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Rural Health Solutions Close to Home

Minnesota Rural Health Policy Summit
November 19, 2025

Presenter: *Steve Gottwalt - ED, MACHP*

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It is always easier to admire problems than to solve them.

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- The recent government shutdown debates around the Affordable Care Act (ACA) have placed new attention on the **need for more effective federal health care reform policies**.
- Lack of effective reforms **disproportionately impacts Greater Minnesota** where residents rely more heavily on public programs.
- The need is greater than ever to **find local solutions** that provide dependable, sustainable access to high quality, affordable care that is responsive to varying local needs across rural Minnesota.

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Challenges

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Medicare policy challenges

- Site-neutral and hospital **payment cuts have reduced reimbursements** for Minnesota's Critical Access Hospitals (CAHs) and small rural facilities.[1]
- **Sequestration and delayed updates** disproportionately hurt low-volume rural hospitals that depend heavily on Medicare payments.[2]
- **Value-based purchasing and quality reporting mandates** penalize rural providers lacking the data systems and staff capacity of larger metro-based health systems.[3]

1 *AHA, "Medicare Site-Neutral Legislative Proposals" - Sept. 2023*
2 *Rural Health Info. Hub: "Rural Healthcare Payment and Reimbursement Overview" - Oct. 2025*
3 *MedPAC: "Medicare's Measurement of Rural Provider Quality" - Jun. 2025*

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Medicaid policy challenges

- Starting in 2027, **new work requirements and more frequent eligibility redeterminations** will place more costly administrative burdens on rural counties.[1]
- **Reduced MA enrollment (140,000 fewer Minnesotans)** will hurt rural hospitals and clinics that rely heavily on MA funding.[2]
- **Inadequate MA funding** puts rural providers at risk. MA FFS pays 70-77% of Medicare rates[3], and MN law originally directed DHS to target PMAP capitation rates 10% below MA FFS.[4]

1 *KFF: "A Closer Look at the Work Requirement Provisions in the 2025 Federal Budget Reconciliation Law" - July 2025*
2 *Minnesota DHS: "Historic cuts to health care will impact every Minnesotan" - Feb. 2025*
3 *Minnesota DHS: "MHCP FFS Outpatient Services Rates Study" –Jan. 2024*
4 *Minnesota Legislative Auditor: "Financial Management of Health Care Programs" - Feb. 2008*

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Medicaid policies hit rural hardest

- **1.3 million Minnesotans** (one out of every four) rely on Medical Assistance or MNCare.[1]
- **Rural communities rely on these programs more heavily** than urban areas, because we have an older, less wealthy and less healthy population overall.[2]
- Inadequate MA funding **disproportionately harms rural communities** because of this greater reliance.[3]

1 *Minnesota DHS "By the numbers: Medicaid and MinnesotaCare", 2023 enrollment, https://mn.gov/dhs/medicaid-matters/by-the-numbers*
2 *Minnesota Dept. of Health "Rural Health Care in Minnesota: Data Highlights" - Nov. 2024*
3 *Minnesota Dept. of Health "Rural Health Care in Minnesota: Data Highlights" – Nov 2023*

