

HEALTH

Improving Rural Health

State Policy Options for Increasing Access to Care



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Improving Rural Health: State Policy Options for Increasing Access to Care

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The National Conference of State Legislatures is the bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories.

NCSL provides research, technical assistance and opportunities for policymakers to exchange ideas on the most pressing state issues, and is an effective and respected advocate for the interests of the states in the American federal system. Its objectives are:

- Improve the quality and effectiveness of state legislatures.
- Promote policy innovation and communication among state legislatures.
- Ensure state legislatures a strong, cohesive voice in the federal system.

The conference operates from offices in Denver, Colorado and Washington, D.C.



Ensuring individuals have [access to health care](#)—or the timely use of personal health services to achieve the [best health outcomes](#)—is critical for managing chronic health conditions, avoiding premature death and reducing health disparities. Rural Americans, however, experience unique challenges in accessing necessary health care services compared to their urban counterparts. More than three-quarters of the nation’s rural counties are designated as [health professional shortage areas \(HPSAs\)](#)—geographic areas, populations or facilities with insufficient access to health care providers and professionals in primary care, dental care or mental health. Moreover, rural Americans are [less likely to have insurance coverage](#) and [more likely to travel longer in both time and distance](#) to the nearest hospital compared to those living in suburban or urban areas. These challenges—along with other [demographic, environmental, economic and social factors](#)—negatively affect the overall health of rural Americans.

To address barriers that impede access in rural areas, states have adopted various strategies to provide affordable and accessible health care services. This report highlights several state policies and investments for increasing rural access to care in three key areas:

- Improving health care coverage.
- Safeguarding rural health facilities.
- Changing rural health care delivery.

COVID-19 and Rural Health

The coronavirus (COVID-19) pandemic and its effect on rural health cuts across many of the policy areas discussed in this brief. For example, many states have looked to bolster health insurance coverage and [waive cost-sharing requirements](#) for COVID-19 testing and associated treatment for both state Medicaid programs and state-regulated insurance plans. Federal legislation expanded [emergency funding](#) for hospitals and other health facilities, which can help offset the financial effects of COVID-19 on [already struggling rural hospitals](#). Moreover, states have identified strategies for [expanding the health care workforce](#)—including granting out-of-state licenses and [evaluating scope of practice laws](#)—to ensure the health care system has the capacity to respond to the pandemic. Many states have also sought to [leverage telehealth](#) in order to limit exposure to the virus and reach patients who live in more rural and remote areas. For additional information on the states’ response to COVID-19, visit NCSL’s [COVID-19 Resources for the States](#).

reinsurance programs, which protect insurers from high medical claims for beneficiaries with complex and costly medical needs. Reinsurance programs usually involve a third party acting as an insurer for the insurance company. Such programs pay part of the insurance company's claim once it surpasses a certain amount or covers the health insurance claims for individuals with predetermined, high-cost conditions. Several studies have demonstrated reinsurance programs are an effective way to lower insurance premiums and maintain insurer participation in the insurance marketplaces.

State Spotlight: Colorado

In 2019, the Colorado General Assembly enacted legislation establishing a two-year reinsurance program and requiring the Colorado Division of Insurance to apply for a Section 1332 State Innovation Waiver. CMS approved Colorado's waiver application for a reinsurance program to be paid for through a mix of federal dollars and states dollars. Colorado's reinsurance program uses a "tiered" system to encourage insurer participation in rural areas of the state, which historically had some of the highest premiums in the country. The reinsurance program reimburses insurers a certain percentage for enrollee claims between \$30,000 and \$400,000. The state, however, reimburses insurers at a lower rate in areas with low health care costs and a higher rate in areas with the highest health care costs—often rural and remote areas. After establishing the reinsurance program, health insurance premiums dropped an average of 20.2% for 2020 health plans, with premiums dropping the most for many rural residents.

States are also modifying insurance regulations to offer greater flexibility to insurers while still maintaining protections for health plan enrollees. One option is allowing for more flexible network adequacy standards—which require health insurance plans to include enough participating providers and specialists so enrollees can readily access health care services—in rural areas with fewer providers. States can establish specific network adequacy standards for rural areas, such as limiting how long and far a person must travel to the nearest in-network provider. Additionally, states may pursue policies to redesign rating areas—or geographic areas in which insurers can vary premiums—in order to expand health insurance risk pools, discourage insurers from exiting rating areas in rural communities, and combine rural rating areas with nearby suburban and urban areas.

