Toolkit: State Strategies to Support Older Adults Aging in Place in Rural Areas

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This toolkit highlights state initiatives to help older rural adults age in place by increasing services that help people remain in their homes, expanding and professionalizing the caregiver workforce, improving transportation access and services, and making delivery reforms within Medicaid programs.

Prepared with support from a National Organizations of State and Local Officials cooperative agreement that NASHP holds with the Health Resources and Services Administration

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Introduction

Rural areas across the nation have higher concentrations of elderly residents than urban areas, 18 percent of rural populations are age 65 or older compared to only 13 percent in urban areas.[1] These rural, older adults are poorer, have more complex health conditions, and experience the impact of health-related social factors such as lack of housing, transportation, and food more acutely than their urban peers.[2] Rural adults are also more likely to be older (exceeding age 85), female, and white than their urban counterparts. Finally, rural older adults were also less likely to use home- and community-based services (HCBS) and more likely to use nursing facility services.[3]

State Medicaid programs, through HCBS waivers and the Medicaid nursing facility benefits, are the de facto long-term care system across the country. States are obviously committed to ensuring that older adults living in rural areas who need nursing facility care be able to access quality care in their communities. However, not only do more than 85 percent of older adults prefer to remain in their own homes and communities,[4] but serving older adults in their homes is almost always less expensive than housing people in facilities.[5] As a result, states are keenly interested in finding strategies that can help keep older, rural adults safely in their homes in their communities.

States can implement a wide range of strategies using differing combinations of policy levers to support rural older adults who age in place, including working across state agencies and with different partners. The strategies discussed in this toolkit were drawn from online research, as well as written correspondence and interviews with state officials. This toolkit showcases these three primary types of strategies that states are using to support aging in place:[6]

- Workforce and training;
- Facilitating access to services in rural areas; and
- Addressing the social determinants of health (SDOH).

This toolkit is designed to help state leaders, especially Medicaid officials, adapt and adopt existing strategies and develop new strategies that build on their peers' experience and insights. While it does not offer a comprehensive compendium of state approaches, it instead provides examples of the types of strategies that states have implemented and presents emerging ideas for consideration. It also identifies and includes links to key documents used to implement these strategies, such as legislation, contracts, and program manuals. These are provided in order to offer officials a springboard for developing their own approaches and policies as they tackle the important issue of how to better support older individuals aging in place in rural areas.

Overview of the Tools States Use to Develop their Strategies

There are a number of state agencies with responsibility for providing or overseeing services to older adults who live in rural areas – often this task is part of a broader scope of responsibilities. This situation creates the potential for cross-agency partnerships. Most of the strategies presented in this toolkit are led by Medicaid or include Medicaid as a partner, but other state partners include aging agencies and departments of rural health, licensing, and transportation. Some states also partner with colleges and universities as well as providers, families, and consumers. Finally, many of these strategies depend on engaging the support of community-based organizations.

States generally use three types of policy levers to implement their strategies — and implementing most strategies depend on more than one lever:

1. States enact ***legislation*** that created or changed laws and authorized funding to better support older adults living in rural areas.
2. States adopt ***regulations*** to implement legislation, including legislatively authorized programs such as Medicaid. This category includes ***guidance*** (e.g., Medicaid provider manuals) that states develop to share regulations with providers and other stakeholders.
3. Sometimes states choose to ***contract*** for services through a process (e.g., request for proposals) that selects an organization or individual to deliver a service.

The state initiatives that informed this toolkit combined these tools in various ways to meet the needs of the target population. Sometimes they built strategies targeting only older adults in rural areas, but more often they developed strategies that addressed this group's needs as part of a broader strategy. The table below draws on two of the strategies detailed in this toolkit to illustrate how states have used the resources at their disposal (partners, policy levers, and federal authorities) to build strategies that meet the needs of older, rural adults.

Table 1: Key elements of Minnesota and Georgia's initiatives to meet the health needs of older, rural adults

Strategy	**Minnesota Community Emergency Medical Technician** Trained emergency medical technicians deliver services, such as safe home evaluations, in the individual's home.	**Georgia Mobile Adult day Care Services** Staff travel from a central location daily to provide adult day care services at various sites.
Legislation	Minnesota Session Laws 2015, Chapter 71, Article 9, Sec. 18. Community Medical Response Emergency Medical Technician (CEMT) services covered under the Medical Assistance Program	Georgia HB 318 Adult Day Center Licensure Act provides for licensure of adult day center.
Regulation and Guidance	The Medicaid provider handbook sets out provider qualifications and billing guidelines CEMTs must meet to receive Medicaid payment.	Section 1103 of the Medicaid provider manual outlines provider requirements, policies, and procedures required for mobile adult day centers to receive Medicaid payment. The Department Of Community Health 111-8-1, Rules And Regulations For Adult Day Centers licensing requirements.
Contracting	Medicaid managed care organization (MCO) contracts require MCOs to cover CEMT services.	The Area Plan for Aging Services, specifies the services area agencies on aging (AAAs) must provide under contract to the Division of Aging.

Partners	Medicaid, Office of Rural Health and Primary Care, Emergency Medical Services Regulatory Board, and the local colleges and universities that offer training.	Medicaid, Department of Human Services' Division of Aging Services
Federal Authority	Medicaid State Plan Amendment for coverage of CEMTs	Medicaid 1915(c) waiver State Plan on Aging

Because several of the programs serving older adults in rural areas are state-federal partnerships — financed by both governments and operating under federal guidelines – a final, important element of each strategy is the federal authority to implement the change. Under Medicaid, these are mostly state plan amendments (SPAs) and waivers.

- Medicaid state plans define the parameters of the Medicaid program in each state, including defining who is eligible and what services are covered. States change these parameters by gaining federal approval of their SPAs.
- Waivers, when approved by the federal government, allow states to establish Medicaid policies that would not otherwise be allowed under federal rules, such as providing long-term services and supports (LTSS) only to a subset of Medicaid beneficiaries or limiting beneficiary choice of providers. Different waivers allow the waiver of different requirements and are approved for different lengths of time.

