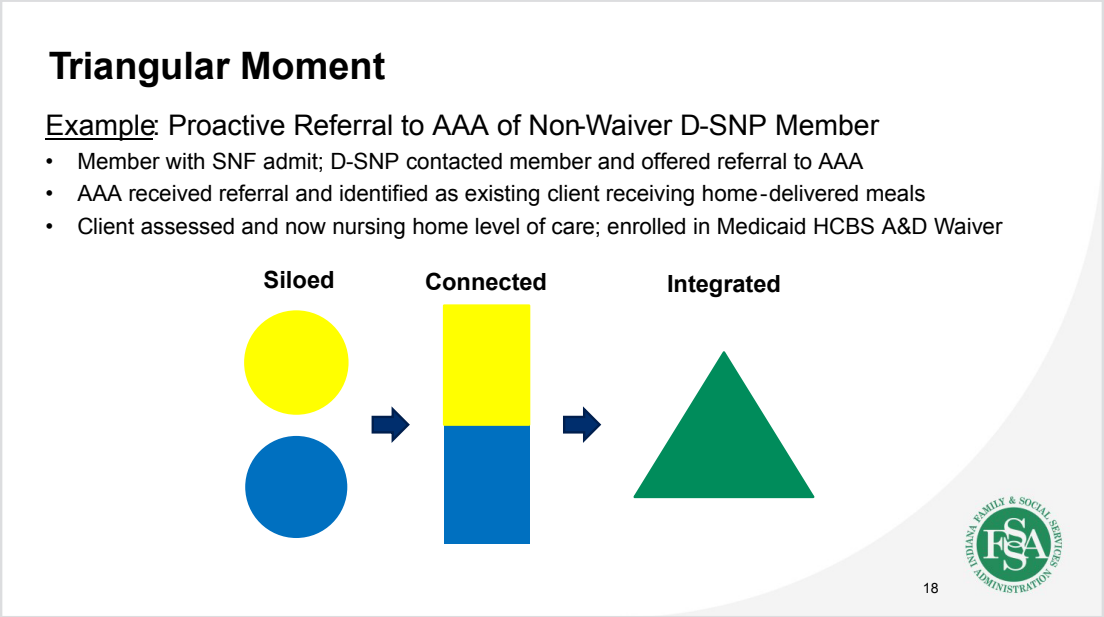
using the SMAC leverages many of the lessons from other states with ICPs.[58] Indiana's requirements capture best practices from other ICP models, including the capitated FAI methodology. States can use Indiana's CY 2022 SMAC language as a starting point.

Indiana's Medicaid team also emphasizes that the state's role is critical to ensuring that the care coordination requirements lead to integration. The state's Medicaid program established a care coordination workgroup to improve health outcomes for D-SNP members with complex needs through enhanced care coordination and integrated health care and social services overseeing the plan and engaging the plans to use the data, to share best practices, and to build a system and an infrastructure. The state has a data dashboard that supports this effort.

The state brings D-SNPs and AAAs to the table at the same time to share data and advance integration. Indiana refers to the moments of success as "triangular moments," as shown in the following image.[59]

FIGURE 19.

Indiana's Triangular Moment Moving from Siloed to Connected to Integrated Care.



Maine is one of the most rural states in the nation, with more than three in five people living in rural areas. Maine's Medicaid approach for leveraging the SMAC increases D-SNP care coordination and care delivery requirements in targeted ways. The state's Medicaid option for dually eligible individuals in rural areas is Medicaid FFS.

Maine's SMAC requires D-SNP network hospitals and nursing facilities to participate in a Health Information Exchange (HIE), which includes a real-time admissions and discharges notification system. It also requires D-SNPs to have coordination Memorandum of Understandings (MOUs) with the state's LTSS service coordination agencies (SCAs), which connects 60-plus long-term care agencies to its statewide HIE.[60]

Tool 3. Establish Targeted D-SNP Care Coordination Requirements

This tool provides language for the SMAC. States with MMC programs or Medicaid FFS programs for dually eligible individuals can use this tool to improve D-SNP care coordination.

Tool 3a. Indiana's 2022 and 2023 SMAC Language to Enhance D-SNP Care Coordination.

See "Indiana SMAC 2022 Language."

See "Indiana SMAC 2023 Language."

Tool 3b. Maine's 2023 SMAC Language to Enhance D-SNP Care Coordination.

See "Maine SMAC 2023 Language."

DOMAIN 2:

Workforce Capacity

2.1 Expand Medicaid Coverage for CHWs.

Lever(s)	MMC Contract, SPA

Rural Access Challenge

States are facing acute workforce shortages. These shortages are hitting rural areas especially hard and taking their toll on dually eligible individuals living in rural areas who need access to a diverse and robust workforce. Rural areas are experiencing a workforce crisis, with shortages in primary and specialty care providers, DCWs, and CHWs.

Across all three states, stakeholders expressed frustration in finding caregivers and providers.

Due to low supply of DCWs in rural areas, stakeholders recommended that the federal and state governments take steps to overhaul the LTSS workforce, accompanied by a major investment to increase pay and benefits for DCWs. Pay and benefits for DCWs are also a major equity issue for workers, given that 90 percent of DCWs are women, and

One stakeholder shared, "

"The ability to find caregivers is difficult. HCBS options are difficult, when traveling between clients can be more than 50 miles."

Another shared:

"Typically, providers accepting new patients are limited, and they're a distance away from the consumers. Some people on reserves have to travel 140 miles to see provider."

60 percent are members of a racial or ethnic minority.[61] Several reports, roadmaps, and toolkits offer many solutions for states. PHI's report calls for a national strategy. The Millbank Memorial Fund's report shares states' innovative ways to overcome the challenges that have long plagued the workforce.

At the same time, stakeholders also focused on CHWs, as a means of increasing access for dually eligible individuals because of the high SDOH needs among people living in rural areas.[62] Stakeholders shared a desire for state Medicaid programs to make CHWs a more universal and permanent component of the Medicaid program.

New Mexico's Medicaid program, one of our roundtable states, covers CHWs. This state's CHWs are known as Promotores(as) de Salud and Tribal Community Health Representatives (CHRs).[63] North Dakota and Tennessee, however, do not pay for CHWs through their Medicaid programs.[64] It is worth highlighting that the Rural Health Association of Tennessee has played a lead role in developing a rural-specific training program for CHWs as 91 of 95 counties are HPSAs.[65]

FIGURE 20.

Definitions for DCW and CHW.

What is a DCW? Direct care workers include individuals providing in person supports, often in the community, such as personal care aides, nursing assistants, home health aides, homemaker service providers, independent living skills workers, and companion service workers.

What is a CHW? The American Public Health Association (APHA) defines a CHW as a frontline public health worker who is a trusted member of and/or has a close understanding of the community served. "This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy."[66] [67]

Many states see CHWs as critical to rural areas.[68] Medicaid covers CHWs in their state plan or through managed care arrangements in almost half of all states.[69] MACPAC notes that most state Medicaid programs limit the range of CHW-provided services or CHW services to specific populations.[70] States reimburse CHW services through the Medicaid FFS program or managed care programs that pay for or hire CHWs directly.

For dually eligible individuals living in rural areas, Medicaid coverage for CHWs could help to:

- Fill the many workforce gaps facing dually eligible individuals in rural areas, which is critical for individuals with high medical needs and chronic conditions. CHWs are trained to provide health services and can receive additional training to expand primary care capacity.
- Prevent and control chronic conditions including diabetes, heart disease, obesity, and other risk factors.[71]
- Make connections between the person and the community to address the range of social needs including food, housing, and transportation.[72]
- Provide services in a culturally and linguistically responsive way. Dually eligible individuals are diverse in race, ethnicity, and language, and CHWs often have strong ties to the communities they serve.
- Help dually eligible individuals navigate the Medicare and Medicaid programs' challenges stemming from misalignment. Dually eligible individuals living in rural areas have limited access to ICPs.

Stakeholders participating in our state roundtables believe that state Medicaid programs should cover CHWs because they can help to address workforce shortages. At the same time, stakeholders acknowledged that Medicaid coverage for CHWs by itself will not solve the workforce dilemma.

The acute workforce shortage has defined the rural health crisis. CHW coverage does not mean that dually eligible individuals in rural areas will not encounter issues in accessing CHWs. However, recruiting and training CHWs is a promising strategy to fill other provider and service gaps to the extent states are willing and able to support and invest in cultivating the CHW workforce.

FIGURE 21.

An Overhaul of the Workforce Required to Address the DCW Shortage in Rural Areas.

Rural areas are facing a major crisis in the supply of DCWs, who provide HCBS and other LTSS to dually eligible individuals in the home, community, and institutions. Increasing the supply of DCWs in rural areas is essential to advance independent living goals and rebalance LTSS.

Across all three roundtable states, stakeholders expressed frustration with the low supply of DCWs in rural areas, citing factors such as low pay and poor benefits, child-care costs, the cost of gas and limited transportation, and competition with urban areas.

Our expert reviewer, Dennis Heaphy, added, "The math does not work. The costs of the job outweigh the paycheck."

University of Minnesota Rural Health Research Center researchers examined existing disparities in the workforce supply of home aides and nursing assistants, comparing rural areas with urban areas.[73] The center's issue brief "Who Will Care for Rural Older Adults? Measuring the Direct Care Workforce in Rural Areas," reported that the LTSS direct care workforce crisis is worse in rural areas than in urban areas. They found, on average, 32.9 home health aides per 1,000 older adults (age 65+) in rural areas compared to 50.4 home health aides per 1,000 older adults in urban areas; and, 20.9 nursing assistants per 1,000 older adults in rural areas compared to 25.3 nursing assistants per 1,000 older adults in urban areas.

Researchers at the center are working on a new project to examine ways to "retain LTSS workers in a climate of growing need,"[74] with an emphasis on improving compensation of direct care workers, given the substantial evidence that the LTSS supply of DCWs is low. Among the many aspects of the project, they are examining rural-urban differences in turnover.

CMS's framework for advancing health care in rural, tribal, and geographically isolated communities includes an important commitment to work with states and other rural health organizations to expand access to HCBS, so people with a range of disabilities and health care needs can thrive and live independently. To operationalize this commitment, CMS must lead a national effort to overhaul the DCW workforce and to reach rural communities.

Actionable Solution

CHWs are a viable solution for dually eligible individuals living in rural areas. CHWs are important for addressing dually eligible individuals' needs in rural communities, advancing health equity, and advancing integration by being flexible workers;[75] providing culturally responsive services; and fulfilling care coordination and care assessment services.[76]

FIGURE 22.

How CHWs Can Help Rural Dually Eligible Individuals.

According to CMS, CHWs can help health care organizations address the socioeconomic and environmental challenges of individuals living in rural areas. Limited public transportation in these areas can make it difficult for individuals to access health care. Lack of providers for some health services can make it difficult to effectively integrate care teams, as fewer care team members for various health services may be available in these communities. CHWs can address these challenges by assisting with transportation or by helping clients navigate the health care system. For example, patient navigators in rural Southern California helped patients find appropriate cancer treatment facilities, fill out required paperwork, and arrange transportation to essential care.[77]

State Medicaid investment in CHWs could make a meaningful difference to the rural community workforce available to dually eligible individuals. State Medicaid programs should consider how other states have designed and implemented coverage.

South Dakota's and Alaska's models include specific features that state Medicaid programs may want to consider as they create a solution for dually eligible individuals living in rural areas.

Model 1. South Dakota's Statewide CHW Coverage. South Dakota is one of the nation's most rural states. The state's Medicaid program largely operates a FFS program; the program covers CHWs to help covered individuals navigate the health care system and provide health care education.[78] The South Dakota DOH and Social Services defined CHW services among other key components such as the credentialing model, based on the input of a constituent workgroup involving health care organizations, public health, the Indian Health Service (IHS), and tribal community services.[79]

The state's Medicaid program covers CHW services related to a medical intervention outlined in the individual's care plan. Covered services may include health system navigation and resource coordination, health promotion and coaching, and health education.[80]

South Dakota also has adopted CHRs to reach dually eligible individuals on tribal reservations. CHWs and CHRs "can connect with any organization within their community to provide resources and patient navigation."[81] South Dakota Medicaid does not enroll individual CHWs. A CHW agency must enroll in South Dakota Medicaid to be paid.[82] This agency is the Community Health Worker Collaborative of South Dakota (CHWSD).[83]

Model 2. Alaska's Targeted CHW Coverage. Alaska's Medicaid program covers CHWs but limits coverage to certain populations; for example, dually eligible individuals living in rural villages.

