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Rural Challenges, Strategies, and Recommendations to Advance Value-Based Payment and Care During and Beyond the COVID-19 Crisis

Angel Bourgoin, Jim Maxwell, Yvette Cho, Rachel Tobey

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There has been much attention on the need to support the public health infrastructure, hospitals, and long-term care facilities in rural areas during the COVID-19 pandemic, but less attention has been given to the vital role of the ambulatory safety net. Primary care has been critical in the COVID-19 response through such efforts as rapid testing, proactively reaching out to at-risk populations, and linking individuals to community resources. Behavioral health care providers have been called upon to meet the expanding and catastrophic needs posed by the opioid and suicide epidemics, social isolation, grief, and domestic violence and trauma. Investment in primary care and behavioral health will be pivotal to how rural areas are able to recover towards better health and economic stability.

COVID-19 has dramatically altered the way primary care and behavioral health services are delivered in the ambulatory safety net, including in rural areas, which have long faced unique challenges. The purpose of this brief is to summarize the key challenges faced by the rural ambulatory safety net in delivering primary care and behavioral health services since COVID-19 and the policy changes that have been implemented in response to those challenges. It also offers state-level policy recommendations to improve rural-specific primary care and behavioral health care through sustaining and supporting the movement towards telehealth, addressing social needs, and advancing value-based payment and care (VBP/C).

Rural Challenges and Concerns

Rural providers in the ambulatory safety net faced many challenges prior to the pandemic, including unmet behavioral health and physical health needs compounded by rural poverty, insufficient payment rates, and lack of access to services. The exacerbation of the challenges nationally have made it particularly difficult for rural community health centers and community behavioral health organizations to deliver care since the onset of COVID-19.

Greater need for behavioral health and social services. The COVID-19 pandemic and associated social and economic consequences have greatly affected the mental health and social wellbeing of Americans. Prior to the pandemic, depression, suicide, and substance use were more prevalent in rural areas, and these behavioral health disparities are linked to the socioeconomic and healthcare access rural-urban disparities. Since the COVID-19 pandemic, Americans are reporting greater levels of adverse mental health conditions, including symptoms of anxiety/depression, increased substance use, social isolation, and suicidal ideation. Recent projections demonstrate an

exacerbated rise in relapses and overdoses, as well as an increase in "deaths of despair." As of June 2020, rural unemployment rates are double those prior to the pandemic, increasing the number of uninsured and economically vulnerable individuals who may encounter food and housing insecurity. At the same time, many community-based organizations that support social needs face greater financial challenges, due to declines in donor giving and canceled fundraising events. Rural safety net providers are likely to find it more challenging to address these greater behavioral health and social needs while administering COVID-specific services in a precarious financial environment.

Significant revenue losses for safety net providers. Rural health care providers have long struggled with their financial viability prior to the COVID-19 pandemic. Compared to providers in urban areas, providers in rural areas generally operate with lower profit margins and less cash reserves, placing rural health organizations at an even higher risk of closing or facing long-term financial instability due to cancelled or foregone services, costs associated with purchasing personal protective equipment (PPE), and other unprecedented financial pressures. A recent survey found that Community Behavioral Health Care Organizations (CBHOs) are struggling while being financially challenged, such that 54% of organizations have had to reduce services and 39% of CBHOs surveyed believe that they can only survive financially for six months or less. Community Health Centers (CHCs) across the nation are also experiencing the financial impact of COVID-19 with at least $8 billion in lost revenue due to significant declines in regular primary and preventative care visits, in turn dramatically impacting operations and employment in both the short-term and long-term. With a continued lesser volume of in-person visits that are not fully offset by increases in telehealth visits, safety net providers, especially those in rural areas, must grapple with reducing staff hours, limiting services, and potentially closing.