Strategies to Build the Workforce

One challenge is there are simply not enough providers in rural communities to serve older adults. In rural areas, there are only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 people in urban areas.[7] There are often shortages of other critical service providers, such as home health providers.[8] As people age they often become less able to drive safely, which make provider shortages even more problematic for this group as they become less able to travel to find care. States can implement strategies that increase access to providers, including increasing provider supply and enhancing the capabilities of existing providers.

Using Emergency Services Personnel in New Ways in Idaho and Minnesota

Minnesota uses both community paramedics and community emergency medical technicians (CEMTs)[9] to meet the health needs of Medicaid beneficiaries living in underserved areas. Both of these professions were established in Minnesota by legislation. One of the reasons for creating the CEMT profession was that a pilot program had demonstrated its potential in rural areas.[10] Minnesota Medicaid pays both CEMTs and community paramedics to deliver services in a beneficiary's home. The Medicaid managed care organization (MCO) contract also requires coverage of these services. CEMTs may deliver post-discharge visits when a beneficiary is released from a hospital or skilled nursing facility as well as safe home evaluation visits. Community paramedics may deliver a broader range of services, including health assessments, medication compliance management, chronic disease monitoring and education, immunizations, lab specimen collection, and minor medical procedures. To qualify for payment, services must be provided by a qualified CEMT or paramedic under the direction of a primary care provider

(PCP). Required qualifications for both providers include minimum experience, specialized training, and certification by Minnesota's Emergency Medical Services Regulatory Board.

Minnesota officials report that building these new professions took time. Although legislation creating CEMTs passed in 2015, in 2017 the Medicaid agency reported that no CEMTs were billing for delivery of their services.[11] However, state officials report that CEMT billings have steadily increased since early 2018 when the first technicians completed their training and became certified CEMTs. The Department of Health reports that more community paramedics are needed — as of May 2019 there were 127 certified community paramedics, half of whom worked in the urban Twin Cities and the other half in greater Minnesota.[12]

How Minnesota Created its Community Emergency Response Technician and Paramedic Programs

<table>
<tr><td colspan="2">Partners:
• Medicaid
• Department of Health, Office of Rural Health and Primary Care
• Emergency Medical Services Regulatory Board
• The state's ambulance association
• Colleges and universities that offer training</td></tr>
<tr><td>State policy levers:
Legislation
• Minnesota Session Laws 2015, Chapter 71, Article 9, Sec. 18. Community Medical Response Emergency Medical Technician Services Covered Under the Medical Assistance Program
• Minnesota Statutes 256B.0625, subdivision 60 Community Emergency Medical Technician Services and Community Paramedic Services
Regulation and guidance
• Medicaid provider manual CEMT and community paramedic sections
• Community Paramedic Toolkit
Contracts
• CEMT and Community paramedic coverage was incorporated into all three types of contracts that served families and children, seniors, and people with disabilities.</td><td>Federal authority:
Medicaid State Plan Amendment for coverage of CEMTs and community paramedics</td></tr>
</table>

Idaho also sought to use emergency medical personnel in new ways, but took a different approach to implementation and payment. Idaho leveraged the State Innovation Model (SIM) award it received from the Centers for Medicare & Medicaid (CMS) in 2015 to establish a training and technical assistance program for community health emergency medical services (CHEMS) agencies. The Bureau of Rural Health and Primary Care, in partnership with the Bureau of Emergency Medical Services (EMS) and Preparedness, was responsible for developing the program. The program sought to prepare existing EMS agencies in rural and underserved areas to take on new roles in the state's health care delivery system, such as providing vaccinations and transitional care after hospital stays, performing medication inventories, and serving as a health care navigator or advocate. Idaho's EMS bureau made changes to the code governing licensure to support the expanded EMS role and is continuing to support CHEMS agencies, for example, developing CHEMS clinical integration protocols through its EMS advisory committee and maintaining an online resource center. The SIM award also enabled Idaho to reimburse

the patient-centered medical homes (PCMHs) that participated in SIM up to $2,500 toward the cost of integrating CHEMS into their practices. As of July 2019, there were 11 CHEMS agencies in the state, several serving rural areas.[13] Although the program does not target older adults, the CHEMS visit may include a fall risk assessment in the home. Also, agencies do not gather data about patients' ages but do serve patients with conditions that indicate they are likely to be older adults (e.g., certain chronic diseases, dementia, falls, congestive heart failure, and chronic obstructive pulmonary disease – COPD).

Although SIM funding has ended, the Medicaid agency continues to encourage PCPs to work with CHEMS agencies. PCPs that integrate a CHEMS agency can qualify for Tier 3 (of four total tiers) of Medicaid's Healthy Connections program, which features per member per month (PMPM) payments for PCMH services. Those who qualify for higher tiers receive higher payments. No payer, however, yet pays for CHEMS services and Idaho has found that to be a challenge. As one state official explained, "Providing training and technical assistance supports program development and implementation, however, additional elements, such as funding, reimbursement, and on-going active engagement with primary care clinicians and the local hospital, are critical to sustainability."

How Idaho Created its Community Health Emergency Medical Services (CHEMS) Agencies

<table>
<tr><td colspan="2">Partners:
Division of Public Health's Bureau of Rural Health and Primary Care and Bureau of EMS and Preparedness)
Division of Medicaid
Office of Healthcare Policy Initiatives
University of Idaho
Ada County paramedics</td></tr>
<tr><td>State policy levers:</td><td>Federal authority:</td></tr>
<tr><td>Legislation:
Legislation not required
Regulation and guidance:
IDAPA 16.01.03 and Idaho Code 56-1012
Healthy Connections Tier III Requirements
Contract
Each agency seeking to use SIM resources to become a CHEMS agency signed a contract with the Idaho Department of Health and Welfare (IDHW), which administered the SIM award.</td><td>Medicaid State Plan Amendment for the Healthy Connections program.