"In some cases, states allow Medicaid payment for only certain CHWs, which may effectively limit the populations that can be served. For example, Alaska covers certified community health aide and practitioner (CHA/P) and behavioral health aide and practitioner (BHA/P) services under its physician services benefit. Because CHA/Ps and BHA/Ps by definition serve only specific communities (i.e., Alaska Natives residing in rural villages), their services are thus limited to beneficiaries residing in those communities (LaRoche 2019)."[84]

Tool 4. Expand Medicaid Coverage for CHWs

State Medicaid programs have many levers to use to compensate CHWs. They could cover CHWs as providers using a SPA or a Medicaid waiver such as a Section 1115 demonstration waiver, or they could also include CHWs in an MMC contract.

This tool provides language for state Medicaid programs to cover and provide Medicaid payment for CHW services under state plan authority. States may decide to limit CHW coverage to dually eligible individuals living in rural areas,[85] including dually eligible individuals receiving care through Medicaid FFS or MMC programs. CHW coverage for dually eligible individuals in rural areas can be covered in other ways. For example, state Medicaid programs could use the SMAC as a lever to require D-SNPs to offer CHW benefits as Special Supplemental Benefits for the Chronically Ill (SSBCI).

The California Health Care Foundation's research on CHW, the file housed in this toolkit contains a summary of State Plan Amendments (SPAs) submitted to CMS for approval. Seven states (California, Indiana, Louisiana, Minnesota, Oregon, Rhode Island, and South Dakota) have submitted SPAs seeking authorization for CHWs to serve a broad Medicaid population. Policymakers can tailor the language to their needs.

See CHCF's "Summary of Medicaid State Plan Amendments for Community Health Workers."

2.2. Close Medicaid and Medicare Provider Network Gaps.

Lever(s)	SMAC

Rural Access Challenge

Across the country, rural residents face significant challenges in accessing Medicare and Medicaid services resulting from provider shortages. According to researchers, rural communities throughout the US lack access to health care. Rural communities represent nearly two-thirds of primary care HPSAs in the country.[86] Rural communities, hit hard by the opioid epidemic, also lack access to treatment facilities offering medication for opioid use disorder (MOUD) or other treatment options. By some accounts, 90 percent of rural communities lack opioid treatment program capacity to meet their needs. Further, approximately 30 percent rural residents live in counties without any buprenorphine providers, compared with only 2 percent of urban residents.[87]

What is a HPSA? A Health Professional Shortage Area (HPSA) is an area that HRSA has identified as having shortages of primary care, dental care, or mental health providers.[88]

Provider shortages profoundly affect dually eligible individuals, given their high need for a diverse and robust provider network to address their medical, behavioral health, and LTSS needs. Improving access to providers for rural residents is a health equity goal for CMS and Medicaid programs. CMS and state Medicaid programs have created new policies to address provider shortages. For example, to expand access to behavioral health services, CMS established a policy that permits clinical staff of hospital outpatient departments to provide services remotely to patients in their home. CMS first implemented this policy in response to the COVID-19 public health emergency.[89] Telehealth and telemedicine are solid solutions for addressing provider shortages in rural areas. They are also a key component of CMS's Rural Health Strategy to expand access to care through telehealth services for individuals in rural areas. Nonetheless, there is still much to consider with respect to telehealth's application to rural residents with disabilities and the limitations of telehealth use because of broadband and internet limitations.[90]

During our state roundtables, stakeholders shared the realities around provider shortages through a rural lens.

As one stakeholder said, it is hard to find a nearby provider:

"Typically, providers are limited in their ability to accept new patients. They're a distance away from the consumers. Some people on reservations travel 140 miles to see a provider."

Stakeholders followed up with comments underscoring the importance of working and partnering with MA plans to address provider shortages and expand access to services for dually eligible individuals by finding innovative solutions.

Another stakeholder said, it is hard to find a plan that covers specialists:

"I traveled 80 miles to a facility to receive an infusion today. There are no MA plans in my zip code; there are no providers for MA outside of Albuquerque. It's difficult to see a specialist and even primary doctors in rural areas."

CMS's network adequacy requirements, in tandem with the Network Exception request, offer a pathway for federal, state, and plans to address provider shortages affecting dually eligible individuals. CMS requires all MA plans to comply with network adequacy requirements.[91] CMS uses the access standards to measure and assess if the provider network is sufficient to provide access to covered services, in the different service areas in which a plan intends to operate.

The network adequacy process also includes an exception process,[92] under which plans can submit detailed requests seeking approval of an exception to the standard Medicare time and distance standards of specific providers in certain service areas. To do this, plans must conduct an in-depth analysis to identify any potential providers to satisfy the network requirement and attempt to add any provider to their network if one is available. If none is available, plans may submit an exception request for CMS consideration. The analysis and exception request process requires plans to provide an extensive analysis that documents a true gap, rationale, and request for approval to offer their "product" in that county even if they can't meet network adequacy requirements. The lack of any provider in the time and distance required for that provider type is an acceptable reason for filing an exception request. Other considerations may include patterns of care or technical errors in provider network location files that plans use to assess network adequacy.

The network exception process stops short of creating a solution to a known gap, however. CMS and/or the state Medicaid programs and plans have no process to collaborate to address an identified gap. This arrangement represents a missed opportunity for improving access to providers and ICPs for dually eligible individuals living in rural areas.

Under its administrative "Dual Demonstration," Minnesota recently tested a new process to permit the state Medicaid agency to provide input into the network exception request. This approach was further evaluated through the MMP demonstrations and hold promise. As a result, CMS and the state partnered to identify all the needed considerations, including applicable state-specific care patterns and provider experiences to make the best determination possible on the exception request. This process was found useful and will be available for all states in 2024 under the CY2023 MAPD Final Rule.

Actionable Solution

State Medicaid programs can more meaningfully leverage the plan expertise to address network gaps. The status quo process falls short. Approving and accepting a gap overlooks the possibilities to offer innovative solutions and recommend change to Medicare and Medicaid policies.

State Medicaid programs can play a more active role in addressing provider shortages on behalf of dually eligible individuals in rural areas by partnering with the plans to fill the network gaps. Through the SMAC, states can require plans with approved Network Exceptions to formulate and submit a gap-closure plan to the state, along with progress reporting expectations to ensure ongoing attention and accountability. Plan progress reports would help states better understand provider challenges and cultivate best practices on how plans can support provider access. Some states already benefit from this type of reporting with respect to recruitment and retention strategies for workforce development of direct support professionals.

Tool 5. Close Medicaid and Medicare Provider Network Gaps

This tool provides language for state Medicaid programs to use in SMACs with D-SNPs.

FIGURE 23.

Network Alignment

Lever	Language
SMAC	**Closing the Provider Network Gap to Improve Access for Dually Eligible Individuals Living in Rural Areas** The MA D-SNP shall submit the following to the state in the timeframes indicated, and in the manner and format specified by the state. a) The MA D-SNP must submit a Medicare Gap Closure Plan for any network exceptions the MA D-SNP plan has had approved in any service area in which the MA D-SNP is offered. b) The Gap Closure Plan shall detail: • The gap • Contributing factors • At least two strategies the MA DUAL SNP will implement during Q2–Q3 of the CY to close the gap. c) Nothing in the agreement shall preclude the MA D-SNP plan from collaborating with other plans and providers to close the gap while adhering to anti-trust laws. d) The MA D-SNP is required to submit a progress report in Q4 outlining: • Actions taken by the MA D-SNP • Impacts of actions • Results • Lessons learned

2.3 Align Medicaid and Medicare Provider Networks.

Lever(s)	SMAC, MMC Contract

Rural Access Challenge

Dually eligible individuals living in rural areas need access to a robust provider network to access Medicaid and Medicare services that meet their whole health needs. However, having access to such a network is challenging for many rural residents, who face "barriers to accessing health care due to a limited number of providers, especially those providing specialized care."[93]

Across our three state roundtables, stakeholders shared many provider challenges affecting service access for dually eligible individuals living in rural areas. Many stakeholders find current Medicaid and Medicare provider network development strategies problematic because they do not consider the realities of provider shortages in rural communities.

Under current policy, plans may establish Medicaid and Medicare provider networks that are misaligned for services covered under Medicaid and Medicare. For example, Medicaid and Medicare cover home care services. ICP alignment between Medicare and Medicaid provider networks for home care would simplify member provider selection needs and make provider reimbursement and Medicare's COB process easier. Medicaid is the payer of last resort by law, which makes Medicare the primary payer.[94] [95] Additional COB rules, such as Medicaid's role to pay second, only when a member uses a provider who is enrolled with Medicare for services that are covered by both payers (such as home care), makes unaligned networks a complexity that most people do not want to navigate. When Medicaid and Medicare provider networks are misaligned, plans and members can face a labyrinthian COB process that can lead to claims denials and add financial burdens for dually eligible individuals.

Specific to ICPs, a complex COB and claims adjudication process could affect plans' network strategies. The lack of alignment between Medicaid and Medicare provider networks can add administrative costs for plans and network providers, particularly around LTSS. For example, a plan without an aligned network may miss the cost efficiencies of coordinating care with providers who offer both personal care attendant (PCA) services under Medicaid and skilled home health services under Medicare. As a result, the plan must coordinate services with two different providers when one might have better optimized outcomes for the individual.

Finally, Medicaid and Medicare have differences in measuring provider network adequacy. This adds another complication. State Medicaid programs have the flexibility to

develop their own quantitative approach to measuring provider network adequacy.[96] Consistent with Medicare's federal framework, Medicare's rules and requirements for measuring network adequacy are national. Plans offering Medicaid and Medicare coverage may meet network requirements with a different number of providers in each program. CMS is aware of this issue and plans to release a notice of proposed rulemaking and overarching Medicaid FFS and Medicaid managed care approach that could improve alignment with MA network standards.[97]

Actionable Solution

State Medicaid programs have the authority to require plans to align Medicaid and Medicare provider networks by leveraging state Medicaid contracts and SMACs. Plans' ability to align provider networks will vary based on the opportunity for alignment. ICPs such as a FIDE SNP model will have more opportunity for alignment with Medicaid. Less integrated models, such as CO D-SNPs, may be unable to achieve perfect alignment given the lack of integration in Medicare and Medicaid benefit coverage.

Tool 6. Align Medicaid and Medicare Provider Networks.

This tool provides language for state Medicaid programs to implement in SMACs and MMC contracts.

FIGURE 24.

Align Medicaid and Medicare Provider Networks

Lever	Language
SMAC	**Align Medicare and Medicaid Network Providers** The contractor agrees to align Medicare and Medicaid network providers for services covered by both Medicare and Medicaid to the extent possible. a) The contractor must annually assess networks to identify Medicaid providers to add to the Medicare network. b) The contractor shall provide the state with an annual report on Medicaid providers excluded from the Medicare network and describe strategies the contractor used to align network providers.
MMC Contract	**Align Medicare and Medicaid Network Providers** The contractor agrees to align Medicare and Medicaid network providers for services covered by both Medicare and Medicaid to the extent possible. a) The contractor must annually assess networks to identify Medicaid providers to add to the Medicare network. b) The contractor shall include Medicare-enrolled home care providers in the MLTSS network. c) The contractor shall provide the state with an annual report on Medicaid providers and describe strategies the contractor used to align network providers.

DOMAIN 3:

Social Determinants of Health Needs

3.1 Identify Community Resources to Address Social Isolation.

Lever(s)	CARE Plan, SMAC

Rural Access Challenge

Social isolation and loneliness are linked to poor health outcomes for adults with disabilities and older adults.[98] [99] [100] The National Council on Aging (NCOC) reports that social isolation can lead to impaired mental performance, a compromised immune system, and an increased risk of chronic disease and depression.[101] According to the CDC, social isolation is associated with about a 50 percent increased risk of dementia or another serious medical conditions, chronic conditions, death, and an increased risk of

emergency department visits and hospitalizations.[102] The COVID-19 outbreak amplified social isolation for dually eligible individuals living in the community or nursing homes.

Dually eligible individuals in rural areas are at higher risk for social isolation because of age, disability, and residence. People in rural areas face factors that contribute to social isolation including distance from community activities, lack of transportation, and the great digital divide. See **Appendix 8** for a summary of the SDOH needs of dually eligible individuals in rural areas.

Participants in the three state roundtables consistently raised social isolation and loneliness as a challenge for dually eligible individuals living in rural areas.

An individual covered under Medicare and Medicaid said,

"A buddy system would help me. Loneliness kills me. Knowing there's a connection would be helpful."

Addressing social isolation and loneliness is important and often the entry point for meeting seniors' other essential needs, such as food, housing, and transportation."[103] All three roundtable states offer companionship programs and services; however, the availability of these programs and services is not widely known.

Actionable Solutions

Dually eligible individuals living in rural areas are not alone in facing the challenges of social isolation and experiencing loneliness; however, they are at increased risk of social isolation.

State Medicaid programs address social isolation through their HCBS. However, dually eligible individuals living in rural areas require more support. State Medicaid programs can take action to address the inherent risk for isolation that living in rural areas creates for dually eligible individuals by crafting solutions that will work in rural areas.