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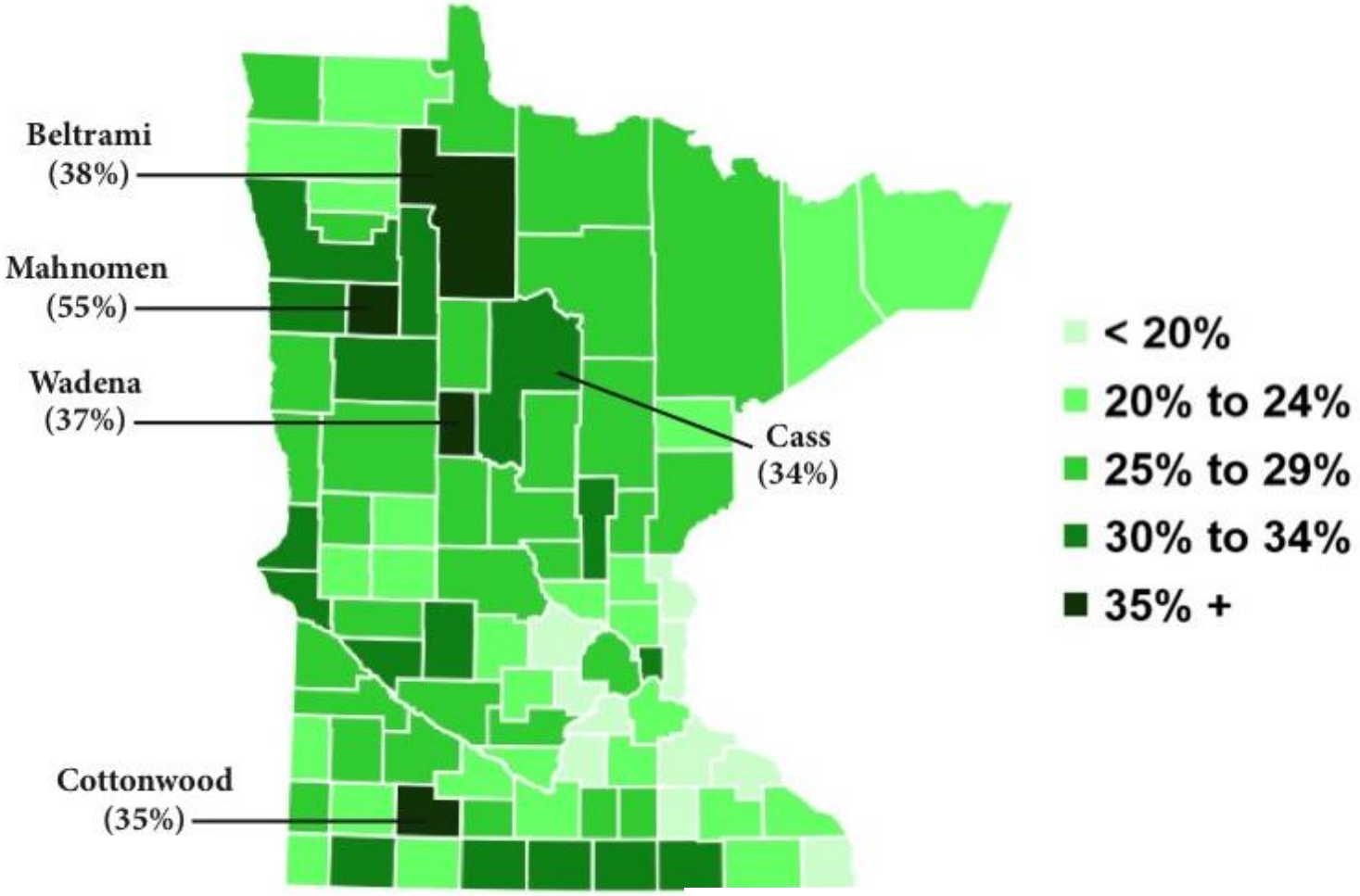
Figure 6. Medical Assistance (MA) enrollment by county, percentage of population, 2023.
Source: Minnesota DHS, 2024



Source: Minnesota DHS: "Who Medicaid and MinnesotaCare Serve" 2024

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History

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History

Year / Period	Event / Policy
1965-1966	Federal Medicaid program established; Minnesota creates Medical Assistance (MA)
1982	Rural: Itasca Medical Care launches as a demo – the state's first rural county-based plan
1985	Prepaid Medical Assistance Program (PMAP) enacted (Minn. Stat. §256B.69)
1992	MinnesotaCare launched to help working poor
1997	County-Based Purchasing (CBP) enacted (Minn. Stat. §256B.692)
2000s	CBP growth (South Country Health Alliance 2001; PrimeWest Health 2003)
2011-2014	ACA Medicaid expansion (90% fed funding for expansion population)
2022	Procurement mediators recommend County Administered Rural Medical Assistance (CARMA)
2022–2025	AMC, CBP plans and DHS collaborate in developing CARMA
2025	CARMA program enacted (Minn. Stat. §256B.695)
Jan 1, 2027	CARMA implementation

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Minnesota turns to managed care

- **1980's -** Minnesota adopted the **Prepaid Medical Assistance Program (PMAP)**, turning to managed care to control rising MA costs and care management challenges.
- **1982 -** Itasca County formed **Itasca Medical Care (IMCare)** as a rural, county-based Medicaid demonstration.