Some states are also promoting alternatives to marketplace plans—including short-term limited duration insurance plans, association health plans (AHPs) and farm bureau plans—as a way for consumers to access more affordable health coverage. For example, the Iowa General Assembly enacted legislation allowing the Iowa Farm Bureau Federation to provide a health benefit plan to its members that is similar to an AHP. Under the new law, Farm Bureau health plans are not considered insurance and not subject to state insurance regulation. Subsequently, the Iowa Farm Bureau developed three coverage plans with premiums generally lower than plans sold on the ACA marketplace. These plans cover preventive services at no cost, as well as some level of coverage for maternity care, mental health and substance abuse, and prescription drug coverage.

While consumers frequently pay lower premiums for these coverage options, they often provide fewer benefits and may not comply with key ACA provisions, such as covering the 10 essential health benefits or guaranteeing coverage for those with preexisting conditions. Additionally, some studies indicate these non-ACA compliant coverage options raise the overall costs for ACA-compliant plans, and several states have enacted legislation banning or limiting the use of these coverage options.

Alternative Coverage Options

Short-term limited duration insurance plans typically offer coverage for less than a year and frequently cover fewer medical benefits to maintain lower overall premiums. These plans are often intended to fill in coverage gaps when an individual is transitioning from one health plan to another.

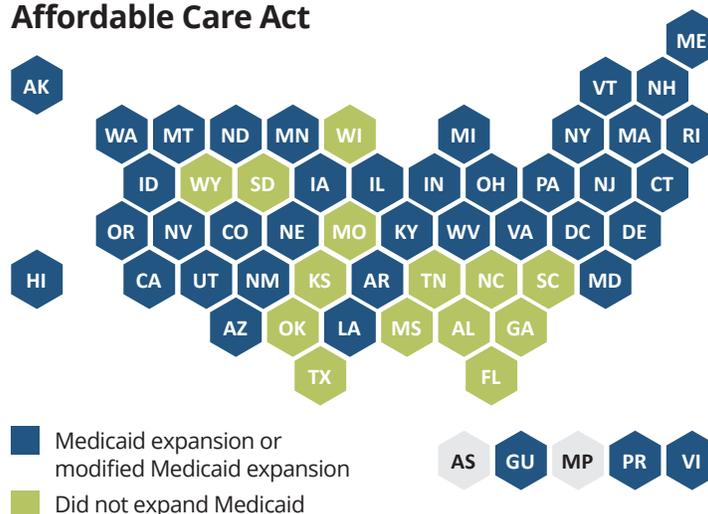
Association health plans allow self-employed individuals and small businesses who share common business interests to band together and purchase health coverage as a larger group.

Farm bureau plans allow farmers and other individuals involved in the agriculture sector to join an association for health care coverage. These plans function similarly to AHPs, but individuals—and in some cases, individuals not involved in agriculture — may be members.

Beyond private insurance plans, many rural residents rely on public insurance options for health coverage. Medicaid, a federal-state partnership with shared authority and financing, is a public health coverage program for low-income children, their parents, older people and people with disabilities. In rural communities—where people have higher rates of poverty and disability and lower rates of employer-sponsored insurance—**Medicaid represents a common source of coverage**. As of 2017, **nearly 1 in 4 non-elderly adults** in rural areas were enrolled in Medicaid, and in many states, Medicaid coverage rates are higher in rural areas compared to urban and non-rural areas.

The ACA prompted many states to expand Medicaid coverage to individuals with an income at or below 138% of the federal poverty level. To date, 36 states and the District of Columbia have adopted Medicaid expansion, though there is some variability in eligibility, premium payments and other requirements for states expanding through CMS Section 1115 Waivers. According to the [Center for Children & Families at the Georgetown University Health Policy Institute](#), the uninsured rate for rural and small town residents dropped to 16% in states expanding Medicaid eligibility for low-income adults, compared to 32% in states that did not expand Medicaid. Furthermore, the health coverage disparities between rural and urban populations lessened in Medicaid expansion states, to an average of 16% of people uninsured in rural areas and 12% uninsured in urban locations.

Medicaid Expansion Under the Affordable Care Act



HEALTH INSURANCE COVERAGE POLICY OPTIONS

- Consider policies, such as reinsurance programs, that make private health insurance more affordable for individuals and small businesses and control rising premiums.
- Determine strategies for improving how the state regulates private health insurance plans, including plans sold on the individual and small group marketplaces.
- Evaluate the effect of Medicaid expansion on state budgets, coverage gains in rural communities and the bottom line for rural health facilities.

Safeguarding Health Care Facilities

While improving insurance coverage is critical for accessing health care services, rural residents often live far from health care facilities offering these vital services. Rural Americans [live an average of 10.5 miles from the nearest hospital](#) compared to 4.4 miles for urban Americans and 5.6 miles for suburban Americans.

In order to ensure rural Americans can readily access services at a health facility, states are actively pursuing policies that improve the financial status of rural hospitals, change how health services are paid for, and expand access to other health care facilities beyond rural hospitals.

