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Realizing Rural Care Coordination

Considerations and Action Steps for State Policy-Makers

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Better coordination of patient care is an increasingly important part of not only advanced primary care models but also of broader strategies to create shared accountability across providers and care settings. States seeking to promote care coordination, either within Medicaid or through participation in multipayer initiatives, will run into long-standing challenges to delivering care and promoting health in rural areas. Rural areas often experience disparities in access to care, health status, and available infrastructure relative to their urban counterparts. Any strategy to coordinate care that aims to operate statewide or target rural areas must consider the needs of rural communities. This issue brief draws from the experiences of six states, Alabama, Colorado, Montana, New Mexico, North Carolina, and Vermont, to identify common policy considerations and action steps for coordinating care in rural environments.

The Importance of Care Coordination

There is no universal definition of care coordination. However, a 2011 report by the *Agency for Healthcare Research and Quality* systematically reviewed more than 40 working definitions to encapsulate the term:

> "Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."[1]

Care coordination connects primary care physicians, specialists, hospitals, behavioral health providers, and non-health social service entities, including schools, housing agencies, correctional facilities, and transportation organizations. It creates seamless transitions as a patient interacts with various providers and services. These activities allow for holistic patient care and for engagement of patients in managing their own care.

Numerous developments in state health policy support the adoption of care coordination models, including patient centered medical homes (PCMHs), accountable care organizations, or enhanced health information technology (HIT) such as telehealth capabilities. The benefits of these and other coordination activities include:

- **Fully informed providers.** Care coordination helps equip providers with the necessary patient information, eliminating duplicative tests or conflicting treatment plans, thereby lowering medical costs and improving efficiency.[2] A 2010 financial analysis of a piloted PCMH in Seattle found a total cost savings of $10.30 per member/per month (PMPM).[3] Other studies of PCMHs and other models that rely on care coordination indicate savings as well.

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- **Support for patient self-management.** As part of care coordination, health and non-health personnel work collaboratively to ensure that each patient receives needed treatment, including self-management for behaviors such as smoking cessation or weight loss.[4,5,6] For example, the Veterans Health Administration implemented a care coordination and patient self-management model involving home telehealth services that has led to 19 percent fewer hospital stays and a 25 percent reduction in the length of hospital stays for diabetes patients.[7]
- **Enhanced patient experience.** With effectively coordinated care, a patient does not have to navigate the system alone and, in many cases, has a multidisciplinary network or team of personnel on which to rely.[8,9,10] In one survey, 96 percent of patients reported that coordination among their various doctors was "somewhat important" or "very important" to them.[11]

Care coordination is especially critical for rural communities. On average, rural communities report poorer health outcomes than their urban counterparts, with a higher prevalence of chronic disease, mental illness, and obesity.[12] Rural communities tend to have higher poverty rates and lower health insurance rates.[13] To help address these disparities, each state has an Office of Rural Health designed to help improve access to and quality of health care for rural residents. Each office supports the health care delivery systems by offering technical assistance, coordinating rural health resources and activities, aiding health workforce recruitment and retention, and collecting and disseminating information.[14] Relationships between Offices of Rural Health and Medicaid vary from state to state, however in some states, Offices of Rural Health work closely with state Medicaid agencies. Approximately 16 percent of rural residents are insured through Medicaid, and that statistic jumps to 42 percent of publicly insured children in rural areas.[15]

Defining "Rural"

The United States Census Bureau defines a rural area as having a population of less than 50,000 people, while acknowledging that there are "urban clusters" of between 2,500 and 50,000 people within rural areas. Using the Census Bureau's definition, as of 2010, nearly 20 percent of the U.S.'s population lived in a rural area.

Considerations for Coordinating Care in Rural Areas

Rural areas offer distinct assets and pose unique challenges, all of which are important to consider when designing or implementing a rural care coordination strategy.

Rural communities may boast strong local relationships and knowledge of local resources. Physicians and care coordinators may have a more detailed knowledge of locally available resources where they exist, such as food banks, behavioral health care, and social services. While the number of available resources may be less in rural areas than in more populous urban centers, closer existing relationships between providers and community-based resources may more readily support coordination of care.

Yet rural areas often experience provider shortages and include small, isolated practices. Currently, there are 5,800 designated Primary Care Health Professional Shortage Areas, and about 65 percent of those areas are rural.[16,17] In some rural counties, a single primary care provider (PCP) serves the entire population, and specialist shortages compel patients to see their PCP for all health care issues, even if a different type of provider would better address the issue. This can lead to prolonged hospital stays if a patient is unable to be discharged because he or she needs to see a specialist for follow-up appointments, and one is not located in the region. Rural PCPs also tend to be solo or small practices,[18] that lack the resources to hire care coordination staff or invest in care coordination tools. For example, small practices are less likely to have invested in HIT, such as electronic health records (EHRs). Nationally, the gap between EHR use in small and large (10 or more physicians) practices grew from 13 percent in 2002 to 42 percent in 2011.[19] Rural practices are also naturally more isolated than practices in more urban areas.