Dually eligible individuals and their caregivers and care coordinators need information about resources available to reduce isolation and address loneliness. They need to know about programs and services that may be available through Medicaid HCBS waiver programs, funded through Older American's Act, or through CBOs.

Often the barrier is communication. Dually eligible individuals in rural locations are not aware of the programs and services that can help.

To address this barrier, state Medicaid programs could require ICPs to develop and disseminate information to dually eligible individuals and their care circle. ICPs could share these resources with dually eligible individuals in rural areas during interactions with individuals. ICPs could also advocate for dually eligible individuals' support systems to use these resources to advance knowledge.

Tool 7. Identify Community Resources to Address Social Isolation

This tool provides guidance and language for state Medicaid programs to use with the CARE Plan development process (Tool 1) and SMACs.

FIGURE 25.

Social Isolation

Lever	Guidance and Language
CARE Plan	**Address Community-Wide Social Isolation and Loneliness for Rural Residents** Planners could make social isolation and loneliness a priority in the CARE Plan. Action steps could include: • Identifying the work required to increase awareness of and access to existing resources to address social isolation and loneliness • Identifying cross-collaborative partnerships across government agencies and between government and stakeholders can bolster awareness and access • Incorporating social isolation and loneliness as a theme in the CARE Plan to raise awareness among the public and policymakers
SMAC	**Coordinate Care for Dually Eligible Individuals Living in Rural Areas at Risk of Social Isolation and Loneliness** The MA D-SNP is responsible for supporting members in accessing companionship support resources when the D-SNP becomes aware that a member is experiencing social isolation and/or is at risk of loneliness. The MA D-SNP's coordination of care efforts shall include dissemination of materials to increase awareness of local and state isolation supports. Coordination of care must include: 1. Developing materials to share with members that provide community-specific and state-specific support resources on loneliness 2. Increasing members' awareness of companion service providers covered by Medicaid and/or LTSS in the [state] service area 3. Assisting members in accessing needed companion or other Medicaid or LTSS supports, to the extent they are available The MA D-SNP's coordination of care efforts to address social isolation and loneliness must include protocols for working with [Medicaid HCBS Waiver Care Managers] and other housing support resources.
SMAC	**Coordination of Care** When a D-SNP member is identified as at risk for or experiencing social isolation and loneliness, the D-SNP must ensure coordination with the state's AAA regarding services and supports that address loneliness. D-SNPs must execute an MoU with each AAA providing services in the D-SNP service area to enable identification of dual-eligible members that the D-SNP serves and to collaborate to ensure effective coordination of member service needs. Whenever possible, the state expects coordination with AAAs to be electronic and automated, but other modes of communication may include fax, email, telephone, in person, and other forms of communication as necessary and appropriate.

3.2 Address Food and Housing Needs.

Lever(s)	CARE Plan, Section 1115 Waiver Demonstration, SMAC, MMC Contract

Rural Access Challenge

Across all three state roundtables, stakeholders expressed support for the role of Medicaid and Medicare in addressing the SDOH needs of dually eligible individuals in rural areas. As the public health crisis continues, stakeholders wondered if rural areas need Medicaid and Medicare to take on an even greater role to address dually eligible individuals' high SDOH needs.

Stakeholders were unequivocal in identifying food and housing needs as a higher priority than health care. They view access to healthy, fresh food and meals as a primary concern among dually eligible individuals in rural areas, as many stores continue to close.

As one stakeholder from Tennessee said,

"We see lots of food deserts. The foodbanks are small, they are church run, not a big distribution center."

A stakeholder from New Mexico said,

"The nearest grocery store to Alamo Reservation is 60 miles."

Stakeholders also highlighted the lack of access to affordable housing and suitable housing for persons with disabilities. They expressed concerns about the lack of affordable housing in many rural areas, and its impact on dually eligible individuals' lives. Inadequate and inaccessible housing are major drivers of preventable institutionalization in long-term care facilities.[104]

As another stakeholder from Tennessee explained,

"Affordable housing is a major problem. There is a lack of inventory. There is no real estate investment because the community has not invested in other major infrastructure."

Finally, although this solution focuses on food and housing support, transportation needs are also critically important for dually eligible individuals who lack adequate transportation to get to and from grocery stores or health care.

Actionable Solution

To respond to this important rural access challenge, we have developed two approaches for policymakers to consider.

- Under the first approach, we propose to expand coverage for dually eligible individuals' SDOH needs by leveraging Medicaid's options such as SPA tools, Section 1115 demonstration waivers, or Medicaid contracts.
- Under the second approach, we propose to expand coverage by leveraging the Medicaid MLR.

Actionable Solution: Approach 1

State Medicaid programs may use the SPA, Section 1115 waivers, Medicaid managed care flexibility, contracting strategies, and integrated care models to address the SDOH needs of members covered under Medicaid.[105] Through Section 1115 waivers, state Medicaid programs can cover HRSNs such as housing supports and services related to food insecurity. Integrated care models cover both medical and non-medical transportation. Through state Medicaid managed care programs including MLTSS programs, as authorized under managed care regulations, state Medicaid programs can propose ILOS to address social needs. State Medicaid programs may cover ILOS under the capitation rates if they are medically appropriate and cost effective. An example of an ILOS might be an in-home visit rather than an office visit.[106] [107] [108] State Medicaid programs may also allow health plans to offer "value-added" services, or extra services beyond the contracted covered services, voluntarily. State Medicaid capitation rate development methodologies exclude value-added services. An example of a value-added service would be a cleaning service to prevent the worsening of a chronic condition such as asthma, or an exercise program to support overall health.

Medicaid waivers

Medicaid's role in addressing the SDOH needs has significantly evolved and expanded in recent years. Historically, the Medicaid program has not been authorized to pay directly for food and housing. State Medicaid programs can pursue waivers to provide direct meal assistance to target populations and/or provide support for enrollees' non-medical health needs including housing-related services.[109] States can use different authorities to cover these services, such as Section 1115 waiver demonstrations and Section 1915(b) managed care waivers.

State waivers: Massachusetts, Oregon, Arizona, Arkansas, New Mexico

State requests for waiver approval have increased in recent years. In 2022 alone, CMS approved groundbreaking and innovative Medicaid initiatives to address unmet HRSNs using Section 1115 demonstration waiver authority.

- Massachusetts and Oregon received new authority "to test coverage for evidence-based nutritional assistance and medically tailored meals, clinically-tailored housing supports, and other interventions for certain beneficiaries where there is a clinical need."[110] [111]

- Arizona received federal approval to address health-related social needs. Like recently approved demonstrations in Oregon and Massachusetts, Arizona's demonstration will test innovative interventions that target critical drivers of health outcomes, including housing insecurity.[112]
- Arkansas received CMS approval for Arkansas' Medicaid Section 1115 demonstration. This demonstration "will test innovative interventions to address housing and food insecurity, as well as other critical health-related social needs." The amendment to the Arkansas Health and Opportunity for Me (ARHOME) demonstration "will drive better health and well-being outcomes for beneficiaries in crisis by providing medically necessary support services, particularly for young people, pregnant and postpartum women, and people with mental illness and SUD."[113]
- New Mexico has a pending section 1115 waiver application to address the "the social and economic determinants of health."[114] [115] New Mexico proposes two new home-delivered meals pilots.

Medicaid managed care contracts

In addition to waivers, states may address HRSNs through Medicaid managed care contracts. ICPs such as Medicaid MLTSS MCOs and aligned D-SNPs (MLTSS+D-SNP) can play key roles. MLTSS plans can offer value-added services such as home-delivered meals.[116] [117] MA plans including D-SNPs can offer supplemental benefits.

Medicare's role in addressing SDOH

Like Medicaid, Medicare's role continues to evolve in this arena. The Medicare program can address the primarily health-related and primarily non-health related needs of dually eligible individuals enrolled in MA plans, including D-SNPs. CMS allows MA plans to offer supplemental Medicare benefits, which provides MA plans with opportunities to be innovative.[118]

Over time, CMS has expanded MA plans' flexibilities to include non-medical benefits.[119] Most D-SNPs offer non-medical benefits such as monthly allowances for healthy foods and home-delivered meals.[120] [121] In 2020, CMS expanded the flexibilities to allow D-SNPs to offer Special Supplemental Benefits for the Chronically Ill (SSBCI) such as food and produce, non-medical transportation, and other services.[122]

Assessments

Assessments are paramount to addressing dually eligible individuals' needs. Managed care plans must include questions on food security, housing security, and transportation on their health risk assessment (HRA) forms. HRAs are an established component of the Medicare program.[123] [124] CMS will be requiring "all SNP HRAs include at least one question from a list of screening instruments specified by CMS on each of the three domains" – however, CMS will not require all SNPs to use the same specific standardized questions."[125]

Tool 8: Approach 1. Address Food and Housing Needs

This tool provides states with many options to address food and housing needs. States may use the following levers: (1) the CARE Plan (Tool 1); (2) Section 1115 waiver authority; (3) MMC contracts; and (4) SMACs.

FIGURE 26.

Food and Housing Services and Supports

Lever	Language and Guidance
CARE Plan	**Address Food and Housing Insecurity for Dually Eligible Individuals Living in Rural Areas.** The CARE Plan development process should make food and housing insecurity important priority issues. Action steps could include: (1) identifying the work required to expand access to food and housing; (2) identifying cross-collaborative partnerships across government agencies and between government and stakeholders to expand access to food and housing; and (3) incorporating food and housing as a theme in the plans to raise awareness among the public and policymakers.
Section 1115 waiver demonstration	**Cover Allowable HRSN Services Under Medicaid** CMS approved Arkansas' request to amend the Section 1115(a) demonstration, "Arkansas Health and Opportunity for Me" (ARHOME, or the "demonstration") (Project Number 11-W-00365/4), originally approved on December 21, 2021, in accordance with Section 1115(a) of the Social Security Act ("Act"). Approval of this request enables the state, through various expenditure authorities, to test the efficacy of innovative practices aimed at promoting consistently high-quality, evidence-based, coordinated, and integrated care with the combined goals of providing medical assistance and improving the health of the communities and populations served. The state may cover the following Life360 HOME services in all three Life360 HOME types: • Housing supports, including pre-tenancy and tenancy sustaining services (i.e., tenant rights education and eviction prevention, housing transition services, one-time transition and moving costs (security deposits, first-month's rent, utilities activation fees, movers, and pest eradication); and housing deposits to secure housing, including application and inspection fees and fees to secure needed identification • Nutrition supports, including nutrition counseling and education • Case management, outreach, and education including linkages to other state and federal benefit program application assistance and benefit program application fees

SMAC	**Address Dually Eligible Individuals' Food and Housing Needs** The MA D-SNP supports members in accessing food resources and housing support when the D-SNP becomes aware of a member experiencing or at risk of food insecurity or housing insecurity through the MA D-SNP's coordination of care efforts. Plan coordination of care efforts must include: • Developing materials that outline state-specific food resources and housing supports, and sharing materials with members • Identifying food resources and housing supports or navigation providers covered by Medicaid and/or LTSS in the [state] service area • Helping members to access needed food resources and housing supports, or LTSS to the extent they are available. The MA D-SNP's coordination of care efforts to link members to food resources, housing supports, or navigation providers must include protocols for working with Medicaid HCBS Waiver Case Managers and other food resources and housing supports.
SMAC	**Prioritize Structural Home Modification as an SSBCI** If the MA D-SNP offers any Special Supplemental Benefits for the Chronically Ill (SSBCI) to targeted chronically ill populations, the state will require the MA D-SNP plan to prioritize the provision of Structural Home Modification services as an SSBCI benefit. The MA D-SNP should leverage the assessment and verification of the qualifying chronic illness administrative processes, operated by MA D-SNPs, to offer other SSBCI benefits. Note: The Structural Home Modification benefit includes structural improvements to homes.
MMC Contract	**Direct Medicaid Managed Care Plans to Hire a Housing Support Staff Person** Like Pennsylvania, state Medicaid programs can designate MLTSS plans to have a full-time equivalent (FTE) staff person to support members in locating housing.
Integrated Care Programs: **MMC Contract** **SMAC**	**Expand Meal Coverage** As a concept, states could require ICPs, through MMC contracts and SMACs, to coordinate with home and community-based providers, expand meal coverage, and make referrals to AAAs because they can provide meals funded under Older Americans Act Title 3, where applicable.

Actionable Solution: Approach 2

State Medicaid programs can leverage the Medicaid managed care MLR to encourage and incentivize MMC plans and D-SNPs to increase SDOH spending on dually eligible individuals in rural areas. This option would apply to states where dually eligible individuals in rural areas enroll in a Medicaid managed care and/or an MA plan. See **Appendix 9** for more information about MLRs.