RURAL HOSPITAL CLOSURES

Rural hospitals provide vital services for their residents and improve the overall economic and social well-being of rural communities. These hospitals, however, face significant financial pressure due to several factors. Rural hospitals [generally have lower patient volumes](#) and serve a high number of uninsured, Medicare and/or Medicaid patients, along with patients who are generally older, sicker and require more costly care. In addition, rural areas struggle to recruit and retain an ample health care workforce and they are often geographically isolated from their target patient populations.

Due to these financial pressures and other factors, rural hospitals are closing or no longer providing inpatient care at an increasing rate. Between 2010 to 2019, [120 rural hospitals](#) closed or ceased providing inpatient services across 31 states, and [1 in 4 rural hospitals](#) are currently at risk of closing. A [2016 Kaiser Family Foundation \(KFF\) study](#) on hospital closures in three rural communities found that closures significantly reduce access to health services (especially emergency care) and result in job loss and other adverse economic effects. In addition, health care providers often leave their local community following a rural hospital closure.

Number of Rural Hospital Closures, 2010-2019

State	Closures	State	Closures	State	Closures
Alabama	6	Louisiana	1	Ohio	2
Alaska	1	Maine	3	Oklahoma	8
Arizona	3	Massachusetts	1	Pennsylvania	3
Arkansas	1	Michigan	1	South Carolina	4
California	4	Minnesota	3	South Dakota	1
Florida	2	Mississippi	5	Tennessee	13
Georgia	7	Missouri	6	Texas	20
Illinois	1	Nebraska	1	Virginia	2
Indiana	1	Nevada	1	Wisconsin	1
Kansas	5	New York	2		
Kentucky	4	North Carolina	7		

Source: UNC Sheps Center for Health Services Research, 2005-2020

Ensuring the financial viability of rural hospitals is a top priority for policymakers who are exploring several options to keep rural hospital doors open. Some states are bolstering Medicaid coverage and expanding eligibility as a strategy to [improve rural hospitals'](#) bottom line. Rural hospitals heavily rely on Medicaid reimbursement for health care services, but states that have not expanded Medicaid coverage have experienced a [higher concentration of closures](#) due to greater amounts of uncompensated care. An analysis in [Health Affairs](#) found that expanding Medicaid eligibility improved the overall financial status of rural hospitals and reduced the likelihood of closures.

States legislatures are also enacting policies providing [targeted technical and financial assistance](#) to rural hospitals. These policies often include establishing task forces, special committees or additional state resources to assist struggling rural hospitals. For example, the Tennessee General Assembly enacted the [Rural Hospital Transformation Act](#) in 2018, which charged the Tennessee Department of Economic and Community Development with creating “transformation plans” for rural hospitals in consultation with professional consulting firms. The transformation plans must include action steps and focused strategies to enhance a rural hospital’s business model. [Alabama](#), [Georgia](#) and [Vermont](#) also established certain resources and supports through legislation to avoid rural hospitals closures.

PAYMENT REFORMS

As another strategy for improving the financial status of rural hospitals and health facilities, some states are transitioning away from traditional fee-for-service payments—which provide payments for each individual service and procedure. Instead, they are adopting [alternative payment models](#) (APMs) for certain payers, such as state Medicaid programs. While potentially providing a more predictable funding source for rural hospitals, APMs emphasize improving patients’ clinical outcomes and lowering overall health care costs.

Prospective payments, such as bundled payments or global budgeting, offer incentives to providers to deliver high-quality care at a lower price tag. Through a bundled payment model, insurers and other payers agree to provide a lump sum for a single “episode of care,” such as a hip replacement or maternity care. The goal of bundled payments is for providers to avoid unnecessary, costly care and prevent expensive medical complications. Global budgeting is functionally similar to bundled payments, but this model provides payments at the population level. Payers provide a fixed dollar amount to broadly cover all patient services over a certain period. Providers are then responsible to keep health care costs below the fixed amount by pursuing the most appropriate and cost-effective treatment options.

While prospective payments and other APMs are becoming more widespread, [rural-specific models](#) may be used to help alleviate financial pressures for rural facilities. Several states—including [Pennsylvania](#), [Oregon](#) and [Texas](#)—are pursuing these payment models to improve rural health outcomes, reduce unnecessary spending and provide a fixed income source for rural hospitals.

The Center for Medicare and Medicaid Innovation

The passage of the ACA prompted the federal government to establish the [Center for Medicare and Medicaid Innovation](#) (CMMI), also known as the Innovation Center. CMMI is tasked with “testing innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits.” CMMI has developed and tested over 40 different payment models across all 50 states, and they have launched demonstration projects targeting rural areas, including the [Rural Community Hospital Demonstration](#) and the Pennsylvania Rural Health Model. State policymakers and other stakeholders play a significant role in determining which innovative models are worth pursuing to improve the financial status of rural hospitals and other facilities in their state.