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Managed care vs. Fee-for-Service

Managed Care

- **DHS contracts with health plans** to administer MA (PMAP), MnCare, MSHO, MSC+ and SNBC, to pay providers and counties, and to manage covered care and benefits to enrollees.

83% of MN Health Care Programs enrollment

DHS Fee-for-Service (FFS)

- **DHS administers** Medical Assistance (MA) only, and directly pays providers and counties for covered care and benefits to enrollees.

17% of MN Health Care Programs enrollment

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County concerns with managed care

- **1980's – Counties grew increasingly concerned** with how HMOs were delivering managed care MA, particularly in rural areas, with many disconnects, cost shifts to counties, and in-and-out participation.

  They wanted **rural health solutions close to home**.

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Greater Minnesota turns to its counties

- **1990's -** Counties came together through the Association of Minnesota Counties (AMC) to push for **a local, county-based model** of delivering MA and other public programs.
- **1996-1997 –** The legislature passed bi-partisan legislation creating **County-Based Purchasing (CBP)** (Minn. Stat. §256B.692).
- **2001-2003 -** CBP grows with the forming of **South Country Health Alliance** and **PrimeWest Health**.

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County-Based Purchasing

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What is County-Based Purchasing?

- **"County-based"** – means county owned and governed
- **"Purchasing"** – means payment of health care services for people enrolled in Minnesota Health Care Programs.

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Why County-Based Purchasing?

"The main reasons that county governments have chosen to pursue CBP are a belief that **care coordination is best done locally**, a desire to **protect the local health care infrastructure**, and the **fear of cost-shifting** from managed care plans to counties."[1]

1 *University of Minnesota Rural Health Research Center, 2001*

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County-Based Purchasing (CBP) Plans

- **Empower rural counties** to exercise local decision-making, self-determination, and community-specific innovations toward improving individual health, population health, and health equity, while reducing health care costs.
- **Owned and operated by the counties** they serve.

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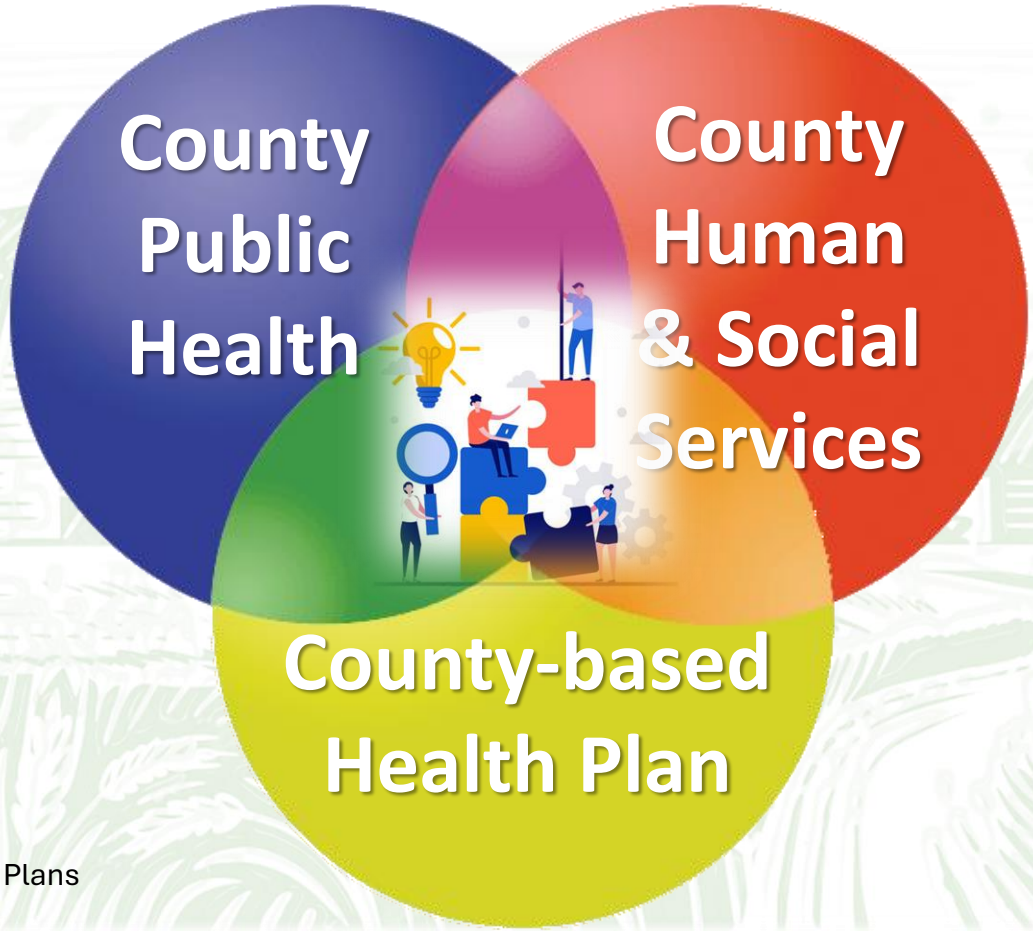
CBP - County Integration and Coordination