During our stakeholder roundtables, Medicaid managed care and MA plan participants shared their commitment to addressing and investing more in SDOH, if CMS and state Medicaid programs more adequately accounted for their investment. Stakeholders expressed concerns about the adequacy of the capitation rates.

Assuming that state Medicaid programs meet all actuarially sound standards for capitation rates, and account for unmet needs, states may use the Medicaid MLR to address the targeted SDOH needs of dually eligible individuals living in rural areas.[126]

Tool 8: Approach 2. Address Food and Housing Needs

This tool provides states with two options to address food and housing needs by including SDOH costs in the Medicaid plans' MLR calculations.

Option 1. Expand the definition of an activity to improve quality to address SDOH.

This option would allow plans to include SDOH expenditures in the numerator by expanding Medicaid's definition of a qualifying activity to address SDOH. This option would neither lower the MLR nor trigger required plan payments or penalties to the state's Medicaid program.

State Medicaid programs currently exclude the costs of value-added services in the capitation rate development methodology. They may, however, account for the SDOH expenditures related to providing value-added services (in the numerator), when calculating the MLR if such SDOH expenditures improve health care quality.[127] The state would not treat any of SDOH expenses as administrative costs. This would permit plans to cover any SDOH activity for food and housing assistance, as well as funding grants to CBOs.

CMS and state Medicaid program could take this option further. Some researchers add that service spending on meeting specific needs for targeted individuals should also be treated as an allowable expense in calculating the MLRs.[128] States also may want to consider activities for rural areas specifically. RUPRI suggested that CMS and state Medicaid programs should consider tailoring the MLR to allow plans to pay for costs related to meeting the needs of individuals in rural areas by including transportation and technology services. This would allow plans to include these costs in calculating the clinical services and quality improvement.

Option 2. Implement a quality-based performance strategy to reward high performers.

In addition to option 1, state Medicaid programs could also introduce a plan-based quality-based performance strategy to advance health equity. Minnesota's Medicaid program adopted this approach as part of its quality strategy. In Minnesota, Medicaid incentivizes plans to advance health equity by rewarding performance with the potential for adjustments to the state Medicaid's MLR requirement.

Minnesota adjusts the MLR based on the plan's success in meeting or exceeding the required score in each of the quality measures, while also accounting for plan spending below or above the target MLR. This option incentivizes plans to invest in additional solutions and innovations to meet the required quality targets for which they will receive a financial reward.

State Medicaid programs could tailor this quality-based approach to address the SDOH needs such as food and housing of dually eligible individuals in rural areas.

Conclusion

Improving access to services, care coordination, and ICPs for dually eligible individuals in rural areas will require a dedicated effort across the federal, state, and local governments. We should not tolerate disparities between this country's rural and urban areas. CMS's commitment to advance rural health equity gives us hope that dually eligible individuals in rural areas will not fall through the cracks of the larger public health crisis.

Appendix 1. Acronyms

Acronym	Meaning
AAA	Area Agency on Aging
ADL	Activities of Daily Living
AK	Alaska
AR	Arizona
ARHOME	Arkansas Health and Opportunity for Me
BH	Behavioral Health
BHA/P	Behavioral Health Aide and Practitioner
CARE	Comprehensive Access and Rural Equity Plan
CB	Community Benefit
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CHA/P	Certified Community Health Aide and Practitioner
CHW	Community Health Worker
CHIP	Children's Health Insurance Program
CHWSD	Community Health Worker Collaborative of South Dakota
CIL	Center for Independent Living
CMS	Centers for Medicare & Medicaid Services
CO D-SNP	Coordination Only Dual Eligible Special Needs Plan
COB	Coordination of Benefits
COVID-19	Coronavirus Disease 2019
DCW	Direct Care Worker
DME	Durable Medical Equipment
D-SNP	Dual Eligible Special Needs Plan
ED	Emergency Department
ESRD	End-Stage Renal Disease
EO	Executive Order
FAI	Financial Alignment Initiative
FBDE	Full Benefit Dual Eligible
FFS	Fee For Service
FIDE SNP	Fully Integrated Dual-Eligible Special Needs Plan

Acronym	Meaning
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
HEARD	Health Equity & Access for Rural Dually Eligible Individuals
HHS	US Department of Health and Human Services
HIDE SNP	Highly Integrated Dual Eligible Special Needs Plan
HMA	Health Management Associates
HPSA	Health Professional Shortage Area
HRA	Health Risk Assessment
HRSA	Health Resources and Services Administration
HRSN	Health Related Social Need
ICP	Integrated Care Program
ICRC	Integrated Care Resource Center
ID	Idaho
IHS	Indian Health Services
IL	Independent Living
ILC	Independent Living Center
ILOS	In Lieu of Services
IN	Indiana
KS	Kansas
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MACPAC	Medicaid and CHIP Payment and Access Commission
MAPD	Medicare Advantage Prescription Drug
MCO	Managed Care Organization
ME	Maine
MedPAC	Medicare Payment Advisory Commission
MI	Michigan
MLR	Medical Loss Ratio
MLTSS	Managed Long-Term Services and Supports
MMC	Medicaid Managed Care Contract
MMCO	Medicare-Medicaid Coordination Office
MMLEADS	Medicare Medicaid Linked Enrollee Data Source (MMLEADS)
MN	Minnesota
MOC	Model of Care

Acronym	Meaning
MoU	Memorandum of Understanding
MOUD	Medications to Treat Opioid Use Disorder
MPA	Master Plan for Aging
NASHP	National Academy for State Health Policy
NCOA	National Council on Aging
ND	North Dakota
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NM	New Mexico
NOSORH	National Organization of State Offices of Rural Health
OMH	Office of Minority Health
PACE	Program of All-Inclusive Care for the Elderly
PCA	Personal Care Aide/Assistant/Attendant
PMPM	Per Member Per Month
RELD	Race, Ethnicity, Language, & Disability
RHIhub	Rural Health Information Hub
RUPRI	Rural Policy Research Institute
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SSBCI	Special Supplemental Benefits for the Chronically Ill
SD	South Dakota
SDOH	Social Determinants of Health
SDRC	State Data Resource Center
SMAC	State Medicaid Agency Contract
SNP	Special Needs Plan
SOGIE	Sexual Orientation, Gender Identify, & Expression
SORH	State Office of Rural Health
SPA	State Plan Amendment
SSA	Social Security Act
SUD	Substance Use Disorder
TA	Technical Assistance
T-MSIS	Transformed Medicaid Statistical Information System
TN	Tennessee
WY	Wyoming

Appendix 2. State Roundtable Participants, Fast Facts, and Quotes

FIGURE 27.

State Roundtable Participants.

State	New Mexico	North Dakota	Tennessee
Date	July 2022	August 2022	June 2022
Participants, (n = 50)	**n = 19**	**n = 17**	**n = 14**
Organizations	• Residents, who are dually eligible living in rural areas • Medicaid • Human Services Department (Tribal Liaison) • Aging & Long-Term Services Department • Presbyterian Health Plan • Blue Cross Blue Shield of New Mexico • Western Sky • New Mexico HealthCare Association/ New Mexico Center for Assisted Living • New Mexico Hospital Association • Servicios Y Más Inc. • The Disability Coalition	• Residents, who are dually eligible living in rural areas • Medicaid • Aging Services • Department of Human Services • Sanford Health Plan • Blue Cross Blue Shield of North Dakota • Community Healthcare Association of the Dakotas • Northland PACE • Center for Rural Health (CRH) at the University of North Dakota (UND), School of Medicine & Health Sciences • Great Plains Food Bank • Grand Forks Housing Authority • Independence, Inc. • ND Center for Persons with Disabilities (NDCPD), a University Center for Excellence on Developmental Disabilities (UCEDD) at Minot State University • North Dakota Protection and Advocacy Project • The Arc of Bismarck & The Arc of North Dakota • North Dakota Center for Persons with Disabilities	• Residents, who are dually eligible living in rural areas • Medicaid • Amerigroup • UnitedHealthcare • BlueCare Tennessee • Tennessee Disability Coalition • Tennessee Justice Center • The Arc Mid-South

Note: Total organizations listed will not add up to total participants, as some organizations sent more than one representative.

FIGURE 28.

State "Fast Facts" for Roundtable States.

Facts	US Average	New Mexico	North Dakota	Tennessee
Total US Population or State Population, CY 2022, (in 1,000s)	328,073	2,095	760	6,922
American Indian/Alaskan Native as a Percent of Total US or State Population, 2019	< 1.0%	8.7%	5.2%	.6%
Hispanic or Latino as a Percent of Total US or State Population, 2019	19%	49.5%	4%	5.7%
Population in Poverty as a Percent of Total US or State Population, 2019	12.3%	17.7%	11%	13.9%
Rural Population as a Percent of Total US or State Population, April 2010	19%	23%	34%	50%
Best and Worst States for Internet Coverage, Prices, and Speeds: State Rankings, 2021	N/A	45	35	22
Primary Care Health Professional Shortage Areas (HPSAs), Percent of Need Met, June 30, 2022	47.15%	38.78%	32.05%	63.55%
Total Dual-Eligible Population, CY 2019 (in 1,000s)	12,184	112	17	296
Full Benefit Dual-Eligible Population, CY 2019 (in 1,000s)	8,667	67	13	164
Percent of Full-Benefit Dual-Eligible (FBDEs) Population Enrolled in an Integrated Care Program, CY 2019	8.6%	0.6%	1.9%	1.3%
Medicaid Home and Community-Based Services as a Percentage of Medicaid Long-Term Services and Supports, FY 2019	58.6%	75.5%	43.6%	49.2%

FIGURE 29.

Raising Rural Voices: Roundtable Quotes.

HEALTH CARE:

"There are pressures on urgent centers to be all, but they can't. If they leave, will this lead to a medical dessert?"

"Bring the care to them instead of expecting them to go to care."

"In rural areas, the basis for access to care are non-traditional, non-health entities. The church, for example, could serve as a first step towards resource integration. They may have a knowledge base and people look to churches for information."

BEHAVIORAL HEALTH:

"I organize a support group (in my area). I tried to get an ABA therapist but there are none in the area. Having a caregiver support group is really helpful to me to manage my daughter's autism and behavioral and social needs. In-person support groups are important while waiting for doctors or specialists."

HCBS:

"The ability to find caregivers is difficult. HCBS options are difficult, when traveling between clients can be more than 50 miles."

"I get HCBS with room and board, but my help lives 50 miles away. I am waiting for her to quit because of the price of gas. I won't be able to find anyone to do respite at $14 an hour."

PACE:

"There are many people who could benefit from PACE, but they're outside the service area. We have a service limit because of the transportation services. If the service area were too large, then the transportation would not be possible."

PROVIDERS AND MEMBER EXPERIENCE:

"Typically, providers accepting new patients are limited, and they're a distance away from the consumers. Some people on reserves have to travel 140 miles to see provider."

"I traveled 80 miles to a facility to receive an infusion today. There are no MA plans in my zip code; there are no providers for MA outside of Albuquerque. It's difficult to see specialist and even primary doctors in rural areas.... One plan asked me to join, but they would only offer 6 trips outside of rural area. Another plan asked me to join, but none of my specialists are their specialists, so I would lose all my doctors."

PAYER CHALLENGES (MEDICAID AND MEDICARE):

"When Medicare denies services, Medicaid follows suit. They need to improve their communication. Medicare can be very picky about recognizing the necessity of durable medical equipment. They don't provide an explanation for service denials and the appeals process needs improvement. Communication is poor and you don't get smooth notification of approvals, denials, etc. It's very challenging to navigate."

CULTURE:

"People look to each other to solve problems, provide resources—not to government funding."

"When you talk about brokers, CHWs, family, friends, small communities operate on the basis of word of mouth. There is a distrust of larger communities. You are going to rely on grandmother/family rather than a broker."

FOOD:

"We see a lot of CBO deserts. The food banks are small, they are church run, not a big distribution center. There is a lack of fresh foods, only a weekly pick up. Fresher foods are lacking. My mind goes to the social determinants of health."

"The nearest grocery store to Alamo Reservation is 60 miles. Around the beginning of the month when everyone gets benefits, everyone goes to town to get groceries. With gas prices going up this is going to be a big impact."

HOUSING:

"Affordable housing is a major problem, and there is a lack of inventory. There is no real estate investment because the community is not seen as investing in other major infrastructure."

MAIL DELIVERY:

"Beyond internet, access to mail is difficult as well. Many of our rural and frontier patients use P.O. boxes and so can't regularly get test kits, which is what we often think of for those who have trouble accessing facilities."

SOCIAL ISOLATION:

"A buddy system would help me. Loneliness kills me. Knowing there's a connection would be helpful."

TRANSPORTATION:

"You don't have public transport. You don't have Ubers or Lyfts. They are not readily available."

"Ground transportation is a challenge when the hospital is three hours away. Paratransit does not cross county lines."