SIM Award</td></tr>
</table>

Emerging Professions: Community Health Workers in Minnesota

In 2007, Minnesota passed legislation officially establishing community health workers (CHWs) as a profession in Minnesota. In 2010, the Medicaid agency obtained state plan amendment approval enabling the agency to pay for diagnosis-related patient education services provided by qualified CHWs under the direction of a physician, advance practice registered nurse, certified public health nurse, dentist, mental health professional, or other registered nurse. Medicaid's MCO contract also requires MCOs to cover these services. Minnesota's provider manual defines CHWs as "a trained health educator who works with Minnesota Health Care Programs (MHCP) recipients who may have difficulty understanding providers due to cultural or language barriers." CHWs work as part of a team to help

patients learn how to manage their conditions and help them access services. Minnesota Medicaid specifies that it will only pay for provision of education services that support delivery of medical services.[14] The CHW cannot bill for services directly, rather an enrolled medical or dental provider must bill for the service. To qualify to deliver Medicaid services, CHWs must, among other requirements, complete an approved curriculum and identify the medical professionals with whom they are affiliated.

Minnesota officials hoped CHWs would extend the reach of existing providers into underserved communities, including rural communities. Although state officials reported that start-up was slow, the number of members in this new profession is growing. CHWs have established both a peer network and a state-level organization to aid their efforts – the Minnesota Community Health Workers Alliance. CHWs operate in rural areas and some have developed expertise in gerontology — enabling them to better meet the health needs of older, rural adults.

How Minnesota Established its Community Health Worker Profession

<table>
<tr><td colspan="2">Partners:
• Medicaid
• Department of Health's Office of Rural Health and Primary Care
• Community and technical colleges
• Minnesota Community Health Workers Alliance
• Minnesota Community Health Worker Peer Network</td></tr>
<tr><td>State policy levers:</td><td>Federal authority:</td></tr>
<tr><td>Legislation
• Minnesota Statutes 256B.0625, Subhead. 49., defining community health worker (CHW)
Regulation and guidance
• Medicaid provider manual, CHW section
• Office of Rural Health and Primary Care CHW Toolkit
Contract
• CHW services were incorporated into all three types of managed care organization contracts that served families and children, seniors, and people with disabilities.</td><td>Medicaid State Plan Amendment</td></tr>
</table>

Project ECHO Used to Enhance New Mexico's Rural Nursing Facility Staff Skills

Project ECHO (Extension for Community Healthcare Outcomes), using multi-point video conferencing, enables primary care providers in remote areas to better manage their patients' chronic conditions by working with and learning from academic specialists. New Mexico is applying this approach to support nursing facility staff who serve people with complex conditions, including behavioral health conditions. In August 2018, the Medicaid agency, in partnership with the University of New Mexico (UNM), launched the 11-member pilot of the Medicaid Quality Improvement and Hospitalization Avoidance ECHO, which seeks to improve care delivered to Medicaid enrollees residing in rural and remote skilled nursing facilities (SNFs). New Mexico Medicaid plans to expand this program to include all SNFs in the state by 2023. The pilot included two ECHOs:

- Quality measures related to pain control, urinary tract infections, and antipsychotic use; and
- Hospitalizations, including SNF readmissions and long-term care admissions.

The pilot will be completed in the summer of 2019, after which project leaders will evaluate and if necessary recalibrate their approach.[15] Medicaid MCO contracts require MCO participation in Project ECHO, including in this project and in working with the UNM's Department of Geriatrics.

How New Mexico Used Project ECHO (Extension for Community Healthcare Outcomes) to Support Nursing Facility Staff *Partners*:	
• Medicaid • University of New Mexico	
State policy levers:	***Federal authority:***
Legislation • No legislation required *Regulation and guidance* • None required *Contract* • Section 4.8.16.2.4 of the Centennial Care 2.0 MCO contracts	Section 1115 Research and Demonstration Waiver, authorizes Medicaid managed care programs and commits to use of Project ECHO

Alaska's Comprehensive, Multi-sector Partnership for Health Workforce Planning

Alaska developed a comprehensive, multi-sector partnership for health workforce planning. An explicit goal of this process was to address rural workforce needs — several of the plan's initiatives are designed to benefit older adults and people with long-term care needs. The Alaska Health Workforce Coalition was formed in 2008 by a broad group of organizations and individuals representing state agencies, health care employers, education providers, and professional associations, among others. The coalition was launched with funding from the departments of Health and Social Services (DHSS) and Labor and Workforce Development (DOLWD), and the Alaska Mental Health Trust Authority, a state agency governed by an independent board and functioning like a foundation. The Alaska Workforce Investment Board (AWIB) asked the coalition to develop a coordinated approach to addressing the state's health workforce shortages. The Alaska Health Workforce Plan was presented to the AWIB in May 2010. Based on that plan, the coalition developed an action agenda that was updated in 2017 to cover the period 2017-2021. The coalition also maintains a "scorecard" that tracks progress on the agenda's items. The coalition merged with the trust in 2017 and, under the trust's leadership, coalition partners continue to work together to advance the strategies included in the plan. Key strategies include:

***Apprenticeships*:** Alaska has leveraged the federal registered apprenticeship program to recruit Alaskans into the health care field, particularly in rural areas. In August 2018, about 300 Alaskans were in health care-related apprenticeships.[16] There are apprenticeships for behavioral health counselors and aides, medical assistants, and others. Of particular relevance, the Alaska DHSS serves as an employee sponsor for a certified nurse assistant (CNA)-registered apprenticeship at its state-owned assisted living facilities. CNA apprentices receive on-the-job training specializing in dementia care over six to twelve months.