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CBP - Local control, responsiveness and accountability

- Governed by **local county commissioners**, not corporate boards.
- Local leaders have **first-hand knowledge** of community health needs, provider networks, and gaps in access.
- Decisions about coverage, care coordination, and provider payments **stay close to the people served**.
- Local governance provides **responsiveness and accountability**.

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CBP - Local Partnering and Community Reinvestment

- CBP plans **partner closely with local providers** to improve and strengthen access, including prioritizing better reimbursements using the same state capitation rate.
- Any margins are **reinvested in our local communities**.

  Example: Grants to critical access dentists to open new dental clinics in underserved areas for **improved MA dental access**.

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CBP - Close to Home

- Even with low MA reimbursement rates, CBP plans achieve stronger results by **keeping spending decisions close to home**.
- **Local governance** and **community knowledge** help CBP plans use limited MA dollars more effectively, **targeting resources** to where they are needed most.
- This **strengthens rural health and local communities**.

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CBP – A Local Rural Health Solution That Works

A **43-year success story**. The result is **better care access, health outcomes, and quality of life** for rural residents enrolled in public health care programs, a **stronger rural provider safety net**, and **stronger rural communities**.

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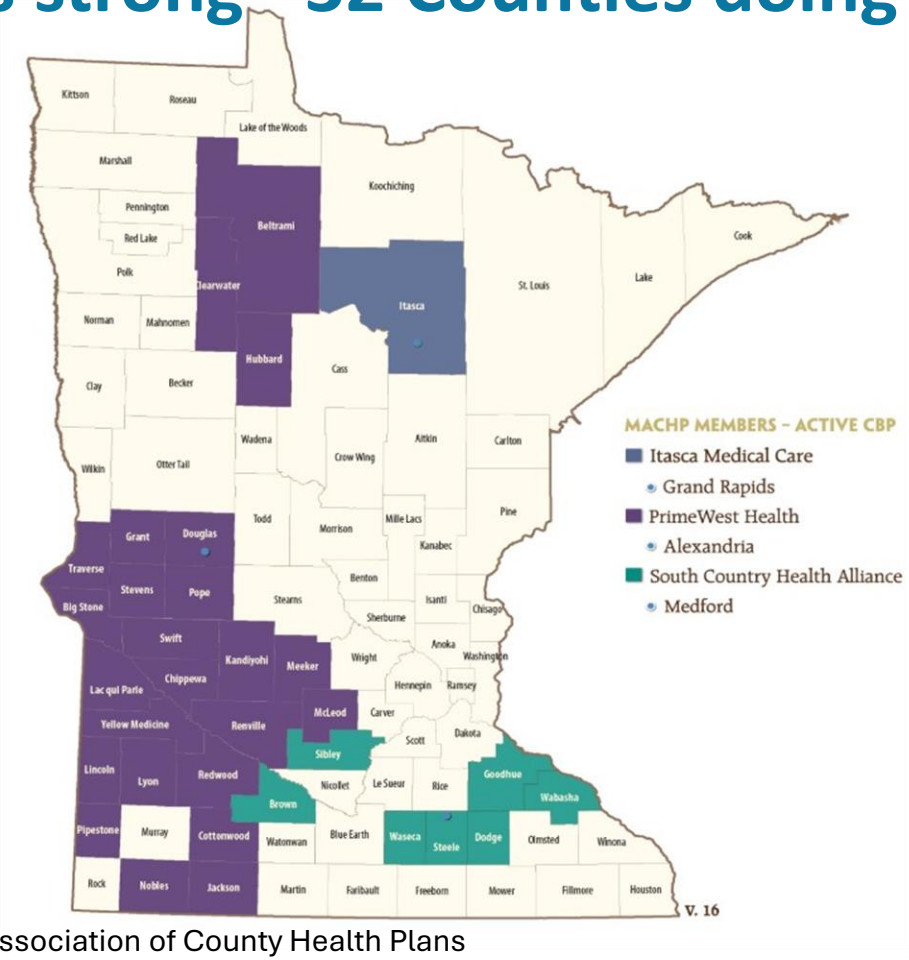
43 years strong - 32 Counties doing County-Based Purchasing