"Rural access means transportation challenges. We have challenges with companies because they do not have enough individuals to transport. Some of our tribal communities also have challenges. The roads are not paved, they can't get to where they need to be for medical services. This is a huge need."

Appendix 3. Rural Landscape and Public Health Crisis Facts

Summary Data Points About the Rural Landscape and Public Health Crisis

Rural Population	1 in 5 people live in rural, tribal, and geographically isolated communities across the US[129]
Rural Disability Prevalence	1 in 3 adults living in rural areas have a disability versus 1 in 4 nationwide
Rural Poverty Rate	15.4 percent in nonmetro versus 11.9 percent in metro areas (2019)[130]
Drug Overdose Deaths in Rural Areas	26.2 per 100,000 in rural areas versus 28.6 per 100,000 in urban areas[131]
Rural Hospital Closures	183 rural hospital closures since 2005 (2022)[132]
Health Professional Shortage Areas (HPSAs)	66 percent of federally designated HPSAs are in rural areas
IHS Vacancies	1 in 4 position vacancies for health care providers in IHS facilities
Personal Care Aides	142 personal care aides to potential need per 1,000 adults with self-care disability in the most remote areas of the most rural states versus 205 per 1,000 adults in the least remote areas of the least rural states[133]
Direct Care Workers (DCWs)	For more information on direct care workers. The supply of home health aides in urban areas is about 34.7% larger than the supply in rural areas relative to the older adult population.[134]
Community Health Workers (CHWs)	35% of the population in Nebraska resides in rural areas, whereas only 22.3% of surveyed CHW work in rural locations (in Nebraska)[135]
Rural Access to HCBS	For more information on rural access to HCBS and supply-side barriers.

Additional Data Points About The Rural Landscape And Public Health Crisis

Population

- Approximately 61 million people live in rural, tribal, and geographically isolated communities across the US.
- Rural communities tend to have a higher proportion of older residents, yet often have fewer available services in areas such as housing, transportation, social services, and nutrition services to support aging in place.
- On average, people living in rural communities are more likely to die prematurely from heart disease, cancer, unintentional injury, chronic lower respiratory disease, stroke, and suicide than those in urban areas.
- Rates of obesity and diabetes are higher in rural areas than in non-rural areas.
- Rural populations experience poorer average maternal health outcomes than their non-rural counterparts, including higher pregnancy-related mortality.
- Opioid overdose rates are disproportionately high in rural populations, as are rates of substance use for alcohol, tobacco, and methamphetamines.
- Moreover, an estimated one in three rural adults, compared with approximately one in four adults nationwide, lives with a disability impacting their hearing, vision, cognition, mobility, self-care, or independent living.

Poverty Rates

- Rural residents have higher average poverty rates than their urban counterparts.
- Poverty Rates (2020)
- US Metro – 11.5%
- US Nonmetro – 14.4%

Physician Rates

- Total physicians per 10,000 (2019)
- US Metro: 34 per 10,000
- US Nonmetro: 13 per 10,000

Transportation and Travel

Many rural residents experience longer travel times to reach their health care practitioners and frequently lack access to public transportation, which can impede timely access to necessary care.

Some rural communities also have poorer high-speed internet access and adoption than urban communities due to limited broadband infrastructure, lack of digital literacy, and/or affordability of internet plans.

Indian Health Service

- Health care facilities operated by the IHS are an important source of care for tribal communities.
- 25 percent vacancy rates for health care providers

Hospital Closures

- 183 hospital closures nationwide since 2005
- 140 rural hospital closures nationwide since 2010

HPSAs

Rural areas account for approximately 66 percent of federally designated Health Professional Shortage Areas, which are facing a loss of primary care, dental health, and behavioral health practitioners.

HPSA Counts		
Primary Care	**Rural**	5,363
	Partially Rural	405
	Non-Rural	2,419
Mental Health Care	**Rural**	3,923
	Partially Rural	477
	Non-Rural	2,087
Dental Health Care	**Rural**	4,832
	Partially Rural	293
	Non-Rural	2,081

Medically Underserved Areas/Populations	
Rural	2,166
Partially Rural	220
Non-Rural	1,206

Sources

- https://www.cms.gov/files/document/advancing-rural-health-equity-11-2022.pdf
- US Census Small Area Income and Poverty Estimates, 2009-2020.
- HRSA Area Health Resources Files, 2020-2021
- https://data.hrsa.gov/topics/health-workforce/shortage-areas

Appendix 4. HMA's Key Findings

FIGURE 30.

HMA' Key Findings from the Literature Review.

1	**Provider capacity:** Provider shortages are greater in rural areas than urban areas.
2	**Virtual care services:** Populations living in rural US face "the digital divide."[136]
3	**Transportation:** Dually eligible individuals in rural areas are affected by many of the same transportation barriers other rural residents experience.
4	**ILOS, VAS, and supplemental benefits:** Medicaid's ILOS provide a vehicle for Medicaid plans to substitute a service covered under the Medicaid managed care contract with a different service or in a different setting. Other tools that Medicaid can use include value-added services. Medicare's supplemental benefits provide MA plans with a vehicle for providing an item or service not covered by original Medicare or Medicaid.
5	**Financing:** Financing is important to advance improvements in network adequacy and access by creating flexibilities, incentives, and payment increases to expand the supply including the workforce capacity.

FIGURE 31.

HMA's Key Findings from the State Roundtables.

1	**Medicare and Medicaid flexibilities and federal resources for states** are foundational to optimizing rural assets to address dually eligible individuals' needs and to advance rural health equity including racial, disability, and geographic equity.
2	The **lack of a designated state leader** with accountability for developing a rural-specific, state-wide strategy is a barrier to advancing comprehensive and integrated care solutions to address dually eligible individuals' needs.
3	Actionable solutions must be grounded in **rural and indigenous cultures, community values,** and the realities of the rural landscape such as small populations and distance.
4	The **basic needs** for fresh food, housing, and non-medical and medical transportation for dually eligible individuals are among the highest priorities for states.
5	**Provider and direct care workforce shortages**, exacerbated by inadequate wages and limited transportation, are a major access barrier to health care and home and community-based services (HCBS) for dually eligible individuals.
6	**Technology solutions** including audio-only telehealth hold great promise for **bringing health care to people rather than people to the care**.

Appendix 5. Rural Health Resources

Rural Health Webpages and resources

- Rural Policy Research Institute (RUPRI)
- Rural Health Information Hub (RHI Hub)
  - Evidence-Based Toolkits for Rural Community Health
- Rural Health Research Gateway
- National Organization of State Offices of Rural Health
  - Member State Offices of Rural Health
- Health Resource & Services Administration (HRSA) Rural Health
  - Rural Health Research and Policy Programs
- Federal Office of Rural Health Policy (HRSA)
  - Rural Communities Opioid Response Program (RCORP)
  - Rural Public Health Workforce Training Network Program
  - Rural Community Programs
  - HRSA Data Warehouse for Rural Health Investments and Grants
- CMS Rural Health Resources
- North Carolina Rural Health Research and Policy Analysis Center
- University of Minnesota Rural Health Research Center

Rural Health Equity Published Documents

- Rural Action Plan, US Department of Health and Human Services (September 2020)
- CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities, Centers for Medicare & Medicaid Services (November 2022)
- Advancing Rural Health Equity, Centers for Medicare & Medicaid Services (November 2022)
- Nursing Homes in Rural America: A Chartbook, Rural Policy Research Institute (July 2022)
- Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, Presidential Documents, Federal Register, Vol. 86, No. 14 (January 2021)

Workforce Published Documents

- Direct Care Workforce Policy and Action Guide, Milbank Memorial Fund (May 2022)

LTSS Published Documents

- Long-Term Services and Supports Rebalancing Toolkit, Centers for Medicare & Medicaid Services (November 2020)

COVID-19 Published Documents

- Rural Crosswalk: CMS Flexibilities to Fight COVID-19, Centers for Medicare & Medicaid Services (May 2021)

Appendix 6. State Level of Integration

In an earlier brief, HMA defined integrated care programs (ICPs) as financing and care delivery organizing entities or programs that coordinate and integrate Medicare and Medicaid-covered services and supports for dually eligible individuals. See HMA Issue Brief 3.

In a more recent June 2022 report, MACPAC identifies the key features of a fully integrated program, and outlines another way to assess states' level of integration along a continuum from minimal integration to full integration.

- **Minimal:** Coordination-only D-SNPs but no HIDE SNPs or FIDE SNPs
- **Low:** At least some HIDE SNPs but has not yet taken active steps to use those D-SNPs to design an integrated care initiative. HIDE SNP status has been achieved because D-SNP parent companies offer Medicaid managed care plans in overlapping service areas.
- **Moderate:** HIDE SNPs or FIDE SNPs or both and has worked with D-SNPs in the state to increase integration through strategies such as selective contracting, in which states contract only with D-SNPs that meet certain state requirements. D-SNPs in the state do not operate with exclusively aligned enrollment.
- **High:** Some FIDE SNPs that operate with exclusively aligned enrollment, but also has non-integrated or less-integrated D-SNPs.
- **Full:** All D-SNPs in the state are either FIDE SNPs or HIDE SNPs that operate with exclusively aligned enrollment.

HMA prepared this summary table, using MACPAC's data contained in the June 2022 report.

No D-SNPs (5)	Minimal (25)	Low (3)	Moderate (9)	High (4)	Full (5)
Alaska	Alabama	Kansas	Arizona	California	District of Columbia
Illinois	Arkansas	Kentucky	Florida	New York	Idaho
New Hampshire	Colorado	Nebraska	Hawaii	Tennessee	Massachu-setts
North Dakota	Connecticut		New Mexico	Wisconsin	Minnesota
Vermont	Delaware		Oregon		New Jersey
	Georgia		Pennsylvania		
	Indiana		Texas		
	Iowa		Virginia		
	Louisiana		Washington		
	Maine				
	Maryland				
	Michigan				
	Mississippi				
	Missouri				
	Montana				
	Nevada				
	North Carolina				
	Ohio				
	Oklahoma				
	Rhode Island				
	South Carolina				
	South Dakota				
	Utah				
	West Virginia				
	Wyoming				

Appendix 7. National & State Data Resources

Several national entities produce data books and reports on the dually eligible population. These reports are useful in framing rural communities' data needs. However, they do not help policymakers and planners to identify and address care gaps and disparities for dually eligible individuals in rural areas.

MACPAC and MedPAC produce a data book with a clear picture of the dually eligible population.[137] This resource is the only one of its kind.

MACPAC and MedPAC began producing this joint data book in 2013 to give a high-level picture of the population served, expenditures, and utilization. The data book provides detailed data on age, gender, race, and ethnicity; selected chronic conditions; and rural or urban residence. The data book also provides activities of daily living (ADL) limitations, self-reported health status, living arrangements, and education for dually eligible individuals.

MACPAC and MedPAC released the CY 2019 data in February 2022, facilitating comparisons between CY 2009 and CY 2019 data.[138] Since CY 2009, the dual-eligible population has increased by 3 million to 12.2 million from 9.2 million individuals and made some shifts. Today's dual eligible population is older, more racially and ethnically diverse, and more urban. Dually eligible individuals ages 65 and older increased to 62 percent from 60 percent of the total. The White population decreased from 58 percent to 54 percent of the total, and rural residents decreased from 25 percent to 21 percent of the total. Total spending also increased by 62 percent ($168.2 billion) to $440.2 billion from $272 billion, with big spikes for Medicare and Medicaid.

The data book's utilization data also are useful in tracking key policy issues such as rebalancing LTSS based on the share of use and spending on HCBS relative to institutional services.[139] LTSS use among FFS FBDEs was 45 percent in CY 2009 and 43 percent in CY 2019 (nearly the same). However, LTSS use shifted markedly between HCBS and institutional use. Institutional use among the FFS FBDE population decreased from 56 percent to 41 percent or by about 15 percentage points, while HCBS use increased proportionately. Unfortunately, the existing data book does not provide population and spending data stratified by age, race, ethnicity, disability type, and rural setting. As a result, it is not possible to measure disparities between rural and urban populations.

The federal government also produces reports focused on the dual eligible population.

Prior to the start and in support of the FAI demonstration,[140] CMS and its MMCO produced a set of national and state profiles and Excel files on the dual-eligible population and Medicaid and Medicare spending. These state data profiles provide per-member per-month (PMPM) Medicare expenditures by service setting and PMPM Medicaid expenditures by service settings for the dual-eligible population and FFS comparison populations.

The MMCO also produced state-specific fact sheets with data on the number of chronic conditions and prevalence of health conditions and LTSS enrollment; and, a public use file of demographic, enrollment, condition prevalence, utilization, and spending.