State Spotlight: Pennsylvania

In collaboration with the [Center for Medicare and Medicaid Innovation](#) (CMMI), Pennsylvania developed the [Pennsylvania Rural Health Model](#) to test how prospective payments could improve the financial status of rural hospitals. The model shifts away from the traditional fee-for-service model and instead uses global budgets for participating hospitals. CMMI and participating payers—including Medicare, Medicaid and certain private insurers—provide each hospital a fixed payment meant to cover all inpatient and hospital-based outpatient services. This establishes a continuous funding stream for rural hospitals and offers providers incentives to deliver value-driven care at a lower cost. In 2019, the Pennsylvania General Assembly [enacted legislation](#) establishing the Rural Health Redesign Center (RHRC), which is responsible for administering the Pennsylvania Rural Health Model and providing tailored, technical assistance to participating hospitals. To date, 13 rural hospitals and six private payers participate in the model.

OTHER RURAL HEALTH FACILITIES

Many communities rely on rural hospitals for necessary services. However, states are exploring alternatives to supplement hospital inpatient care, including community health centers, rural health clinics, school-based clinics and free-standing emergency departments. For rural communities that [lose their full-service hospital](#), or who are on the brink of losing their hospital, these facilities can help fill in some health care service gaps, improve overall health outcomes and avoid costly hospitalizations.

The [Health Resources and Services Administration](#) (HRSA) operates the [Health Center Program](#). Through the federal program, community health centers offer a consistent source of primary health care to people living in underserved communities and often improve access to other necessary services—such as mental health, substance use disorder treatment or oral health services. Health centers provide preventive and primary care services to nearly [28 million patients annually](#), including 1 in 5 rural residents. Increased access to community health centers is associated with [improved health outcomes](#)—such as patients with hypertension controlling high blood pressure—all while reducing health care costs.

[School-based health centers](#) (SBHCs), which often receive federal funding through HRSA's Health Center Program, increase access to primary care and preventive services among school-aged children and their families. [In 2018](#), children represented 1 out every 9 patients seen in a health center. SBHCs provide a wide range of services, including primary care, mental health, oral health and other health care services. The [number of SBHCs in rural communities](#) quadrupled to over 800 between 1998 and 2017, and the reach of SBHC services in rural areas continues to improve through innovative delivery options, such as telehealth. An [economic systematic review](#) of several studies found that using SBHCs resulted in net savings to state Medicaid programs of between \$30 and \$969 per visit.

CMS operates the [Rural Health Clinic](#) (RHC) program, which aims to increase primary care services for Medicaid and Medicare patients in rural communities. To qualify as an RHC, a clinic must operate in a rural and designated health professional shortage area, provide primary care services, and employ non-physician providers like physician assistants or nurse practitioners. These facilities receive enhanced reimbursement rates for providing primary care services to patients enrolled in Medicare or Medicaid. As RHC patients are often [older and poorer](#), RHCs help facilitate wellness, health promotion and disease prevention for these underserved populations.

State-licensed [free-standing emergency departments](#) (FSEDs) function as fully operational emergency departments and are often required by state statute to be open 24/7. These physically separate, stand-alone facilities either operate under a larger health system, subjecting the FSED to the same federal or state regulations as the parent health system, or are independently owned and operated. However, independent FSEDs do not meet the federal definition of a hospital, and thus are [ineligible for Medicare and Medicaid reimbursement](#). Beyond filling [emergency service gaps](#), rural residents can often access other vital health services, such as urgent and primary care, at FSEDs. Although these facilities may provide key emergency

services, some reports have highlighted frequent [instances of surprise medical billing](#) for patients unaware that the FSED is out-of-network.

State policymakers can bolster the role of these facilities in rural areas by evaluating state regulations and ensuring sustainable investments for outpatient health facilities. For instance, 35 states and Washington, D.C., maintain [Certificate of Need \(CON\)](#) laws, which require certain facilities to seek state approval if they plan to establish or expand their service capacity. The extent to which state CON laws regulate facilities varies greatly state to state, and a state may require CON approval for health facilities such as FSEDs.

Additionally, states can fund and support rural health facilities through general fund appropriations. For example, 16 states and the District of Columbia appropriated an average of \$5.3 million in state funds [explicitly for SBHCs in FY 2017](#), and the number of SBHCs receiving dedicated state funding has continued to increase throughout the U.S.