***Non-traditional providers*.** Alaska Medicaid pays for services delivered by non-traditional providers, including behavioral health peer support specialists, community health aides,[17] behavioral health aides, and dental health aide therapists. Some in these professions qualified as Medicaid providers through the apprenticeship program. According to state officials, many in these positions work in the frontier regions of the state.

Collaboration across organizations: One critical element of the plan was to more effectively deploy resources by helping participating organizations understand and build on each other's work. For example, the trust and DHSS collaborated with the Alaska Training Cooperative to develop core competencies documents and a corresponding assessment tool for direct care workers. These resources are designed to give employers the information they need to build and assess the skills of direct care workers.

How Alaska Developed its Multi-sector Health Care Workforce

<table>
<tr><td colspan="2">Partners:
• Departments of Health and Social Services, Labor and Workforce Development, and Education and Early Development
• Alaska Mental Health Trust Authority
• Alaska Workforce Investment Board
• University of Alaska Anchorage
• Alaska Area Health Education Centers
• Alaska Native Tribal Health Consortium
• Alaska Primary Care Association
• Alaska State Hospital and Nursing Home Association
• Alaska Behavioral Health Association
• Alaska Alliance for Developmental Disabilities</td></tr>
<tr><td>State policy levers:</td><td>Federal authority:</td></tr>
<tr><td>• Implementing the plan has required the use of many state policy levers including legislation to establish a loan repayment program and, more recently, new legislation to expand that program to all areas of the state.</td><td>Each strategy engaged federal authorities relevant to the approach, including Medicaid State Plan Amendments to allow payment for non-traditional providers and Apprenticeship Program Registration with the US Department of Labor.</td></tr>
</table>

Emerging Ideas: Tennessee and Washington Offer Distance Learning and a Career Pathway to High School Students

Tennessee and Washington are implementing statewide initiatives to enhance the home- and community-based services and the LTSS workforce. While neither initiative explicitly focus on older adults living in rural areas, both have potential to benefit this group.

Tennessee is launching a statewide LTSS workforce development initiative focused on competency-based learning and career pipeline development. Medicaid developed this initiative because it was experiencing escalating challenges in the recruitment and retention of LTSS workers in HCBS waiver programs. It also knew developing competent staff capable of delivering high-quality services as key to successful implementation of the managed LTSS program for people with developmental disabilities. The state plans to incentivize completion of the training program by establishing value-based payment (VBP) arrangements that reward workers with higher wages for increased competency and also rewards providers for employing a more highly trained workforce. Tennessee worked with experts to design this initiative to correspond to the set of core competencies for direct service workers produced by CMS in 2014. The Medicaid agency worked with the Tennessee Board of Regents to create a post-secondary

certificate program and to leverage state last dollar funding programs to help cover training costs. Steps taken to ensure that the initiative would benefit rural areas included:

- Delivering training through Tennessee's statewide system of community colleges and Colleges of Applied Technology;
- Distance learning; and
- A virtual assessment environment that allow for reliable and valid demonstration of competencies to be completed remotely in a more cost-efficient manner.

In **Washington,** many home care aides (referred to as individual providers or IPs) are hired and supervised by the person needing LTSS, but are paid by the state. The state is experiencing a shortage of aides, which it expects to grow. In September 2019, Washington plans to launch its High School Home Care Aide training program, which targets high school juniors and seniors. This program will allow high school students to take state-required courses before graduating and learn how to apply their new knowledge through practicums in facilities. Those who complete the course become certified by the state's health department and will be eligible to work as aides starting when they are 18.[18] State officials see this not only as a way to address the shortage of home care aides it currently faces, but as offering young people an opportunity to start a health care career.

Strategies that Increase Services in Rural Areas

State agencies can implement strategies that increase the availability of existing services in rural areas. Most of these strategies focus on modifying billing policies to make it easier for providers to deliver services in rural areas. But at least one state has also modified its Medicaid eligibility policies to begin serving older adults in rural communities before they need LTSS in hopes of delaying or preventing the need for such services.

Mobile Adult Day Care and Health Services to Better Serve Rural Georgia

Georgia pays for mobile adult day health services, which are provided by staff who travel from a central location on a daily basis to various sites, primarily (but not limited to) rural areas. The Department of Community Health (DCH) licenses adult day care, including mobile adult day care. The Medicaid program will pay for the service under two Medicaid 1915(c) waiver programs that serve the elderly and younger adults with disabilities. According to the Medicaid provider handbook, the purpose of these services is, "to allow caregivers in rural and/or underserved areas a respite from 24-hour-a-day, care-giving responsibilities and to allow members the opportunity to participate in social, health, and rehabilitative services."[19] The Department of Human Services' (DHS) Division of Aging Services will also pay for mobile day care services for older adults (60 and older) who do not qualify for Medicaid services. In Georgia, local Area Agencies on Aging (AAA) deliver non-Medicaid services under contract to the Division of Aging Services and at least one AAA that serves a largely rural area (Coastal Georgia AAA), provided the service during fiscal year 2019.

How Georgia Developed Mobile Adult Day Care and Health Services

Partners: • Medicaid • DHS Division of Aging Services	
State policy levers:	***Federal authority:***

Legislation • HB 318 Adult Day Center Licensure Act *Regulation and guidance* • Department Of Community Health 111-8-1, Rules And Regulations For Adult Day Centers (defining licensing requirements) • Medicaid provider manual *Contract* • Area Plan for Aging Services, which specifies the services AAAs provide under contract to the Division of Aging.	Medicaid 1915(c) waiver State Plan on Aging

Paying More for Services Delivered to Rural Residents in Arizona and Utah

The Arizona Health Care Cost Containment System (AHCCCS), which is Arizona's Medicaid program, uses differential payments to reward providers "who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth." For example, nursing facilities that have fewer than average patients with pressure ulcers are eligible for a 2 percent increase in their reimbursement rates. Most relevant for older adults living in rural areas is a differential payment for Critical Access Hospitals – among other requirements, these hospitals must be more than 35 miles from any other hospital[20]. These providers qualify for a 0.5 percent increase in payments by joining the State Health Information Exchange, allowing them to access more complete information about the services their patients receive which, in turn, supports quality improvement and care coordination. MCO contracts require the MCOs to make these payments. The state, however, will reimburse MCOs for the added costs of the differential payments.