In light of these challenges, physicians in rural communities may be more likely than others to benefit from state care coordination initiatives, particularly within the Medicaid program. Rural physicians receive almost 20 percent of their revenue from Medicaid, a higher proportion than the national average of 17 percent for physicians.[20] State initiatives offer rural providers an opportunity to benefit from new models and tools to better link patients to needed services and to leverage community strengths necessary for collaboration across providers, settings, and services.

Care coordination strategies can be tailored for rural community assets and challenges. Strategies may include a special emphasis on: recruiting or training personnel to assume care coordination responsibilities or support other staff in taking on this role; developing new or making creative use of existing resources; and exploring innovations like telehealth to address practice isolation.

Overview of Select State Strategies

The challenges of coordinating care in rural areas demand state strategies that purposefully address rural needs. This brief was informed by interviews with state officials representing six state initiatives that promote or support care coordination in rural areas. Each highlighted initiative seeks to better deliver services and better coordinate care and each operates in rural environments, either as part of a statewide effort or on a regional basis. Some highlighted states' strategies, e.g., Montana and New Mexico, narrowly hone in on care coordination, including in rural areas, whereas strategies in Alabama, Colorado, North Carolina, and Vermont incorporate care coordination in

rural areas as one component of broader health care delivery transformations.

Colorado's Accountable Care Collaborative

Under its Accountable Care Collaborative (ACC), Colorado has reorganized much of its Medicaid program around three components: 1) PCPs serving as medical homes for beneficiaries; 2) seven regional care collaborative organizations (RCCOs) responsible for coordinating care, assisting with medical, non-medical, and social supports, and connecting beneficiaries with specialist services; and 3) a statewide data and analytics contractor that supports coordination and other functions by providing RCCOs and providers with relevant claims and utilization information.[21] The ACC carves the entire state into seven regions, each of which has a single RCCO. Some of the RCCOs' regions are predominantly rural.

Montana's Health Improvement Program

In 2009, Montana launched its Health Improvement Program (HIP), which replaced a traditional disease management program with a larger care coordination program that placed care managers in all but one of the state's federally qualified health centers (FQHCs). The HIP focuses on high utilizers, offering care coordination services primarily to the top five percent of chronically ill Medicaid patients, though PCPs can also refer other patients into this system. Under the HIP, care managers offering care coordination services work directly for the health centers, and the FQHC receives a PMPM payment for each eligible Medicaid beneficiary.

Each participating health center—13 FQHCs and one tribal health center—covers a geographically distinct area of the state, coordinating care for Medicaid beneficiaries in multi-county regions. Although the care managers are based in FQHCs, PCPs participating in Montana Medicaid's primary care case management (PCCM) program are required to collaborate with the care managers serving their patients through the HIP.

New Mexico's Centennial Care

New Mexico recently launched a new comprehensive Medicaid managed care program, Centennial Care, under a 1115 Demonstration Waiver. The program integrates a range of benefits—physical, behavioral, and long-term care—that had previously been managed separately. As a result of this more integrated approach, Centennial Care is expanding Medicaid's emphasis on care coordination, which under the state's previous managed care program had focused on enrollees with long-term care needs. All managed care enrollees now receive health risk assessments that determine the level of care coordination they require; explicit levels are spelled out in managed care contracts. Managed care organizations (MCOs) are then responsible for providing care coordinators to meet the coordination needs of their enrollees. In addition to devising their own approaches, MCOs must utilize existing care coordination strategies, such as core service agencies, which are local behavioral health entities with care coordination responsibilities, and telehealth. Medicaid MCOs in New Mexico are required by regulation to cover telehealth services as part of the benefit package offered to beneficiaries.[22,23]

Patient Care Networks of Alabama and Community Care of North Carolina

Both North Carolina and Alabama have implemented a system of community-based networks that support primary care practices by offering services—including care coordination—shared across PCPs. These non-profit networks receive PMPM payments to support PCPs and Medicaid beneficiaries through a variety of population management and population health initiatives. Community Care of North Carolina (CCNC) networks first developed when the state Office of Rural Health put out a request for proposals for networks in the late 1990s to help rural clinics and providers better serve their areas. CCNC networks are aimed at all Medicaid beneficiaries who need their services. The Patient Care Networks of Alabama (PCNA), which drew from the CCNC model, focuses on patients with chronic conditions who qualify for the state's Health Homes for Enrollees with Chronic Conditions authorized under the Affordable Care Act. Care managers supported by the networks in both states conduct assessments to identify key factors that pose challenges to care coordination, such as lack of transportation, lack of education on illnesses, non-compliance, and missed appointments.