State Spotlight: Georgia

In March 2014, Georgia’s governor established the [Rural Hospital Stabilization Committee](#)—chaired by state legislators and comprised of legislators, health care professionals and other stakeholders—in order to address the growing number of hospitals closing throughout rural Georgia. In response to the committee’s recommendations, the Georgia General Assembly appropriated \$3 million in ongoing state general funds to the [Rural Hospital Stabilization Grant Program](#), and increased funding to \$5 million for 2020 in response to COVID-19. The grant program funds rural hospitals’ efforts to develop sustainability plans. These sustainability plans incorporate a “hub and spoke” model which designates a hospital as the “hub” for overnight services and various outpatient facilities—including federally qualified health centers, local primary care offices, school clinics and telehealth-equipped ambulances—as the “spokes” for services not requiring hospitalization. The model aims to provide necessary services for rural patients at the appropriate facility and reduce the financial burden of costly emergency room visits on rural hospitals. The committee’s analysis of the grant program noted funds helped “stabilize” the financial status of participating hospitals and no participating hospitals closed during the program period. The committee, however, could not draw a definitive conclusion that grant funds prevented hospitals from closing due to many variables beyond the scope of the program.

HEALTH CARE FACILITIES POLICY OPTIONS

- Evaluate Medicaid reimbursement policies and other targeted state policies to improve the financial status of rural hospitals and reduce uncompensated care.
- Examine the current payment and delivery systems for rural facilities and identify ways to improve access and lower costs through alternative payment models. States can establish special committees or task forces to assess various models.
- Gather information and data from primary care associations and other organizations on certain rural health facilities offering primary and preventative services.
- Examine current state funding and policies that support rural health facilities.

Changing Health Care Delivery

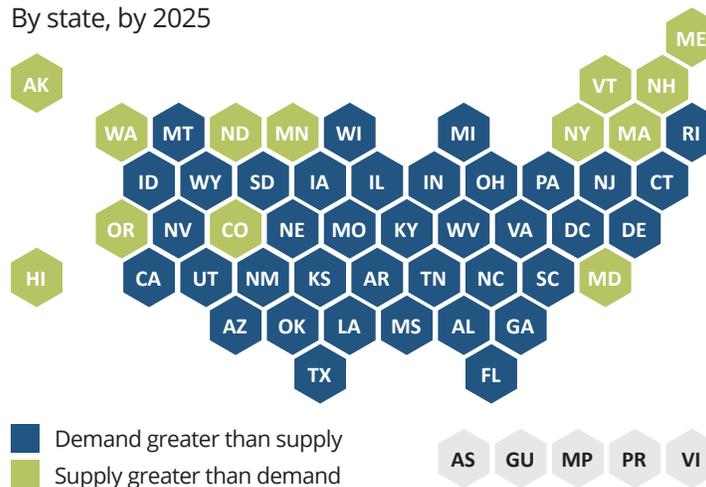
Rural America struggles to recruit and retain health care providers, its residents are isolated from services, and its older population may be unable to access services in order to live safely and independently. Due to the unique health care landscape—and geographical landscape—of rural America, state policymakers, stakeholders and providers often take innovative approaches to how health services are delivered. States are exploring ways to address health service gaps and provide necessary care for rural patients, including leveraging the role of non-physician providers, using telehealth services, and providing home and community-based services for older adults.

NON-PHYSICIAN PROVIDERS

Rural areas are disproportionately affected by provider shortages and other barriers to health care access for patients. A [2016 HRSA report](#) found that, without any substantive changes to the rural health delivery system, 37 states are projected to experience primary care physician shortages by 2025. Additionally, medical students are more likely to [pursue medical specialties](#) and work in urban or suburban areas. While rural areas continue to experience primary care physician shortages, [demand for primary care services](#) is growing, partly due to an aging population and higher rates of chronic diseases.

Primary Care Physician Supply vs. Demand

By state, by 2025

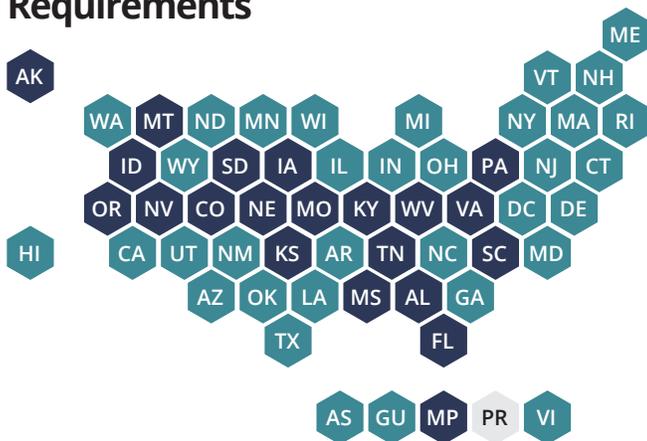


Source: Health Resources and Services Administration, 2016

Many states are leveraging non-physician providers—such as nurse practitioners (NPs) and physician assistants (PAs)—to address primary care service gaps. Each year, [approximately 16,000 NPs](#) graduate from primary care programs compared to 5,000 graduating primary care physicians. NPs are also more likely to practice in medically underserved communities, such as rural areas. The number of PAs practicing in the primary care field is expected to increase 39%, from 33,000 to 46,000, by 2025. Additionally, [15% of PAs](#) practice in rural or frontier counties and many PA programs in rural states have a higher percentage of rural-practicing PAs.