Intensified need to address telehealth challenges. Prior to COVID-19, telehealth was a valuable approach for rural providers to mitigate workforce scarcity and address transportation barriers, but it was limited due to regulatory and reimbursement barriers and the lack of broadband access and patients with the proper technology and skills to use telehealth. Since COVID-19, telehealth use has expanded dramatically in rural and urban areas as federal, state, and private payers have implemented unprecedented reimbursement for telehealth services under the public health emergency. However, a third of rural Americans lack access to high-speed broadband internet, and current reliance on telehealth may have created an additional disparity for the digitally isolated. Medicare fee-for-service data has demonstrated that telehealth visits made up a smaller proportion of all primary care visits in rural compared to urban areas, peaking at 25% compared to 45% in April 2020. The national movement towards telehealth has highlighted the potential for telehealth payment and policy as a means to deliver care efficiently and effectively, and there is an opportunity to leverage the current momentum to address health disparities experienced by those living in rural communities.

Strategies to Address Rural Challenges and Concerns

In considering strategies to address rural challenges and concerns in the context of COVID- 19, it is important to realize that approaches must both respond to the pandemic-induced challenges and the pre-pandemic reality of an under-resourced rural health infrastructure. In a June 2019 rural health environmental scan, we argued that "VBP/C in rural areas may need to emphasize more investment in ambulatory care and improving outcomes while maintaining critical access to care,

with less focus on assuming reductions in total costs." Having sufficient health system infrastructure in rural areas is a public good, which may require higher spending to offer access to care and comprehensive services than in urban areas. The need to maintain critical access to ambulatory care, with less focus on cost reduction, remains true in the COVID-19 context.

The strategies described below build on findings from our prior research on VBP/C in rural environments, and they are specific to how healthcare policy and delivery have changed in response to COVID-19. To understand the impacts of COVID-19 on rural CHCs and CBHOs and the strategies to address rural-specific challenges, we reviewed more than two dozen peer-reviewed articles and more than a hundred sources in the gray literature focusing on state-level policy and payment actions to improve financial sustainability for provider organizations and whole person care in rural areas. Our research was also informed by virtual convenings and conversations with national and state behavioral health and primary care associations participating in the Robert Wood Johnson Foundation-funded Delta Center for a Thriving Safety Net. The Delta Center provides a unique opportunity for primary care associations (PCAs) and behavioral health state associations (BHSAs) to collaborate in their work with state governments to advance policies that would support care delivery in the COVID-19, including advocating for improved telehealth access, support to address social needs, and financial sustainability. Many of these strategies apply to states as a whole, but they are critical for rural areas that have long been underserved.

Supporting and Aligning the Movement to Telehealth. In the rural context where there are substantial barriers to accessing in-person care, telehealth is especially valuable because it offers expanded access to primary care, behavioral health, and specialty services. Telehealth reportedly may have particular advantages for behavioral health as it reduces stigma associated with in-person visits, eliminates transportation barriers, and addresses provider shortages, especially of psychiatrists in rural areas. In addition, telehealth has the potential to be a highly effective means of identifying and addressing medical and non-medical needs in an integrated and measurable way, paving the way towards VBP/C. Though there are limitations to the benefits of telehealth, such as quality concerns, lack of technological literacy, and services and populations that are not as well suited to telehealth, it is an essential means of care delivery in the COVID-19 context that will likely persist at elevated levels even after the pandemic subsides. A recent Executive Order on Improving Rural Health and Telehealth Access commits to preserving the expansion of telehealth services for rural healthcare providers, investing in physical and communications healthcare infrastructure, and testing innovative payment mechanisms to enable rural healthcare transformation. The CARES Act also provided an additional $100 million in funding for expanding broadband in rural areas through the ReConnect Program, and the Health and Human Resources Administration awarded about $12 million to rural organizations to improve rural telehealth services.