How Arizona Medicaid Implemented its Provider Incentive Program

Partners: Arizona Health Care Cost Containment System	
State policy levers:	***Federal authority:***
Legislation • No legislation required *Regulation and guidance* • R9-22-712.35, R9-22-712.61, and R9-22-712.71 govern standards for payments *Contract* • MCO contracts, Section D.81 for all programs, including those serving people with long-term care needs	Medicaid State Plan Amendment Note: Although Arizona operates its Medicaid program under a Section 1115 Research and Demonstration waiver, it did not need to amend the waiver to make these payments.

Utah Medicaid implemented the Rural Home Health Travel Enhancement, under which higher rates are paid to those providers who deliver home health services in rural areas. In most of Utah's rural counties, Home Health Service payment enhancements are offered for cases in which the provider must travel more than 50 miles. However, enhancement payments for services provided to residents of San Juan and Grand Counties vary by location within the county, with the largest enhancement offered for services delivered to residents of San Juan County's Monument Valley region.

How Utah Implemented Enhanced Rural Home Health Rates

<table>
<tr><td colspan="2">Partners:
• Medicaid</td></tr>
<tr><td>State policy levers:
Legislation
• No legislation required
Regulation and guidance
• Medicaid home health provider manual, p 15
Contract
• None</td><td>Federal authority:
Medicaid State Plan Amendment, page 10</td></tr>
</table>

Washington State: Helping Older Adults Delay or Avoid the Need for LTSS

In January 2017, the Washington Health Care Authority, which includes the state's Medicaid agency, launched its Medicaid Transformation Project that operates under a Section 1115 Research and Demonstration Waiver. Through this waiver, Washington established two new Medicaid benefits designed to help older adults delay or avoid the need for LTSS – primarily by supporting older adults' unpaid caregivers. The *Medicaid Alternative Care* (MAC) benefit is targeted to older adults (55 and older) who qualify for Medicaid-financed LTSS, but have chosen to wrap services around their unpaid caregiver rather than receive traditional Medicaid-funded services, such as personal care. The *Tailored Supports for Older Adults* (TSOA) benefit targets older adults who are not currently Medicaid-eligible but are at-risk for future Medicaid-financed LTSS use. TSOA offers two packages of services:

- If the older adult has an unpaid caregiver, the adult receives a package that consists solely of supports for the benefit of the caregiver, such as respite care or training in dementia care. Caregivers qualify for the support based on the financial and functional status of the older adult for whom they care.
- If the older adult does not have an unpaid caregiver, the package offers services, such as personal care, adult day services, home-delivered meals, and personal emergency response systems.

Both MAC and TSOA are administered by the Department of Social and Health Services' (DSHS) Aging and Long-Term Support Administration (ALTSA). The ALTSA contracts with the AAAs to determine eligibility for services and help caregivers access approved services. This local presence helps ensure that staff determining eligibility are familiar with the caregiver resources available in their areas — a benefit for both rural and urban caregivers. Both benefits also feature presumptive eligibility that enables eligibility staff to begin delivering services quickly.

As of July 2019, state officials report that 2,493 people were participating in TSOA and MAC and almost 5,000 had participated since the start of the program in September 2017. Officials report that major challenges included developing and implementing a new eligibility system for the new benefits. They also found that many informal caregivers (who are often family members) do not think of themselves as caregivers until they become very stressed and, as a result, delay seeking these supports.[21] MAC and TSOA are modeled after Washington's Family Caregiver Support Program, which produced significant savings.[22] State officials are optimistic that these new benefits will prove their value, enabling Washington to continue to fund the services after the end of the waiver.

How Washington Launched its Initiative to Help Older Adults Avoid or Delay the Need for LTSS

<table>
<tr><td colspan="2">Partners:
Health Care Authority's Healthier Washington Initiative and Medicaid agency
Department of Social and Health Services' Aging and Long-Term Support Administration (ALTSA)</td></tr>
<tr><td>State policy levers:</td><td>Federal authority:</td></tr>
<tr><td>Legislation
WAC 182-513-1600 (MAC) and WAC 182-513-1610 (TSOA)
Regulation and guidance
WSR 17-12-019
Long-Term Services and Supports Manual for MAC, TSOA, and Presumptive Eligibility
Contract
The ALTSA AAA contract</td><td>Section 1115 Research and Demonstration Waiver</td></tr>
</table>

Legislation to Support Telehealth, Telemedicine, and Telemonitoring in Texas

Since 1997, the Texas legislature has enacted multiple bills that support the use of telehealth, telemedicine, and telemonitoring. Recently, in 2019, Texas enacted SB 670 to remove barriers to the use of telehealth and telemedicine. Among other things, SB 670 directs the Health and Human Services Commission (HHSC) to ensure Medicaid MCOs do not deny reimbursement for a covered service solely because that service was not provided in an in-person consultation. A study by the state's Health and Human Services Commission found that the use of telehealth services in Medicaid increased by 30 percent between FY 2016 and 2017 and that the use of telemonitoring services more than doubled.[23] Texas Medicaid plans to implement its new legislation through medical policies, administrative rule-making, and MCO contract changes, which it plans to develop with the input of stakeholder workgroups that will include MCO representatives.