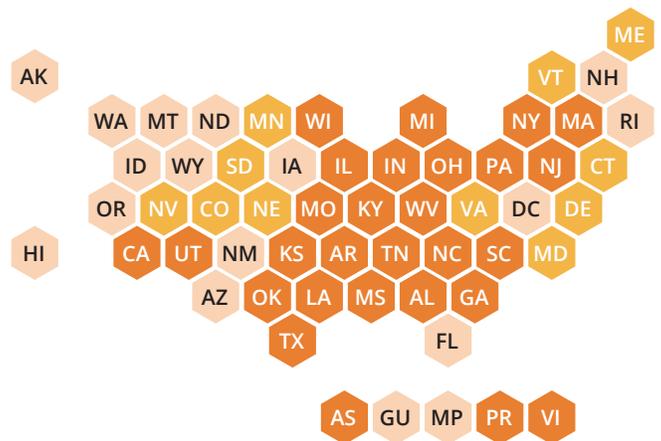
For NPs and PAs to meet the growing primary care needs of rural communities, many state legislators are evaluating laws and regulations defining the roles and responsibilities of these health care workers, also known as scope of practice (SOP) laws. A number of states have [taken steps to increase](#) the practice authority licensure for non-physician primary care providers, as well ensure non-physician providers are [reimbursed the same rate](#) as physicians when providing the same services. Proponents of these laws say non-physician providers can be [trained quicker and less expensively](#) than physicians without compromising quality. [Others argue](#) that physicians' longer, more intensive training equips them to diagnose more accurately and treat patients more safely.

Physician Assistant Supervision Requirements



- Supervision determined by state medical board or law
- Supervision determined at practice level (between PA and supervising physician)

Nurse Practitioner Practice Authority



- Physician relationship required
- Transition to independent practice period required
- Full independent practice authority

Source: *ScopeofPracticePolicy.org*, 2020

States are evaluating SOP policies not only to improve access to primary care services, but to bolster necessary **behavioral health services**. While the prevalence of certain **mental health conditions and substance use disorders** are greater in rural areas than in urban locations, there continue to be behavioral health provider shortages in rural communities. Many states have allowed NPs and PAs to prescribe buprenorphine-containing products, which are used to treat opioid dependency. States have also established different licensing and credentialing standards for licensed professional counselors and **addiction counselors** to meet the mental and behavioral health needs of rural Americans.

NCSL's Scope of Practice Policy Website

NCSL's [Scope of Practice Policy](http://www.ScopeofPracticePolicy.org) website is designed to provide state leaders with resources about scope of practice (SOP) issues for several non-physician providers, including nurse practitioners and physician assistants as well as six other providers. The website features interactive policy maps, a legislative database and case studies in SOP policy. For instance, the website tracked over 400 bills in the 2015 to 2019 legislative sessions related to NP and PA scope of practice.

Designed by NCSL with support from the Health Resources and Services Administration (HRSA), this resource aims to provide policymakers with a tool to explore the range of SOP legislation introduced around the country. This easily accessible information helps state leaders as they consider ways to meet the health care needs of their constituents at the right place, right time and right cost. Learn more at www.ScopeofPracticePolicy.org.

Beyond SOP laws, states are also developing various recruitment and retention policies to bring primary care providers—including physician and non-physician providers—to rural communities. These often include pathway programs and scholarship and loan repayment programs. Pathway programs aim to introduce students from backgrounds underrepresented in health professions to health care careers. Participating students **may be more likely** to practice in their communities, such as rural or other underserved areas.