Nearly all state Medicaid programs have implemented emergency regulations or policies to pay for telehealth primary care and behavioral health services since the onset of COVID-19. Most states have introduced similar approaches as the actions taken by Centers for Medicare & Medicaid Services (CMS) for the Medicare program, which allows for comparable payments for telehealth (in multiple forms such as virtual visits, phone calls and use of asynchronous technologies, including patient platforms and text messaging) and in-person visits. In particular, audio-only services have been an essential form of telehealth during the pandemic. State actions generally take the form of

mandating payment parity between telehealth and in-person visits, and waiving regulatory and workforce requirements that have hindered widespread adoption of telehealth, such as allowing providers with out-of-state licenses to practice. Other actions include the state of Massachusetts incentivizing CBHOs' transition to telehealth by offering payments based on the proportion of encounters conducted via telehealth, and the Oregon Office of Rural Health creating an interactive repository of state and federal telehealth payment and policy changes.

Despite the problem of limited access to computers and smartphones among rural residents, to our knowledge, this has not yet been addressed at the state-level. However, local provider organizations have used phone calls as a substitute for telehealth video visits or provided rural residents with cell phones or computer devices (e.g. Integral Care, a community mental health center in Texas).

We offer several potential state-level strategies to keep and enhance the current advantages of telehealth, including:

1. Make permanent recent payment changes towards telehealth and seek to remove remaining regulatory and workforce barriers to telehealth access.
2. Make permanent recent payment changes that have allowed reimbursement for audio-only services.
3. Expand broadband access and telehealth technology (e.g., mobile phones, tablets) to rural residents and those lacking it in urban areas.
4. Partner across state agencies to expand broadband access in rural communities. For example, new partnerships might include state departments of education and commerce given the widespread move to online education and remote work during the pandemic. State health agencies might also explore opportunities to expand telehealth access through partnering with telecommunications providers that have been participating in the USDA's ReConnect program.

Addressing Social Needs. As described above, rural residents have many unmet social and economic needs that have been exacerbated by the COVID-19 pandemic, including social isolation (especially among the rural elderly), food insecurity, and housing insecurity. State departments of public health, state offices of rural health, and Medicaid agencies have been responding to these issues on both a state and local basis, which can benefit the ambulatory safety net population in these areas. Some examples of state actions to address these social needs since the onset of COVID-19 include the Governor of Virginia authorizing $2.5 million of emergency funding for the homeless, and the South Carolina Department of Rural Health assisting local community organizations to distribute healthy food. Many states, such as Illinois, New Jersey, Washington, have adapted existing or created new hotlines and other proactive outreach strategies to address the stress, grief, and social isolation caused by the pandemic. Social isolation is a particular challenge for rural older adults, which has recently been shown to be associated with increased physical and psychological morbidity and even premature mortality. California has established a program to reduce social isolation and provide support for elders where neighbors are able to check on older adults in their neighborhoods through the Next Door Website; Nevada has developed a COVID-19 Aging Network Rapid Response Plan, which supports a Social Support Action Team that provides one-on-one check-in calls, and small group peer-support opportunities for older adults. To support

health equity, Oregon has required all Medicaid-enrolled providers to apply National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) to all health services, including telemedicine.

Prior to the onset of COVID-19, some states through Medicaid accountable care organizations, Accountable Communities of Health, and a Whole Person Care program under a Medicaid 1115 Waiver (CA) have sought to promote cross-sector collaboration across healthcare and social service organizations in order to respond flexibly to the social needs of their vulnerable populations. Improved health outcomes for the safety net population are unachievable without addressing social needs, and providers play an important role in identifying these needs and connecting patients to community resources. As the U.S. continues to struggle through and emerge from the health and economic devastation of the pandemic, there will continue to be a pressing demand for these social services, and aligning payment policies will offer a more sustainable way to address these social needs. Though the approach will need to be tailored to individual state contexts, we offer the following recommendations for state-level policy mechanisms to address social needs:

1. Pay, through Medicaid health plans or the state, directly for social and behavioral health needs screening of all users of CHCs and CBHOs, especially given the known behavioral health and socioeconomic rural-urban disparities.
2. Allow, or even require, a portion of the Medicaid health plans' medical loss ratio to be spent on non-medical services and their coordination to build a sustainable system of addressing non-medical needs that contribute significantly to health.
3. Make permanent emergency regulations or institute new policies to provide access to home- and community-based social and human services to high-risk populations such as socially isolated older adult and disabled populations.
4. Build on Medicaid agencies' recent COVID-19-related collaborations with state and county human service agencies, including state offices of rural health, public health, aging services, and disability departments to identify and serve patients in most urgent need of social and human services effectively.
5. Explicitly require health providers or Medicaid health plans to provide CLAS services (i.e., CLAS Standards) to ensure that populations who are disproportionately impacted by the pandemic have reliable, meaningful access to services.