One technology-based service that may provide benefit to older adults is telemonitoring. Texas Medicaid will pay for telemonitoring provided by a hospital or home health agency to beneficiaries with diabetes or hypertension who also exhibit specified risk factors, such as two or more hospitalizations within the previous 12 months. In fiscal year 2017, 5,961 Medicaid beneficiaries received this service, which covers daily or weekly monitoring of a patient's clinical data transmissions. Texas has developed extensive guidance material for providers of these services. Some expressed concern that older adults might not be comfortable using the telehealth equipment, so Texas established some requirements that could mitigate those concerns. Providers are required to have written protocols defining service provision that must discuss the provider's process to ensure, "The client is able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data."[24] Currently Texas' MCO contracts, including those for programs serving older adults in rural areas, specify these services are covered as described in the Texas Medicaid Provider Procedures Manual.[25]

How Texas Launched its Telehealth, Telemedicine, and Telemonitoring Initiatives

<table>
<tr><td colspan="2">Partners:</td></tr>
<tr><td colspan="2">Health and Human Services Commission (HHSC)</td></tr>
<tr><td>State policy levers:</td><td>Federal authority:</td></tr>
</table>

Legislation • SB1107, defining scope-of-practice requirements and delivery modalities • SB670, most recent legislation, containing multiple changes to support use of telehealth and telemedicine • And others *Regulation and guidance* • Medicaid provider procedures manual *Contract* • Telehealth, telemedicine, and telemonitoring is specified as a covered benefit in all MCO contracts (page 8-195)	Current Medicaid State Plan authority will support these changes.

Emerging Ideas: Arizona Plans Use Electronic Visit Verification System for Planning and MCO Oversight

Federal statute requires states to implement electronic visit verification (EVV) systems for all Medicaid-funded personal care services by Jan. 1, 2020 and home health services by Jan. 1, 2023.[26] EVV systems must be able to verify specific information about each in-home visit, including type of service provided, person receiving the service, date of service, and start and end times of the service. [27] AHCCCS is leveraging this new requirement to gather data for planning and MCO oversight. MCOs are required to initiate home health services within 30 days of identifying the need for the service for new members or in 14 days for existing members in need of new services. The system will also allow better monitoring of the population's access to care (i.e., gap reporting[28]) by tracking at a system level how often providers fail to arrive for their visits. For individual patients, AHCCCS intends for this new system to enable real-time resolution of missed visits — improving patient care by ensuring receipt of critical services.[29] Finally, state officials plan to use the system to analyze provider networks by geographic region. Officials view this capability as particularly beneficial for older adults living in rural areas as they have anecdotal evidence that access to care is a large problem in rural areas and this system will enable them to assess the accuracy of the anecdotal information.

Strategies to Address the Social Determinants of Health

Transportation is one of the major barriers to care in rural areas. It particularly impacts older adults, as 21 percent of Americans age 65 or older do not drive.[30] In addition, older adults in rural areas have other social concerns that affect their health, such as food insecurity. Many states are working to address transportation needs and some are moving to a more comprehensive approach to identify and address these social determinants of health (SDOH).

Using Technology to Address SD0H in North Carolina

North Carolina's Department of Health and Human Services (DHHS) entered into a public/private partnership with the Foundation for Health Leadership and Innovation (FHLI) to build the North Carolina Resource Platform, a secure shared technology platform that manages referrals for social services (e.g., housing and food assistance), with the capability to "close the loop" on referrals. In 2018, FHLI selected NCCARE360[31] to build a statewide, coordinated care network using this platform. NCCARE360 also includes a statewide resource directory (building on the state's 2-1-1 program) and a call center. NCCARE360 plans to succeed by empowering the communities it serves to be key leaders in building the system. Therefore, NCCARE360 assigns a community engagement manager to each region in the state.

The manager works with the community to implement NCCARE360 and then continues to work in that region to update the system and, along with a customer success team, ensures smooth operations. As of May 2019, one health system had embedded this platform into its electronic health records (EHR). As of August 2019, NCCARE360 was operating in eight rural counties and four urban/suburban counties. Implementation was underway in an additional 17 counties, 16 of which are rural. State officials anticipate NCCARE360 will be fully operating statewide by the end of 2020. Prepaid Health Plans (North Carolina Medicaid's managed care organizations) are required to use the "NC Resource Platform" (NCCARE360) to identify and connect their members to community-based resources. While the system is not targeted specifically to older adults it was developed with a consideration of their needs and contains information about the resources available to them.

How North Carolina Launched the NCCARE360 Resource Platform

<table>
<tr><td colspan="2">Partners:
• Department of Health and Human Services (DHHS)
• Foundation for Health Leadership and Innovation
• And many others</td></tr>
<tr><td>State policy levers:</td><td>Federal authority:</td></tr>
<tr><td>Legislation
• No legislation required
Regulation and guidance
• Part of DHHS' Healthy Opportunities Initiative and the State's IT Roadmap
Contract
• Prepaid Health Plan contract requires contractors to use NCCARE360, page 125</td><td>Section 1115 Research and Demonstration Waiver allows implementation of managed care and Healthy Opportunities.</td></tr>
</table>

Community Health Teams Address the SDOH Needs of High-Risk Patients in Rhode Island

Rhode Island's SIM Initiative fostered the growth of community health teams (CHTs) in Rhode Island as a way to address the SDOH of high-risk patients, including those with behavioral health needs. A CHT must include at least one licensed, community-based health professional (often a behavioral health clinician) and two certified CHWs, but they often include additional staff, such as a Screening, Brief Intervention, and Referral to Treatment screener.[32] These multi-disciplinary teams work as extensions of PCPs in the community to provide comprehensive care plan development and coordination to high-risk patients, including identification and management of physical, behavioral, substance use, and social needs. CHTs conduct health assessments, develop and implement care plans, facilitate referrals, assist with medical appointments, and link patients to community resources. As of July 2019, there were eight CHTs operating in Rhode Island, some of whom serve rural areas. Most CHTs negotiate partnerships with multiple practices, including negotiating patient referral criteria and processes. The CHTs are designed as a "place-based" intervention, working in identified geographic regions, and CHT members do work within PCPs' offices, but spend much of their time visiting patients in their homes or finding patients in community settings. An additional benefit is CHT members know local resources and have established relationships in the community.