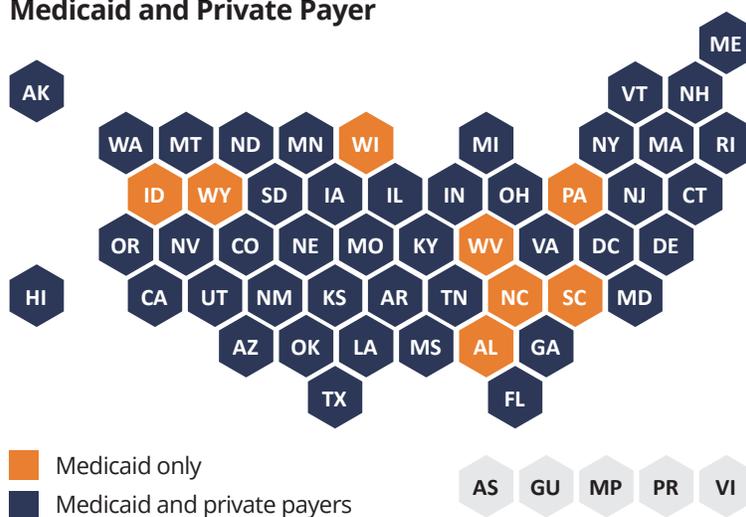
Scholarship and loan forgiveness or repayment programs provide financial incentives for students to practice in [HPSAs](#)—including several medically underserved rural areas—often for a minimum of two years. States can establish state-run programs and/or seek federal dollars for loan forgiveness and scholarship programs. For example, 41 states, Washington, D.C., and the Mariana Islands (U.S. territory) receive federal cost-sharing grants through the [State Loan Repayment Program](#). States can use these federal dollars to provide loan repayments to various primary care providers, including physicians, NPs and PAs.

TELEHEALTH

States are increasingly relying on telehealth to increase access to care for rural patients. [HRSA defines](#) telehealth as “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.” For patients living in remote areas with few providers, health professionals can provide a broad range of services virtually, including primary care and care for mental health, substance use disorder or oral health. Telehealth can also support rural providers by facilitating continuing education and collaboration among health care providers.

States are assessing payment, licensure and practice standards policies to further enhance the reach and effectiveness of telehealth services. All states and Washington, D.C., provide some form of Medicaid reimbursement for telehealth services, though coverage varies state to state based on telehealth modality and the scope of services covered. Forty-two states and Washington, D.C., have state laws relating to [private insurance reimbursement for telehealth services](#), which typically entails private insurers offering comparable or equivalent coverage and/or reimbursement for telehealth services as for in-person services.

Telehealth Coverage and Reimbursement Policies: Medicaid and Private Payer



Source: Center for Connected Health Policy, 2020

Additionally, states are [evaluating licensure standards](#) for health care workers to increase the use of and access to telehealth. Because telehealth often crosses state borders, providers may be held to several state-specific licensure requirements. Thus, states are adopting temporary licenses, telehealth-specific licenses and/or [licensure compacts](#) to facilitate services across state lines.

Lastly, providers using telehealth technology may experience barriers due to state-specific practice standards. Standards of care—or what another similarly trained and equipped provider would do in a similar situation—apply to all health care services, delivered remotely or in person. [Some states](#), however, are adopting standards specifically requiring that the applicable standards of care that apply to in-person care also apply to telehealth.

Telehealth Modalities

States are continuously evaluating different telehealth modalities to expand access to telehealth services. The three primary methods of telehealth are real-time communication, store-and-forward and remote patient monitoring. Mobile health is still an emerging modality.

- **Real-time communication** allows patients to connect synchronously with providers via video conference.
- **Store-and-forward** refers to transmission of data, images, sound or video from one care site to another for evaluation.
- **Remote patient monitoring** involves collecting a patient’s vital signs or other health data while the patient is at home or another site and transferring the data to a remote provider for monitoring and response as needed.
- **Mobile health** (mhealth) is an emerging field that includes health education, information or other services via a mobile device. Mhealth references are much less common in state policy, with Hawaii as the only state with mobile health defined in statute.

Sources: Health Resources and Services Administration, NCSL, 2015

HOME AND COMMUNITY-BASED SERVICES

With an older and sicker population making up a large share of rural communities, ensuring access to high-quality long-term services and supports (LTSS) for seniors and people with disabilities is of high importance for rural America. LTSS includes a [broad range of day-to-day assistance](#) for individuals with chronic health conditions and significant health challenges affecting daily activities. LTSS is often delivered by [nurses](#) and [direct care workers](#), and demand for these workers is anticipated to increase markedly in the coming years.

Medicaid is the nation’s [largest payer for LTSS](#), and although older individuals and people with disabilities make up [less than one-quarter of Medicaid beneficiaries](#), they account for almost two-thirds of Medicaid spending. These high costs are [especially prevalent in rural areas](#) where a larger share of residents, especially older residents, are covered through Medicaid. For example, studies of rural LTSS use found rural Medicaid beneficiaries were [more likely to use nursing home services](#) compared to their urban counterparts, often restricting consumer choice and [driving up costs for state Medicaid programs](#).