The latest release of the Medicare-Medicaid Linked Enrollee Data Source (MMLEADS) 2006−2012 includes information by county. County profiles identify Medicare beneficiaries by county, including data on demographics, age, race, gender, end-stage renal disease (ESRD) status, and Medicare, and Medicaid spending. However, these data sources do not capture LTSS use and other key measures such hospital length of stay.[141]

County-level data are important to rural communities because more than half of the Medicaid population of some counties in rural states—such as Nebraska, North Dakota, South Dakota, and Montana—are dually enrolled in Medicare.

As the Kaiser Family Foundation (KFF) once reported, "County-level data on dual eligible enrollment may help policymakers develop state or local initiatives."[142]

For several years, CMS also has produced an annual LTSS expenditure report. This report is useful in tracking national and state progress on rebalancing LTSS expenditures from institutional use to HCBS by state and population group.[143]

However, CMS LTSS expenditure reports do not report LTSS use by dual-eligible population or by rural community. These reports require significant improvement overall. As CMS officials consider ways to improve these reports, they should consider an approach for stratifying the LTSS expenditure data by dual eligibility and apply a rural lens to advance health equity measurement for dually eligible residents in rural communities.

HCBS access is a critical measure of IL and compliance with the Olmstead decision.[144] In 1999, the US Supreme Court rendered a decision in Olmstead v. L.C., 527 U.S. 581 (1999), indicating that states have a legal obligation to administer programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.[145]

These suggested improvements to the LTSS data book also would be consistent with the federal government's commitment to rural health equity, by applying a rural perspective to Medicare and Medicaid policy and programs.

States and state-based foundations also have prepared data books on dually eligible individuals to facilitate educational sessions, share information, develop programs, measure quality and program impact, and engage bidders.

States like Minnesota and Massachusetts, and Wisconsin began linking Medicare and Medicaid data more than 25 years ago to inform the development of ICPs for dually eligible individuals.[146] To better understand dually eligible individuals' chronic conditions and disabilities, and health care use and spending patterns, Minnesota produced extensive data books on the dual eligible population, investing in data resources to link Medicare and Medicaid data. Minnesota used the data to support the nation's first ICPs.[147] Massachusetts produced similar data books to inform the development of the Senior Care Options (SCO) program, which began nearly 20 years ago.

The FAI demonstration also served as a catalyst for states to produce data books, often at the state and county levels. In 2011, for example. The Blue Cross Blue Shield of Massachusetts Foundation produced a chart pack of combined Medicare and Medicaid spending data for adults ages 21 to 64 who are eligible for Medicare and Medicaid coverage in Massachusetts to help stakeholders understand the dually eligible population.[148] In 2013, Massachusetts produced a data book for interested parties, with summarized information related to the Massachusetts Demonstration to Integrate Care for Dual Eligible individuals (One Care) Program. The commonwealth's actuarial contractor also produced a data book for prospective health plan bidders.[149] And in 2021, the Blue Cross Blue Shield Foundation produced a second data chart pack, offering a detailed analysis of enrollment, demographics, and spending trends among dual eligible individuals in Massachusetts.[150] Unfortunately, many states never produced data books linking Medicare and Medicaid data to provide an integrated view of spending and utilization on the dual-eligible population.

Appendix 8. SDOH Needs of Rural Dually Eligible Individuals

Dually eligible individuals have high SDOH needs, including low health literacy, poverty, food and housing insecurity, social isolation, and limited transportation. Dually eligible individuals in rural areas may feel these challenges most acutely, due to limited access to fresh food, suitable housing, and transportation. Indeed, all adults with disabilities face higher rates of food insecurity than adults without disabilities.[151]

Food availability and accessibility is more limited for adults in rural areas than urban areas, based on the number of food establishments per 1,000 residents.[152] Food is a necessity and essential to health and controlling chronic diseases. Access to fresh food is worse in rural areas because of limited public transportation options or no personal transportation.

Housing is more limited for dually eligible individuals in rural areas. In rural areas of the country, the housing stock may be old and in need of repairs, maintenance, and accessibility modifications.[153] The housing conditions create affordability pressures and make housing unsuitable for dually eligible individuals with disabilities. Access to affordable and suitable housing is essential to health and to independent living.

Transportation is also limited, yet critical to many health and health-related social needs including accessing food,[154] participating in community activities to prevent social isolation, getting to health care facilities, and being able to have DCWs provide HCBS and remain in the community.

Appendix 9. Medicaid and Medicare MLRs

According to federal and state rules, state Medicaid programs and CMS calculate plan MLRs for Medicaid and Medicare separately. This holds true even for ICPs.

State Medicaid programs have the flexibility to set a minimum MLR at 85 percent or higher, apply and set remittance requirements for plans, and adjust the formula for calculating the MLR, according to federal rules. If the state sets a remittance requirement, then the state must account for this requirement as part of the federally required actuarial certification. States may include additional plan spending on HRSNs in the MLR calculation, as they have the flexibility to identify which health plan activities may improve health care quality.

- On the Medicare side, MA plans must "reasonably achieve an MLR of at least 85 percent for the rate year."
- On the Medicaid side, managed care plans must calculate and report MLRs to the state Medicaid program.

The following table summarizes Medicaid MCO and MA plan requirements, respectively. State Medicaid programs may use a different methodology than Medicare's MLR methodology.

FIGURE 32.

General Medicaid and MA Plan Requirements.

Payer	Applies to	Plan Requirement	MLR Calculation: Numerator	MLR Calculation: Denominator
Medicaid	Medicaid managed care plans	Plans are required to report the MLR; states also may require plans to meet a minimum of 85% or higher. The state may or may not require remittance.	Sum of health care spending on "patient care" and other allowable expenditures including activities to improve health care quality and fraud prevention activities. States may vary on how to attribute expenditures.	Earned premiums minus the plan's federal, state, and local taxes and licensing and regulatory fees. Capitation payments for required services under the contract are included in the denominator. Incentive payments are not counted as premium revenue for purposes of the MLR. Pass-through payments are also excluded from MLR calculations (42 CFR 438.6(d)).
Medicare	MA plans, including D-SNPs	Plans must achieve a minimum of 85% or face sanctions and financial penalties.	Sum of health care spending on incurred medical claims (including supplemental benefits) and activities that improve health care quality.	Earned premiums minus allowable deductions.

The following table summarizes how state Medicaid programs treat ILOS and value-added services in developing capitation rates and in calculating MLRs.

FIGURE 33.

ILOS and Value-Added Services.

Medicaid Service	Coverage	Capitation Rates	MLR
Medicaid: ILOS	States and plans may elect to cover ILOS to substitute for services or settings covered in a state plan because they provide a medically appropriate and cost-effective alternative.	The costs of ILOS are included in the capitation rates.	ILOS can be included in the numerator of the MLR.
Medicaid: Value-added services	Plans may cover services not covered under the Medicaid state plan.	The costs of value-added services cannot be included in the capitation rates.	These services can be included in the numerator of the MLR if it is part of a quality initiative.

The Medical Loss Ratio

An MLR applies to capitated health plans or MCOs under contract with the state's Medicaid program and to MA plans. Under current rules, the state oversees the Medicaid MCO MLR and CMS oversees the MA MLR. Plans calculate two separate MLRs. A Medicaid MCO that operates a D-SNP is not required to report a blended MLR that combines the Medicaid and Medicare experience for dually eligible individuals.

MLRs are a way to: (1) ensure that plans spend a certain percentage of the total capitation or premiums on health care or quality improvements; (2) make transparent how much a plan spends on administrative activities and earns in gains; and (3) promote greater value for members enrolled in MCOs or in MA plans.

Example: A Blended MLR

In this example, let's assume the following:

1. The plan is an ICP.
2. The state and CMS have established an aligned methodology for calculating the Medicaid and Medicare MLRs.
3. The state and CMS set the MLR requirement at 85 percent. (Some states may wish to set a higher percent.)
4. The state and CMS require a remittance from the plan if they do not meet the MLR requirement.
5. The state and CMS require the ICP to report a blended MLR based on the combined Medicare and Medicaid experience of dually eligible individuals.

Simple Financial Assumptions:

1. The plan's denominator = 100 members x 12 months x $250 per member per month (PMPM)
2. The plan's total capitation revenue = $300,000
3. The plan's numerator = spending on claims plus quality improvement activities
4. The plan spent $240,000
5. MLR =$240,000/$300,000 = .80 or 80%
6. Math: (.85-.80) X $300,000 = $15,000 remittance

Interpretation:

1. The plan did not meet the federal and state standard.
2. The plan must pay 5 percent of capitation rate revenue back to the state and to CMS.
3. The state and CMS share in savings, using an agreed-upon allocation methodology to support ICP goals.

Endnotes

1 Justice in Aging. December 2022, "An Equity Framework for Evaluating California's Medi-Cal Home and Community-Based Services for Older Adults & People with Disabilities," An Equity Framework for Evaluating California's Medi-Cal Home and Community-Based Services for Older Adults & People with Disabilities (justiceinaging.org)

2 Centers for Medicare & Medicaid Services. "CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities," December 2022, https://www.cms.gov/files/document/cms-geographic-framework.pdf

3 New York Times. A Rural Hospital's Excruciating Choice: $3.2 Million a Year or Inpatient Care, December 2022, https://www.nytimes.com/2022/12/09/health/rural-hospital-closures.html

4 CMS. "CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities," December 2022, https://www.cms.gov/files/document/cms-geographic-framework.pdf

5 Sarah Barth, Ellen Breslin, Samantha DiPaola, Narda Ipakchi. Brief Fact Sheet for "*Medicare-Medicaid Integration: Essential Program Elements and Policy Recommendations for Integrated Care Programs for Dually Eligible Individuals,"* Health Management Associates, July 2021, https://www.healthmanagement.com/wp-content/uploads/07.14.21-Dual-Integration-Brief-3-Final.pdf

6 The White House. "A Proclamation on National Rural Health Day, 2022" November 16, 2022, https://www.whitehouse.gov/briefing-room/presidential-actions/2022/11/16/a-proclamation-on-national-rural-health-day-2022/

7 Health Resources & Services Administration, National Rural Health Day Agenda. Accessed December 12, 2022, https://www.hrsa.gov/rural-health/about-us/rural-health-day

8 MACPAC. Chapter 1, "Integrating Care for Dually Eligible Beneficiaries: Background and Context," June 2020, https://www.macpac.gov/publication/chapter-1-integrating-care-for-dually-eligible-beneficiaries-background-and-context/

9 CMS. "About the Medicare-Medicaid Coordination Office," Accessed December 12, 2022, https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office

10 CMS. "CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F)," April 2022, https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-final-rule-cms-4192-f

11 Thomas Bubolz, Constance Emerson, and Jonathan Skinner. "State Spending on Dual Eligibles Under 65 Shows Variation, Evidence of Cost Shifting from Medicaid to Medicare," Health Affairs, May 2012, State Spending on Dual Eligibles Under Age 65 Shows Variations, Evidence Of Cost Shifting From Medicaid To Medicare | Health Affairs

12 Medicaid and CHIP Payment Advisory Commission. Chapter 5, "Raising the Bar: Requiring State Integrated Care Strategies," June 2022, https://www.macpac.gov/publication/raising-the-bar-requiring-state-integrated-care-strategies/

13 Bipartisan Policy Center. "A Pathway of Full Integration of Care for Medicare-Medicaid Beneficiaries," July 2020, A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries | Bipartisan Policy Center

14 The Dual Eligible Coalition. Leavitt Partners, May 2022, available at Dual-Eligible-Coalition-Overview_May-2022_clean-527.pdf (leavittpartners.com)

15 MACPAC. Chapter 4, "Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations," March 2021, https://www.macpac.gov/wp-content/uploads/2021/03/Chapter-4-Establishing-a-Unified-Program-for-Dually-Eligible-Beneficiaries-Design-Considerations.pdf

16 Portman Senate Newsroom. "Portman, Brown Introduce Legislation to Improve Care For Those Eligible For Both Medicaid and Medicare," July 2022, https://www.portman.senate.gov/newsroom/press-releases/portman-brown-introduce-legislation-improve-care-those-eligible-both

17 Actuary.org. "Proposed Rule, Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs," March 2022, https://www.actuary.org/sites/default/files/2022-03/American_Academy_of_Actuaries_DSNP_Proposed_Rule_Comment_Letter_03072022.pdf

18 MACPAC. "June 2022 Report to Congress on Medicaid and CHIP," June 2022, https://www.macpac.gov/publication/june-2022-report-to-congress-on-medicaid-and-chip/

19 North Dakota Health and Human Services. "North Dakota Medicaid," North Dakota Medicaid | Health and Human Services North Dakota

20 HealthInsurance.org. "North Dakota and the ACA's Medicaid expansion," ACA Medicaid expansion in North Dakota [Updated 2022 Guide] | healthinsurance.org

21 Medicaid.gov. "Managed Long Term Services and Supports," accessed December 2022, https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html