One recent study found that over a six-month period in 2018, eight CHTs served 2,202 patients. Researchers examined detailed information about a subset of patients[33] and found they:

- Ranged in age from 18 to 96;
- 60.1 percent were female; and
- 90 percent had at least one SDOH challenge.

CHT engagement lowered health risk and other screening scores.[34] Four of the CHTs were established with the support of braided funding from the state's SIM award, which ended in June 2019. Moving forward, CHTs are supported by braided funding that includes funding from:

- Medicaid Health System Transformation Project to enable CHTs to be a place-based support for accountable entities (AEs are Rhode Island Medicaid's ACO-like provider organizations);
- State Opioid Response (SOR) grants to bolster the opioid related substance use response provided by the CHTs; and
- Commercially licensed health plan spending facilitated by the Office of the Health Insurance Commissioner (OHIC). (Note: Insurance regulations in Rhode Island incentivize health plans to make investments in primary care, and when primary care investment targets are missed by health plans, OHIC can assist with directing remaining funds toward activities, such as CHTs.)

How Rhode Island Launched Community Health Teams to Address SDOH

<table>
<tr><td colspan="2">Partners:</td></tr>
<tr><td colspan="2">Rhode Island Department of Health
Executive Office of Health and Human Services (EOHHS)
EOHHS Division of Medicaid
Office of the Health Insurance Commissioner (OHIC)
Department of Behavioral Healthcare, Development Disabilities and Hospitals</td></tr>
<tr><td>State policy levers:</td><td>Federal authority:</td></tr>
<tr><td>Legislation
No legislation required.
Regulation and guidance
OHIC's Regulation 2 establishes the requirement for health plans to invest in primary care
Contract
Contract for CHT support
MCO Contract</td><td>SIM award authorized funding to support CHTs

SOR grant funds support CHTs

Section 1115 Waiver (Rhode Island operates its Medicaid program, including the Medicaid Health System Transformation Project, under the waiver but did not need to amend it to begin paying for CHTs)</td></tr>
</table>

Creation of Voluntary Transportation Programs in Tennessee

Tennessee enacted legislation in 2015 (Public Chapter #152) to limit the liability of volunteer drivers who provide rides for older residents through a charitable organization or human services organization. The state's Commission on Aging and Disability worked to facilitate the formation of these programs, which offer rides to medical appointments as well as for other purposes, such as going to grocery stores. Among these programs are MyRide TN, which is sponsored by the Tennessee Commission on Aging and Disability and serves multiple counties in the state, including eight rural counties. The volunteer programs leverage the legislation when recruiting volunteer drivers. They also leverage Older Americans

Act funding. In addition, riders who must be at least 60 years of age, pay a small fee for rides. According to state officials, 40 percent of the trips provided by the volunteer services are for doctor visits.[35]

How Tennessee Launched MyRide TN

Partners: • Tennessee Commission on Aging and Disability	
State policy levers:	***Federal authority:***
Legislation • Public Chapter No. 152 (Senate Bill No. 117) *Regulation and guidance* • None *Contract* • None	Tennessee State Plan on Aging

Leveraging Federal Transportation Funding in Ohio

Ohio estimates that five state agencies (including Medicaid) spends about $228 million each year on client transportation.[36] Ohio has taken several steps to better coordinate these transportation networks at the regional level, including providing tools and resources to help rural counties develop coordinated transportation plans. These plans are a requirement for three grant programs, including the federally funded Specialized Transportation Program, the Ohio Coordination Program, and the Ohio Mobility Management Program. These plans all consider the needs of older adults. State officials point to the mobility management program as particularly beneficial to older adults in rural areas. The state Department of Transportation oversees this program, which distributes federal funding authorized under the Elderly Individuals with Individuals with Disabilities (Section 5310) Program to private non-profit, as well as, designated state and local government authorities to support mobility management activities. This program supports local mobility managers across the state. These managers work with stakeholders to meet the transportation needs of older adults and people with disabilities by connecting individuals to available resources, promoting transportation resources, and working with stakeholders to identify and develop plans to meet local needs.

How Ohio Used Federal Transportation Funding

Partners: • Ohio Department of Transportation	
State policy levers:	***Federal authority:***
Legislation • No legislation required *Regulation and guidance* • State program guidance for mobility management program *Contract* None	Section 5310 Funding

Emerging Ideas: Arizona Medicaid's Ride-sharing Services and North Carolina's SDOH pilots

Effective May 1, 2019, AHCCCS (Arizona's Medicaid agency) allowed Transportation Network Companies (i.e., ride-share companies such as LYFT and Uber) to register to provide non-emergency medical transportation (NEMT) to Medicaid beneficiaries. The first ride-share company completed registration in June 2019. These companies may only provide medically necessary rides to beneficiaries who do not need personal assistance, which enabled AHCCCS to establish reduced training requirements for drivers (e.g., CPR training is not required for ride-share drivers). In Arizona, MCOs are responsible for delivering NEMT and they have, in turn, contracted with brokers to deliver the service. Therefore, the ride-share company will need to develop payment arrangements with the MCO's broker before it can be paid for delivering NEMT services and the ride will need to be scheduled by the broker. One state official described the potential benefit to older adults living in rural areas this way, "Over a quarter of members reside in rural areas, and half of utilization occurs in rural areas. That would predict that there is disproportionate benefit [in this new NEMT option] for rural areas."

North Carolina Medicaid is implementing the Healthy Opportunities pilot program in several, yet-to-be-determined, areas of the state. As part of this pilot, North Carolina will contract with competitively selected Lead Pilot Agencies that will serve as the connector between managed care entities and local social services agencies. These agencies will implement and test evidence-based interventions to address the SDOH needs of Medicaid beneficiaries, including housing, food insecurity, and transportation. North Carolina is implementing this program under its Section 1115 Waiver for Medicaid Transformation and has earmarked up to $650 million over five years for the pilot projects. If the pilots prove effective, the Medicaid agency anticipates establishing them across the state. As of August 2019, the Medicaid agency anticipated completing its Lead Pilot Agency selection process in early 2020.