- **Itasca Medical Care**
  Headquartered in Grand Rapids, owned and governed by Itasca County, with enrollment of nearly 8,000 members. “IMCare” is the original CBP county in MN, starting in 1982.

- **PrimeWest Health**
  Headquartered in Alexandria, owned and governed by 24 counties with enrollment of nearly 50,500 members. Began serving MHCP in 2003.

- **South Country Health Alliance**
  Headquartered in Medford, owned and governed by 7 counties, with enrollment of over 21,000 members. Began serving MHCP in 2001.

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New

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Building On Success

County Administered Rural Medical Assistance (CARMA)

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New

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County Administered Rural Medical Assistance

CARMA builds on the successful legacy of CBP, offering a modernized path forward that **clarifies county choice**, **strengthens collaboration** with DHS, and reinforces shared commitment to **rural health innovation**.

We appreciate legislators' bi-partisan support of CARMA.

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County Administered Rural Medical Assistance

- **2022 -** Counties contest state public programs procurement decisions; state and county mediators recommend pursuing CARMA
- **2023-2025 -** DHS, AMC and CBP plans form a collaborative Work Group to develop CARMA – “build something better together”
- **2024 -** Bi-partisan legislation passes directing DHS and counties to bring forward CARMA model legislation in 2025
- **2025 -** Bi-partisan **legislation passes enacting CARMA** (Minn. §256B.695)

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New

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County Administered Rural Medical Assistance

1. provides a **county-owned and county-administered alternative** to PMAP
2. **facilitates integration** of health care, public health, and social services to address health-related social needs (HRSN) in rural communities
3. **accounts for the fewer enrollees and local providers** of health care and community services in rural communities, and
4. **promotes accountability** for health outcomes, health equity, customer service, community outreach, and cost of care.

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New

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County Administered Rural Medical Assistance

- **County Participation** – RFP: Rural counties meeting CBP requirements.
- **Benefits and Services** – State plan benefits (PMAP), MinnesotaCare, MN Senior Health Options (MSHO), MN Senior Care Plus (MSC+), or Special Needs Basic Care (SNBC) programs.
- **Direct Contracting** – No more convoluted procurement process: DHS contracts directly with CARMA counties for an initial term of three years. **State and counties working hand-in-glove**.

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New

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County Administered Rural Medical Assistance

- **Collaborative Rate-setting** – DHS and counties work together to develop more accurate and adequate capitated rates. Includes risk corridors, and a “settle-up” at the end of the initial 3-year contract period.
- **Quality Measures** – DHS and counties collaboratively develop quality and improvement targets for measurable results.
- **Systems and Data Integration** – DHS and counties collaboratively improve integration and interoperability of data, data systems and regulatory streamlining for better enrollee care and outcomes.
- **Starting in 2030** – Address Health Related Social Needs (HRSN).

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New

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CARMA strengthens county-based solutions

"This is an important step . . . to further integrate and expand the common goals of **better health and well-being** of all our public program enrollees with county public health and social services, to address social determinants of health, and **deliver better and longer-lasting care outcomes**."

- Steele County Commissioner, Greg Krueger, March 2024

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New

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CARMA strengthens county-based solutions

"The model . . . Help[s] counties **wrap services around people** by connecting [county-based] health plans, public health and social services locally."

- Goodhue County Commissioner, Brad Anderson, March 2024

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County-Based Purchasing

New interest in solutions close to home

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New Rural Health Solutions Close to Home

- With recent legal affirmations, the passage of CARMA, and legislative interest in county-based alternative models[1], the **basis for CBP has never been stronger**.
- Rural counties are expressing **renewed interest in CBP**.
- While CBP is **not for every county**, and requires a significant commitment, for the **32 Greater Minnesota counties** currently doing CBP, it has been **a game-changer**.