States can leverage home and community-based services (HCBS) to shift away from institutionalized care and help older individuals “age in place.” HCBS refers to services provided in one’s own home or community rather than a health facility. Rural seniors and individuals can receive [various types of health and social services](#) through HCBS, including skilled nursing care, occupational and physical therapy, hospice care or everyday personal care. With [3 in 4 Americans](#) preferring to remain in their homes while aging, HCBS not only meets patients’ preferences but also results in significant cost savings to state Medicaid budgets. The Medicaid and CHIP Payment and Access Commission found [an increase in HCBS compared to institutional care](#) for Medicaid beneficiaries due to concerns about the high costs of institutional care and overall patient preferences. Additionally, a [2013 AARP analysis](#) of publicly funded HCBS programs found lower per-person costs for HCBS compared to institutionalized care and an overall slower growth in health care costs.

In order to improve access to HCBS, states may [seek federal funds](#) to help older individuals and those with disabilities transition from institutional care to home and community-based settings, evaluate [HCBS benefits for state Medicaid programs](#) and target specific populations requiring long-term care. For example, nearly all states and Washington, D.C., offer long-term care services through a [Medicaid HCBS waiver](#), also

known as a 1915(c) waiver. States can “waive” certain federal requirements for state Medicaid programs to better fit the local context and HCBS needs of their state. Through a Medicaid HCBS waiver, states can target a certain area with a greater need rather than the entire state, make Medicaid services available only to a particular group or population, and provide Medicaid services to individuals who would otherwise only receive Medicaid coverage in an institutionalized setting. Medicaid HCBS waiver programs vary greatly, reflecting the significant role legislators, government officials and other stakeholders play in shaping a state’s HCBS policies.

Additionally, several states are enacting policies to relieve the financial burden for family caregivers, who provide a large share of HCBS, [often without compensation](#). [Several states](#) have enacted paid family leave laws, which allow family caregivers to receive employer benefits while caring for older family members. Furthermore, various states—including [Arizona](#), [Hawaii](#), [Minnesota](#), [Virginia](#) and [Washington](#)—have established state-run programs that provide reimbursement and other financial assistance to family caregivers.

State Spotlight: Wisconsin

[Wisconsin Family Care](#) is a Medicaid long-term care program for eligible older adults and adults with physical, mental and intellectual disabilities. The program, which aims to provide support and services for individuals in their own homes whenever possible, has two major organizational components. The [Aging and Disability Resource Centers](#) (ADRCs) provide information on which long-term services are available for older adults and adults with disabilities in their local communities. [Managed care organizations](#) (MCOs) collaborate with ADRCs to ensure enrollees have a coordinated care team to provide services specific to an enrollee’s needs and preferences. Medicaid MCOs pay for HCBS through capitated payments, a per-patient monthly payment, to control costs and promote quality. Due to the program’s costs savings and positive clinical outcomes, the Wisconsin Legislature [enacted legislation](#) to expand the Family Care program statewide and eliminate all remaining waiting lists for HCBS.

HEALTH CARE DELIVERY POLICY OPTIONS

- Assess and consider scope of practice, licensure and payment parity policies for the non-physician workforce.
- Establish and fund recruitment and retention programs for the rural health care workforce. Policy-makers can do this by supporting new or expanded residency programs, trainings and rotation opportunities in rural health care facilities.
- Consider policy options expanding access to health services via telehealth, including payment and reimbursement, licensure standards and standards of care.
- Evaluate effective state policies for improving access to and the quality of HCBS for older rural residents, such as increasing HCBS benefits and supporting family caregivers.

Conclusion

The policy options discussed in this brief highlight only some of the innovative strategies that state legislators and stakeholders are employing to improve access to care in rural communities. Regardless of the policy, legislators can adopt common approaches to improve the health and access to health care services for residents in rural communities. These include:

- Assess the magnitude of the problem. Gathering data about unmet health care needs, rural financial pressures and workforce challenges can help legislators understand the most pressing problems and ensure that access, workforce, long-term care and other aspects of rural health care support the overall wellness of rural residents.
- Engage stakeholders to review policies, identify challenges and opportunities, and develop effective programs.
- Align policies and investments to support programs that work. Legislators play an important role by ensuring that programs and state funds support approaches that have proven results.
- Look at the workforce differently. While strengthening the workforce involves strategies for increasing the quantity of providers in rural areas, states and localities are demonstrating that innovation plays a role. They are employing technology, including telehealth, and redefining roles for primary care providers and care extenders to expand the reach of the current workforce and improve access to care.

Legislators can play important roles by ensuring that the state's health care policies and investments meet the unique needs of rural communities and the workforce that supports them, and that the strategies have been evaluated and proven to be effective.

Additional NCSL Resources

- [Understanding Medicaid: A Primer for State Legislators](#)
- [Increasing Access to Health Care Through Telehealth](#)
- [10 State Strategies for Improving Medicaid: Quality, Outcomes and the Bottom Line](#)
- [Long-Term Services and Support: Case Studies from Four States](#)
- [Improving Access to Care in Rural and Underserved Communities: State Workforce Strategies](#)

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