Lessons Learned and Key Findings from States' Experiences

Providing appropriate and timely patient care in the home along with assessment of other needed services can support older adults' desires to remain in their homes and communities, support families, and limit more costly care in nursing facilities. This toolkit provides examples of state policies and programs that address the health care needs of older, rural adults. Many of these programs also facilitate older adults' access to social services, which can bolster the health of the population. Several lessons learned and key findings emerged from this research and discussions with state officials and others involved in program implementation:

Designing strategies based on community-defined needs and involvement leads to success. Both Tennessee's voluntary transportation program and North Carolina's technology platform to address SDOH, for example, are implemented on a region-by-region basis as stakeholders are engaged. One Minnesota official observed that, "…Usually, that results in a faster uptake of the service if the provider community is driving the development."

Using pilot programs to field-test strategies enabled states to gather data for building the case for wide-scale implementation and improve operations before expansion. Washington State's new programs to support caregivers, for example, were built on the success of their Family Caregiver Support Program (FCSP) which, state officials report, was "found to have positive ROI [return on investment]

when caregivers are supported and care receivers delay or avoid Medicaid LTSS." Minnesota's Community Paramedics program, Tennessee's voluntary transportation program, and Georgia's mobile day care program were each built on the success of a single local pilot.

While technology can facilitate service delivery, it still requires human resources and community engagement to be effective. North Carolina is implementing its shared technology platform that manages referrals between health and social services providers, which states that, "NCCARE360 will only be successful if it is built by the community it serves."[37] To turn that sentiment into action, NCCARE360 hires a locally-based community engagement manager to implement the system in each region. The manager brings together stakeholders to plan and work with health and social services providers to incorporate them into the system and, in turn, help them incorporate the platform into their workflows. A community-based organization in Missouri operates a transportation program (without state agency involvement) that relies on a cloud-based, similar platform to enable providers to book rides for their patients within two minutes. The leaders of these programs agree that the technology only succeeds in engaged communities where providers, transportation providers, and other stakeholders work together to populate and use the platform with the facilitation of a local coordinator.[38]

Professionalizing the caregiver workforce benefits both the people receiving services and the workers. Both Washington and Tennessee have made efforts to ensure that HCBS workers have a career path and are rewarded for increasing their capabilities through training. Washington State focuses on formal caregivers (those who are paid to provide personal care services). It offers caregivers who become certified as a home care aide training, health care coverage, paid time off, and retirement benefits. Aides are also represented by the Service Employees International Union (SEIU 775). State officials report they believe that building the knowledge of caregivers, who act as the eyes of the delivery system, results in better care. Also, offering aides a career path, including increased payment for increased capabilities, reduces caregiver burnout and, in some cases, serves as a stepping stone to other careers in health care.

States have chosen to keep the broad delivery system and payment reforms they implement focused on improving health outcomes statewide, including older adults living in rural areas. Some states did implement reforms that focused on LTSS providers and the Medicaid beneficiaries they serve, but none had a rural focus.[39] Some states also implemented complementary strategies to ensure that the statewide programs operate with local knowledge, which would help ensure that the statewide reforms met rural needs. For example, Washington created regional Accountable Communities for Health (ACHs) throughout the state. The ACH's bring together local leaders to plan for and support local implementation of statewide payment and delivery system reforms.

The Medicaid program offers states flexibility to design and implement a wide variety of strategies designed to support older adults living in rural areas. Nearly all strategies presented in this toolkit were implemented within Medicaid programs. States had to amend their Medicaid State plans or obtain a waiver to implement some of these strategies. Many, however, were implemented under the state's existing federal authority — and Arizona leveraged the new federal requirement for electronic visit verification to create a new tool for planning. Most of the strategies however, required partners, drew

on the resources and expertise of other agencies (e.g., aging), and relied on contractors (such as MCOs) and local agencies for implementation.

Conclusion

Not only are there higher concentrations of elderly residents in rural areas than in urban areas, but compared to their urban peers, older, rural adults are poorer, have more complex conditions, and experience the impact of health-related social factors more acutely. Older adults living in rural areas are also less likely than those in urban areas to use home- and community-based services and more likely to use nursing facility services. These factors, combined with provider shortages in rural areas, make it difficult for older adults to remain in their homes and communities as they age. States want to help older adults remain in their communities both because it is what older adults want and to contain cost. In recent years, states have implemented a number of strategies to help older adults remain in their communities. These strategies have been implemented by different agencies working with a wide variety of partners and leveraging multiple federal authorities. The examples presented are designed to help states learn from each other as they continue to work to meet the health needs of older adults living in the nation's rural regions.

Acknowledgements

NASHP wishes to thank the following state agencies and organizations for their staffs' time and insights that made this toolkit possible: Alaska Mental Health Trust Authority and Department of Labor and Workforce Development, Arizona AHCCCS, Georgia Department of Community Health and Department of Human Services, Idaho Department of Health and Welfare, Minnesota Department of Human Services, Department of Health, and Emergency Medical Services Regulatory Board, Ohio Department of Medicaid and Department of Transportation, New Mexico Department of Human Services, North Carolina Department of Health and Human Services, Rhode Island Department of Health, Tennessee Commission on Aging and Disability, TennCare, Texas Health and Human Services, Utah Department of Health, Washington State Health Care Authority and Aging and Long-Term Support Administration.

The authors also wish to thank Trish Riley, Kitty Purington, and Rachel Donlon for their contributions to this paper. Finally, the authors with to thank their Health Resources and Services Administration (HRSA) project officer, Lynnette Araki, and her HRSA colleagues for their review and guidance.

This project was supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) under grant number UD3OA22891, National Organizations of State and Local Officials. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the US government.

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