Supporting & Sustaining the Financial Viability of the Ambulatory Safety Net. Many rural CHCs and CBHOs operated on slim financial margins even before the onset of COVID-19. The available evidence suggests that this situation has only worsened since the pandemic began, threatening cutbacks in services or the closure of many facilities in rural areas. Many individual organizations have benefited from a number of provisions and programs in the CARES Act, including the $10 billion rural distribution to rural providers (including community health centers), the Paycheck Protection Program and the Provider Relief Fund, but many rural safety net providers are still struggling financially.

Some states have stepped in on an emergency basis to supplement the resources in these federal programs, even as state revenues have declined in response to the deepening economic recession. Many states have used their Medicaid managed care organizations (MCOs) to address care in the

COVID-19 context, and CMS has offered guidance to states seeking to modify provider payment methodologies under their Medicaid managed care contracts and utilize state directed payments to require managed care plans to enhance provider payment. In Arizona, which had been incentivizing behavioral health integration through their MCOs through their Targeted Investment Program, Arizona's Medicaid program recently accelerated $41.3 million in interim payments towards their participants to supply financial relief for providers. To provide crucial, stabilizing funding for members enrolled in managed care, Massachusetts instituted temporary payment rate increases for acute hospital, ambulance, Home Health, diversionary and outpatient behavioral health, early intervention, and specific physician service providers. States such as Washington and Pennsylvania have encouraged or required MCOs to make upfront payments to community health centers and behavioral health organizations.

The pandemic has highlighted the weaknesses of fee-for-service payment models, which have long been challenging for rural areas. For the long-term, beyond the current state of emergency, rural providers would greatly benefit from sustainable funding models and financial incentives. Value-based payment models such as Primary Care First, which acknowledges the centrality of primary care, and payment models that feature integrated behavioral health, reward providers for offering effective access to and continuity of care, care management, and improving population health outcomes. These healthcare system functions are crucial in the rural context, where there is great need for these services relatively few specialists to provide behavioral health services. In states with large rural populations, it is important to align state Medicaid and Medicare payment policies given that the same providers serve the entire community, and creating one set of financial incentives across payers will allow providers to increase access and change care in ways that meet Triple Aim goals.

The following recommendations are to complement federal efforts and enhance financial sustainability for the ambulatory safety net:

1. Monitor the financial performance of rural CHCs and CBHOs and offer clear guidance on the circumstances (e.g. remaining operational expenses available) under which provider organizations would be eligible for state assistance.
2. Provide upfront payments through state subsidies or MCOs to ambulatory care providers, especially under resourced community mental health centers. These upfront payments could be a bridge to more long-term payment reform.
3. In providing these upfront payments, states should try to maintain or create payment parity between primary care and behavioral health care.
4. Align Medicaid provider payments with Medicare's increasing emphasis on supporting the delivery of advanced primary care, as demonstrated through CMS's Primary Care First program. This alignment is even more important in rural areas as CHCs and CBHOs have more patients with Medicare coverage.

Conclusion

The challenges of the COVID-19 pandemic have prompted unprecedented changes in healthcare payment and policy, creating an opportunity for transformative innovation. State policies to support and sustain the movement towards telehealth, address social needs, and advance value-based payment and care will greatly benefit safety net providers and their communities. The recommendations would be especially valuable in a rural context, in which VBP/C must emphasize access, with the necessary upfront payment and reimbursement flexibility to address the whole-person needs of beneficiaries. State policymakers should harness the momentum of recent policies supporting telehealth and rural health to institute lasting changes that will strengthen rural provider organizations and the health of their communities.