22 Sarah Barth, Ellen Breslin, Sam Di Paola, Narda Ipakchi, Health Management Associates. Brief #3, "Medicare-Medicaid Integration: Essential Program Elements for Integrated Care Programs for Dually Eligible Individuals," July 2021, https://www.healthmanagement.com/wp-content/uploads/07.14.21-Dual-Integration-Brief-3-Final.pdf

23 Dennis Heaphy. Heller.Brandeis.edu, Community Living Policy Center, "From Principle to Practice: Operationalizing Independent Living Philosophy and Recovery Principles in Capitated Managed Care," May 2020, https://heller.brandeis.edu/community-living-policy/publications/il-coordinator-accessible.pdf

24 MACPAC. Chapter 2, "Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options," June 2020, available at https://www.macpac.gov/publication/chapter-2-integrating-care-for-dually-eligible-beneficiaries-policy-issues-and-options/

25 National Conference of State Legislatures. "Improving Rural Health: State Policy Options for Increasing Access to Care," June 2020, Improving Rural Health: State Policy Options for Increasing Access to Care (ncsl.org)

26 US Department of Agriculture. "Opioid Misuse in Rural America," accessed December 2022, https://www.usda.gov/topics/opioids

27 MACPAC. "Creating a Duals Strategy in a FFS environment – WA," September 2022, https://www.macpac.gov/wp-content/uploads/2022/09/09_Creating-a-Duals-Strategy-in-a-FFS-environment-and-Integrated-Care-in-Maine-Current-Work-and-Future-Opportunities.pdf

28 CMS. "CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities," November 2022, CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities

29 Center for Rural Health, University of North Dakota School of Medicine & Health Sciences. https://ruralhealth.und.edu/

30 Center for Rural Health. "State Office of Rural Health (SORH)," https://ruralhealth.und.edu/projects/state-office-of-rural-health

31 Health Resources & Services Administration. "State Offices of Rural Health (SORH) Program," March 2022, https://www.hrsa.gov/rural-health/grants/rural-hospitals/sorh

32 Rural Health Information Hub. "State Rural Health Plans," State Rural Health Plans - Rural Health Information Hub

33 Center for Health Care Strategies. "Getting Started with a Master Plan for Aging," November 2021, https://www.chcs.org/resource/getting-started-with-a-master-plan-for-aging/

34 National Conference of State Legislatures. The NCSL Blog, "Crafting Master Plans: States Supporting an Aging Population," January 2022, https://www.ncsl.org/blog/2022/01/19/crafting-master-plans-states-supporting-an-aging-population.aspx

35 National Conference of State Legislatures. "Comprehensive Policy Approaches to Support the Aging Population," May 2021, https://www.ncsl.org/research/health/comprehensive-policy-approaches-to-support-the-aging-population.aspx#:~:text=The%20term%20%E2%80%9CMaster%20Plan%20for,housing%2C%20transportation%2C%20workforce%2C%20health

36 Health Affairs. "Integrating Medicare And Medicaid Data to Improve Care Quality And Advance Health Equity Among Dual-Eligible Beneficiaries," November 2022, https://www.healthaffairs.org/do/10.1377/hpb20221011.325614/

37 Health Affairs. "Integrating Medicare And Medicaid Data to Improve Care Quality And Advance Health Equity Among Dual-Eligible Beneficiaries," November 2022, https://www.healthaffairs.org/do/10.1377/hpb20221011.325614/

38 Medicaid.gov. "Using Integrated Medicare-Medicaid Data to Inform Data Driven Decision Making," May 2019, https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/integrated-medicare-medicaid-data.pdf

39 MACPAC. "Data Book: Beneficiaries Dually Eligible For Medicare and Medicaid," December 2013, Data Book: Beneficiaries dually eligible for Medicare and Medicaid (December 2013) (macpac.gov)

40 Dashconnect.org. "Data Across Sectors for Health (DASH)," Data Across Sectors for Health (DASH) - Empowering communities through shared information (dashconnect.org)

41 Rural Health Information Hub. "State Offices of Rural Health," https://www.ruralhealthinfo.org/organizations/state-office-of-rural-health

42 Rural Health Research Gateway. "Characteristics and Utilization Patterns of Rural Dual-Eligible Medicare Beneficiaries," August 2014, https://www.ruralhealthresearch.org/projects/100002239 Characteristics and Utilization Patterns of Rural Dual-eligible Medicare Beneficiaries: Rural Health Research Project

43 Rural Health Information Hub. "Rural Health Research Centers," https://www.ruralhealthinfo.org/organizations/rural-health-research-centers

44 UW Medicine. "WWAMI: A five-state medical education creating national impact," https://www.uwmedicine.org/school-of-medicine/md-program/wwami

45 Health Management Associates. "Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches," March 2019, Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf (macpac.gov)

46 Health Management Associates. "Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches," March 2019, Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf (macpac.gov)

47 Office of the Assistant Secretary for Planning and Evaluation. "Integrating Care through Dual Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges," April 2019, https://aspe.hhs.gov/reports/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-challenges

48 Rural Health Information Hub. "Care Coordination Model," accessed December 2022, https://www.ruralhealthinfo.org/toolkits/services-integration/2/care-coordination

49 CMS. "Advancing Rural Health Equity: Fiscal Year 2022 Year in Review," November 2022, Advancing Rural Health Equity: Fiscal Year 2022 Year in Review (cms.gov)

50 Dennis Heaphy, Heller.Brandeis.edu, Community Living Policy Center. "From Principle to Practice: Operationalizing Independent Living Philosophy and Recovery Principles in Capitated Managed Care," May 2020, https://heller.brandeis.edu/community-living-policy/publications/il-coordinator-accessible.pdf

51 CMS. Special Needs Plans, "Model of Care (MOC)," accessed December 2022, https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

52 CMS. Special Needs Plans, "Model of Care (MOC)," accessed December 2022, https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

53 Integrated Care Resource Center. "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Integrating Medicaid Managed Long-Term Services and Supports into D-SNP Models of Care," June 2019, Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Integrating Medicaid MLTSS into D-SNP Models of Care (integratedcareresourcecenter.com)

54 Integrated Care Resource Center. "Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans," May 2020, https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_SMACSampleLanguage.pdf

55 Health Management Associates. "Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches," March 2019, https://www.macpac.gov/wp-content/uploads/2019/03/Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf

56 Health Management Associates. "Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries—Health Plan Standards, Challenges and Evolving Approaches," March 2019, Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries—Health Plan Standards, Challenges and Evolving Approaches : MACPAC

57 Indiana.gov. "Professional Services Contract," 2022, https://www.in.gov/medicaid/partners/files/IN-SMAC-2022.pdf

58 Center for Health Care Strategies. "A New Era in Supporting State Efforts to Improve Care for Dual-Eligible Individuals," September 2022, https://www.chcs.org/resource/a-new-era-in-supporting-state-efforts-to-improve-care-for-dual-eligible-individuals/

59 Center for Health Care Strategies. "A New Era in Supporting State Efforts to Improve Care for Dual-Eligible Individuals," September 2022, https://www.chcs.org/resource/a-new-era-in-supporting-state-efforts-to-improve-care-for-dual-eligible-individuals/

60 Washington State Department of Social and Health Services. "Creating a Duals Strategy in a FFS Environment – WA," accessed December 2022, https://www.macpac.gov/wp-content/uploads/2022/09/09_Creating-a-Duals-Strategy-in-a-FFS-environment-and-Integrated-Care-in-Maine-Current-Work-and-Future-Opportunities.pdf

61 PHInational.org. "Racial Disparities in the Direct Care Workforce: Spotlight on Black/African American Workers," February 2018, https://www.phinational.org/resource/racial-disparities-direct-care-workforce-spotlight-black-african-american-workers/

62 Rural Health Information Hub. "Need for Addressing Social Determinants of Health in Rural Communities," March 2016, https://www.ruralhealthinfo.org/toolkits/sdoh/1/need-in-rural

63 New Mexico Department of Health. "Office of Community Health Workers," accessed December 2022, https://www.nmhealth.org/about/phd/pchb/ochw/

64 National Academy for State Health Policy. "State Community Health Worker Models," December 2021, State Community Health Worker Models - The National Academy for State Health Policy (nashp.org)

65 Rural Health Association of Tennessee. "Community Health Workers," accessed December 2022, Community Health Workers (tnruralhealth.org)

66 American Public Health Association. "Community Health Workers," 2022, Community Health Workers (apha.org)

67 Families USA. "How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities, July 2016, Community-Health-Workers-Brief.pdf (national-complex.care)

68 Rural Health Information Hub. "Community Health Workers in Rural Settings," October 2021, Community Health Workers in Rural Settings Overview – Rural Health Information Hub

69 National Academy for State Health Policy. "State Community Health Worker Models," December 2021, State Community Health Worker Models – The National Academy for State Health Policy (nashp.org)

70 MACPAC. " Medicaid Coverage of Community Health Worker Services," April 2022, Medicaid Coverage of Community Health Worker Services: MACPAC

71 Center for Disease Control and Prevention. "States Implementing Community Health Worker Strategies," December 2014, https://www.cdc.gov/dhdsp/programs/spha/docs/1305_ta_guide_chws.pdf

72 US Department of Health and Human Services. "Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans," 2018, https://aspe.hhs.gov/sites/default/files/private/pdf/259896/MAStudy_Phase2_RR2634-final.pdf

73 University of Minnesota Rural Health Research Center. "Who Will Care for Rural Older Adults? Measuring the Direct Care Workforce in Rural Areas," November 2022, https://rhrc.umn.edu/publication/who-will-care-for-rural-older-adults-measuring-the-direct-care-workforce-in-rural-areas/

74 Rural Health Research Gateway. "The Direct Care Workforce in Rural Areas," September 2021, https://www.ruralhealthresearch.org/projects/100002553

75 Rural Health Information Hub. "Community Health Workers Toolkit," accessed December 2022, Community Health Workers Toolkit – RHIhub Toolkit (ruralhealthinfo.org)

76 Health Affairs. "To Improve Dual Eligibles' Health, Create Targeted SDOH Funds And Increase Integration," September 2022, https://www.healthaffairs.org/content/forefront/improve-dual-eligibles-health-create-targeted-sdoh-funds-and-increase-integration

77 CMS. "On the Front Lines of Health Equity: Community Health Workers," April 2021, https://www.cms.gov/files/document/community-health-worker.pdf

78 South Dakota Association of Healthcare Organizations. "Community Health Workers in South Dakota," August 2022, https://sdaho.org/2022/08/05/community-health-workers-in-south-dakota/

79 South Dakota Department of Health. "South Dakota Community Health Workers Workgroup: Summary and Workgroup," February 2017, https://doh.sd.gov/documents/diseases/chronic/CHW_WorkgroupRecommendations.pdf

80 South Dakota Department of Social Services. "South Dakota Medicaid Billing and Policy Manual; Community Health Worker Services," June 2022, Community_Health_Worker_Services.pdf (sd.gov)

81 South Dakota Association of Healthcare Organizations. "First Annual South Dakota Community Health Worker Conference A Success," May 2022, First Annual South Dakota Community Health Worker Conference A Success | SDAHO

82 South Dakota Department of Health. "South Dakota Community Health Workers Workgroup: Summary and Workgroup," February 2017, https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/Community_Health_Worker_Services.pdf

83 Community Health Worker Collaborative of South Dakota. "Community Health Worker Collaborative of South Dakota," accessed December 2022, Home - Community Health Workers Collaborative of South Dakota (chwsd.org)

84 MACPAC. "Medicaid Coverage of Community Health Worker Services," April 2022, https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf

85 MACPAC. "Medicaid Coverage of Community Health Worker Services," April 2022, https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf

86 Center for American Progress. "How States Can Expand health Care Access in Rural Communities," February 2022, https://www.americanprogress.org/article/how-states-can-expand-health-care-access-in-rural-communities/

87 Rural Health Information Hub. "Barriers to MOUD in Rural Areas," December 2020, https://www.ruralhealthinfo.org/toolkits/moud/1/barriers

88 HRSA Health Workforce, 'What is Shortage Designation," August 2022, What is Shortage Designation? | Bureau of Health Workforce (hrsa.gov)

89 CMS. "HHS Continues Biden-Harris Administration Progress in Promoting Health Equity in Rural Care Access Through Outpatient Hospital and Surgical Center Payment System Final Rule," November 2022, https://www.cms.gov/newsroom/press-releases/hhs-continues-biden-harris-administration-progress-promoting-health-equity-rural-care-access-through

90 Rocky Mountain ADA. "Telehealth Use Among Rural Individuals With Disabilities," January 2020, https://rockymountainada.org/sites/default/files/2020-02/Rural%20Telehealth%20Rapid%20Response%20Report.pdf

91 Federal Register. "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," May 2022, https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