1 *Minnesota Statutes § 256.9631 (2023-2024)*

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CBP – A game-changer

"[CBP] . . . enhances the county's **ability to address local needs**, become more cost-effective, and **provide better service** to [public programs] enrollees . . . It just makes so much sense for our citizens."

- Kandiyohi County Commissioner, Roger Imdieke
West Central Tribune Sept. 2019

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CBP – A game-changer

"... county-based purchasing has helped the counties that they're in – they help the local providers **not just for Medicaid clients, but for all who live here** . . . I feel we have a much better plan of integrating all of our services together for people – public health and social services."

- Nobles County Human Services Director, Stacie Golombieke
The Globe (Worthington, MN) Sept. 2019

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CBP – Counties taking a fresh look

- Our association is **here to help counties** that might be considering CBP. Contact: **steve@MACHP.org**
- We have **43 years of experience to share** about how this works, what counties need to consider and how to get into CBP.
- **County commissioners, administrators and staff** ready to share their own experiences, processes and rationale for choosing CBP.

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Questions

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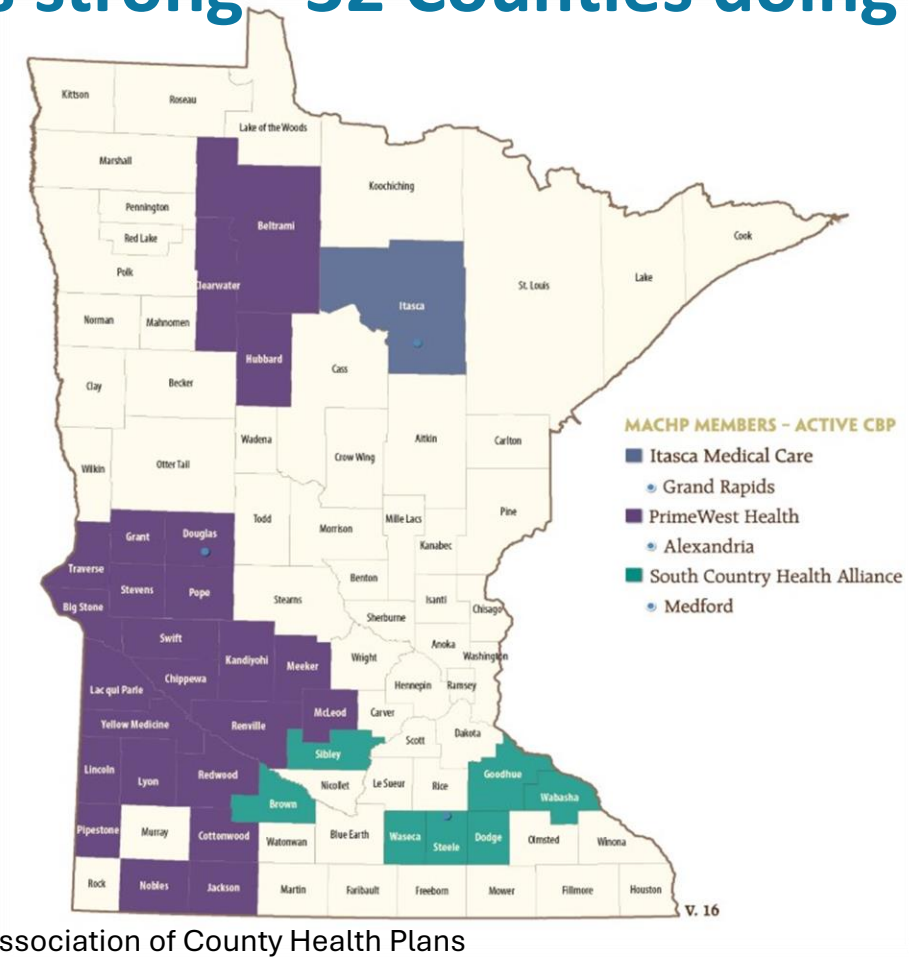
43 years strong - 32 Counties doing County-Based Purchasing



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Thank you!

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PrimeWest HEALTH™

South Country HEALTH ALLIANCE

IMCare