92 CMS. "Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance," June 2020, https://www.cms.gov/files/document/medicareadvantageandsection1876costplannetworkadequacyguidance6-17-2020.pdf

93 MACPAC. Issue Brief, "Medicaid and Rural Health," April 2021, https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf

94 MACPAC. "How Medicaid interacts with other payers," accessed December 2022, https://www.macpac.gov/subtopic/how-medicaid-interacts-with-other-payers/

95 Medicare Interactive. "How Medicaid works with Medicare," accessed December 2022, How Medicaid works with Medicare - Medicare Interactive

96 Kaiser Family Foundation. "Network Adequacy Standards and Enforcement," 2022, https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/

97 Kaiser Family Foundation. "Network Adequacy Standards and Enforcement," 2022, https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/

98 National Institute on Aging. "Social isolation, loneliness in older people pose health risks," April 2019, https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks

99 University of Montana. "Social Isolation and Loneliness Among People with Disabilities," November 2021, https://www.umt.edu/rural-institute/rtc/stories/news-2021/11.29.21-social-isolation-and-loneliness-among-people-with-disabilities.php

100 National Academies of Sciences, Engineering, and Medicine. "Social Isolation and Loneliness in Older Adults," 2020, https://nap.nationalacademies.org/catalog/25663/social-isolation-and-loneliness-in-older-adults-opportunities-for-the

101 National Council on Aging. "Understanding Social Isolation and its Impact on Older Adults and Those Living with Disabilities," July 2021, https://www.ncoa.org/article/understanding-social-isolation-and-its-impact-on-older-adults-and-those-living-with-disabilities

102 Center for Disease Control and Prevention. "Loneliness and Social Isolation Linked to Serious Health Conditions," accessed December 2022, Loneliness and Social Isolation Linked to Serious Health Conditions (cdc.gov)

103 National Academies. "Health Care System Underused in Addressing Social Isolation, Loneliness Among Seniors, Says New Report," February 2020, https://www.nationalacademies.org/news/2020/02/health-care-system-underused-in-addressing-social-isolation-loneliness-among-seniors-says-new-report

104 National Library of Medicine. "Toward a National Strategy for Long-Term Care of the Elderly: A Study Plan for Evaluation of New Policy Options for the Future.," accessed December 2022, https://www.ncbi.nlm.nih.gov/books/NBK222681/

105 Kaiser Family Foundation. "Medicaid Authorities and Options to Address Social Determinants of Health (SDOH)," August 2021, https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/

106 U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy. "Research Report: Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans," 2018, Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans (hhs.gov)

107 The Commonwealth Fund. "New Policy Opens the Door for States to Address Drivers of Health in Medicaid," April 2022, https://www.commonwealthfund.org/blog/2022/new-policy-opens-door-states-address-drivers-health-medicaid

108 Cornell.edu, Legal Information Institute. "42 CFR § 438.3 - Standard contract requirements.," accessed December 2022, https://www.law.cornell.edu/cfr/text/42/438.3

109 Kaiser Family Foundation. "Food Insecurity and Health: Addressing Food Needs for Medicaid Enrollees as Part of COVID-19 Response Efforts," August 2020, https://www.kff.org/report-section/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of-covid-19-response-efforts-issue-brief/#:~:text=While%20Medicaid%20generally%20cannot%20pay,'%20non%2Dmedical%20health%20needs

110 Healthcare Innovation. "Medicaid Waivers Approved for Massachusetts, Oregon, Around Food and Housing Insecurity," September 2022, https://www.hcinnovationgroup.com/policy-value-based-care/medicare-medicaid/article/21282438/medicaid-waivers-approved-for-massachusetts-oregon-around-food-and-housing-insecurity

111 Oregon Department of Human Services. "Federal Government Approves Oregon Medicaid Waiver, Including First-in-Nation Medicaid Funding for Food and Housing," September 2022, Federal Government Approves Oregon Medicaid Waiver, Including First-in-Nation Medicaid Funding for Food and Housing (govdelivery.com

112 HHS. "HHS Approves Arizona's Medicaid Interventions to Target Health-Related Social Needs," October 2022, https://www.hhs.gov/about/news/2022/10/14/hhs-approves-arizonas-medicaid-interventions-target-health-related-social-needs.html

113 HHS. "HHS Approves Arkansas' Medicaid Waiver to Provide Medically Necessary Housing and Nutrition Support Services," November 2022, https://www.hhs.gov/about/news/2022/11/01/hhs-approves-ar-medicaid-waiver-to-provide-medically-necessary-housing-nutrition-support-services.html

114 New Mexico Human Services Department. "Medicaid 1115 Waiver Renewal," accessed December 2022, https://www.hsd.state.nm.us/medicaid-1115-waiver-renewal/

115 Medicaid.gov. Section 1115 Demonstrations Waiver List, "New Mexico Centennial Care 2.0 (formerly New Mexico Centennial Care)," accessed December 2022, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82611

116 Kaiser Family Foundation. "Medicaid Authorities and Options to Address Social Determinants of Health (SDOH)," August 2021, https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/

117 Medicaid Health Plans of America. "Medically Tailored Meals as Value-Added Benefit (VAB) in Medicaid," February 2022, https://medicaidplans.org/2022/02/medically-tailored-meals-as-value-added-benefit-vab-in-medicaid/

118 U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy. "Research Report: Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans," 2018, https://aspe.hhs.gov/sites/default/files/private/pdf/259896/MAStudy_Phase2_RR2634-final.pdf

119 The Commonwealth Fund. "Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment," February 2021, https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/medicare-advantage-plans-supplemental-benefits

120 MedicareAdvantage.com. "Does Medicare Cover Meal Delivery?" October 2021, https://www.medicareadvantage.com/coverage/does-medicare-cover-meal-delivery

121 The Commonwealth Fund. "Taking Stock of Medicare Advantage: Special Needs Plans," March 2022, https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-special-needs-plans

122 Anne Tumlinson Innovations Advisory. "A Turning Point in Medicare Policy: Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill," July 2019, https://atiadvisory.com/wp-content/uploads/2019/07/2019-07-24_GuidingPrinciplesForSSBCI.pd

123 Better Medicare Alliance. "Fact Sheet: Health Risk Assessments in Medicare Advantage," June 2022, https://bettermedicarealliance.org/publication/fact-sheet-health-risk-assessments-in-medicare-advantage/

124 CMS. "CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F)," April 2022, https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-final-rule-cms-4192-f

125 CMS. "CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F)," April 2022, https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-final-rule-cms-4192-f

126 MACPAC. Issue Brief, "Medical Loss Ratios in Medicaid Managed Care," January 2022, https://www.macpac.gov/wp-content/uploads/2022/01/Medical-loss-ratio-issue-brief-January-2022.pdf

127 The Commonwealth Fund. "Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools," January 2018, https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjpq-7famP76AhWvKlkFHTD1DywQFnoECBIQAw&url=https%3A%2F%2Fwww.commonwealthfund.org%2Fpublications%2Ffund-reports%2F2018%2Fjan%2Fenabling-sustainable-investment-social-interventions-review%23%3A~%3Atext%3DThe%2520cost%2520of%2520value%252Dadded%2Cpart%2520of%2520a%2520quality%2520initiative.&usg=AOvVaw0O4R_OFFtl46Ysjr30FuMD

128 Georgetown University Health Policy Institute, Center for Children and Families. "Medicaid Managed Care: SDOH, MCO, and MLR," March 2022, Medicaid Managed Care: SDOH, MCO, and MLR – Center for Children and Families (georgetown.edu)

129 CMS. "CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities," November 2022, https://www.cms.gov/files/document/cms-geographic-framework.pdf

130 U.S. Department of Agriculture, Economic Research Service. "Rural Poverty & Well-Being," November 2022, USDA ERS - Rural Poverty & Well-Being

131 Centers for Disease Control and Prevention. National Center for Health Statistics Pressroom, "Urban-Rural Differences in Drug Overdose Deaths," July 2022, https://www.cdc.gov/nchs/pressroom/podcasts/2022/20220729/20220729.htm

132 Becker's Healthcare Hospital Review. "183 rural hospital closures since 2005," November 2022, 183 rural hospital closures since 2005 (beckershospitalreview.com)

133 Health Affairs. Volume 41 No. 10, "Personal Care Aides: Assessing Self-Care Needs And Worker Shortages In Rural Areas," October 2022, https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00483

134 University of Minnesota Rural Health Research Center. Policy Brief, "Who Will Care for Rural Older Adults? Measuring the Direct Care Workforce in Rural Areas," November 2022, https://rhrc.umn.edu/wp-content/uploads/2022/11/UMN-Policy-Brief_Who-will-care-for-rural-older-adults-1.pdf

135 Center for Reducing Health Disparities, College of Public Health, University of Nebraska Medical Center. "Urban and Rural Differences in Community Health Worker Workforce in Nebraska," December 2021, https://dhhs.ne.gov/MCAH/Urban%20and%20Rural%20Differences%20in%20CHW%20Workforce%20in%20NE%20January%202022%20final.pdf

136 PRB.org. "Digital Divide in High-Speed Internet Access Leaves Rural Areas Behind," December 2021, https://www.prb.org/articles/digital-divide-in-high-speed-internet-access-leaves-rural-areas-behind/

137 MACPAC. "Data Book: Beneficiaries Dually Eligible For Medicare and Medicaid," December 2013, Data Book: Beneficiaries dually eligible for Medicare and Medicaid (December 2013) (macpac.gov)

138 MACPAC. "Data Book: Beneficiaries Dually Eligible For Medicare and Medicaid," February 2022, February 2022 MedPAC MACPAC Dually Eligible Data Book

139 Medicaid.gov. "Long-Term Services and Supports Rebalancing Toolkit," November 2020, Rebalancing Toolkit (medicaid.gov)

140 CMS.gov, "MMCO Statistical & Analytic Reports," August 2022, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics

141 CMS.gov. "County Level Profiles 2012," 2012, https://www.cms.gov/files/document/county-levelprofiles2012.xlsx

142 Kaiser Family Foundation. "Quick Take: Geographic Variation in Dual Eligible Enrollment," May 2012, https://www.kff.org/health-reform/fact-sheet/quick-take-geographic-variation-in-dual-eligible/

143 Medicaid.gov. Long Term Services & Supports "Reports & Evaluations," https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html

144 Administration for Community Living. "Delivering on the Promise of Olmstead: A Spotlight on Centers for Independent Living," June 2022, Delivering on the Promise of Olmstead: A Spotlight on Centers for Independent Living | ACL Administration for Community Living

145 Commonwealth of Massachusetts. "Commonwealth of Massachusetts Olmstead Plan and Update," https://www.mass.gov/orgs/commonwealth-of-massachusetts-olmstead-plan-and-update

146 CMS.gov. "Redesigning Integrated Medicare and Medicaid Financing and Service Delivery for People with Dual Eligibility in Minnesota," April 2012, https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/minnesotaproposal.pdf

147 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. "Minnesota Managed Care Longitudinal Data Analysis," March 2016, https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis

148 Blue Cross Blue Shield of Massachusetts Foundation. "Dual Eligibles in Massachusetts: A Profile of Health Care Services and Spending for Non-Elderly Adults Enrolled in Both Medicare and Medicaid," September 2011, https://www.bluecrossmafoundation.org/publication/dual-eligibles-massachusetts-profile-health-care-services-and-spending-non-elderly

149 CommBuys: Operational Services Division. Bid Solicitation, "One Care Plan Procurement Information," June 2019, https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-18-1039-EHS01-EHS02-20518&external=true&parentUrl=bid

150 Ellen Breslin and Tony Dreyfus, Blue Cross Blue Shield of Massachusetts Foundation. "The Dual Eligible Population in Massachusetts: DATA CHART PACK," March 2021, https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2021-03/Primer_Data_Chartpack_FINAL_1.pdf

151 Interagency Committee on Disability Research. ICDR Toolkit, "Federal Housing Resources for People with Disabilities: A Toolkit for Interagency Collaboration," September 2020, https://icdr.acl.gov/system/files/resources/ICDR-Housing-9.8.20_508.pdf

152 Urban Institute, Income and Benefits Policy Center. "The Geography of Disability and Food Insecurity," March 2022, https://www.urban.org/sites/default/files/2022 03/The%20Geography%20of%20Disability%20and%20Food%20Insecurity.pdf

153 Hud User, Office of Policy Development and Research (PD&R). "Housing Challenges of Rural Seniors," Summer 2017, https://www.huduser.gov/portal/periodicals/em/summer17/highlight3.html

154 Transportation Research Board. "Utilizing Public Transportation to End Food Insecurity in the Rural and Small Urban Area by Providing Better Access: A Case Study of Rural Counties in North Dakota," June 2022, https://rip.trb.org/view/1984636

HMA

www.healthmanagement.com

REV012623