Vermont's Blueprint for Health

Vermont's Blueprint for Health is a public-private primary care transformation initiative that grew out of a pilot launched in 2003. The Blueprint fosters enhanced primary care practice with a three-pronged approach to care delivery based on commitment to 1) continuous quality improvement and adoption of PCMH infrastructure, 2) participation in the state's HIT infrastructure, and 3) dedication to coordination of care, including embedding community health teams (CHTs) into their practice. PCPs in the Blueprint are expected to manage most patient needs, with the CHTs providing more intensive care coordination and support for higher need patients.

The CHTs, locally designed and implemented multi-disciplinary teams that provide care coordination and management services, are the centerpiece of the Blueprint's care coordination strategy. Blueprint practices and CHTs serve enrollees from all payers. The practices receive PMPM payments from all payers in the state—including Medicare, through the Medicare Advanced Primary Care Practice Demonstration—to provide services. CHTs receive $350,000 for every 20,000 patients served.

Action Steps for States

The experiences of these states reveal a set of key decision points common to the development of each initiative. States considering care coordination strategies that will incorporate or exclusively

target rural areas will need to consider a number of potential action steps in designing and implementing an effective strategy.

Assemble Key Stakeholders in Rural Areas and Seek Out Partners in State Government

State partners hoping to better coordinate care for rural populations will need to engage a variety of stakeholders in the design and planning of new initiatives. The voices of rural stakeholders are critical for ensuring that unique challenges to care coordination in rural areas are adequately addressed, including in broader initiatives that will reach both rural and urban areas.

Use public forums and develop formal roles for local rural stakeholders to build relationships in rural areas. Physicians and other local stakeholders are key to the planning and execution of care coordination strategies, particularly in rural areas where direct relationships and a strong sense of community are dominant dynamics. Engaging local partners—particularly those who will be charged with implementing key components of any care coordination strategy—is essential for securing buy-in. Several states indicated that providers in rural areas were initially wary of new state programs or of personnel brought in from other areas of the state. Officials in Colorado pointed to logistical challenges of engaging with the small independent providers common to rural areas: "We were asking primary care providers to sign a 40 page state contract, which is extremely intimidating [for providers with no legal department]."

Each state addressed provider wariness by engaging providers from across the state in public forums. While Colorado did not have the resources to hold stakeholder meetings outside of the state capital during the planning process, interviewees felt that other states would benefit from doing so if they are able. The state instead held teleconferences with stakeholders unable to travel to the capital. Following the launch of the RCCOs that are primarily responsible for working with PCPs to coordinate patient care, RCCOs have held ACC Program Improvement Advisory Committee meetings in their communities. These forums sometimes allow them to take stock of available community resources relevant to care coordination, like food and housing services. In developing its FQHC-based care coordination strategy, Montana benefited from a robust working relationship with the state's Primary Care Association (PCA) and health centers. The PCA helped the state to facilitate meetings with the health centers during the design phase, building trust and encouraging engagement of the providers critical to the initiative's implementation.

In some cases, states secured buy-in by incorporating rural stakeholders into formal roles on decision-making structures that oversee the state initiative. Informal conversations between insurers, the executive branch, and other stakeholders in Vermont during the initial planning process evolved into a formal committee structure for governing the Blueprint. One official stressed that consideration of rural needs was a natural and essential part of this planning process due to the state's geography and noted that this multistakeholder process was a critical factor in the success of the Blueprint. This approach will be especially important for programs that aim to garner multi-payer support and extend their reach beyond publicly insured patients.

Partner with state agencies that serve rural areas. Successful care coordination initiatives also require strong collaboration within state government. An "all hands on deck" approach to building needed infrastructure or repurposing existing infrastructure in rural areas to facilitate coordination means engaging multiple agencies that have a stake in serving rural communities. Vermont's Blueprint has a close working relationship with the state Office of Rural Health at the Department of Health; the Blueprint incorporates goals and tools for improving access in rural areas identified by the Department of Health into its on-the-ground work with rural practices. During the past year they have jointly sponsored learning collaboratives on asthma, cancer screening, and opiate addiction and have put forth the *Hub and Spoke* initiative which adds licensed addictions treatment counselors and nurse care coordinators to practices offering medication assisted treatment for opiate addictions.

Similarly, Alabama's Medicaid agency collaborates with the state's Office of Primary Care and Rural Health, allowing the office to produce brochures highlighting care coordination services available under the Patient Care Networks. The state's Medicaid agency also has a close relationship with the public health department, which retains care management and coordination responsibilities for areas of the state not served by the Patient Care Networks. Recognizing that care coordination is a major undertaking, Colorado's Department of Health Care Policy and Financing consulted a number of partners at the state level during the design process, including departments focused on public health, human services, housing, and corrections. The state tried to align services across agencies where possible, including those serving rural areas, and invited representatives of other state agencies to participate in public forums on the initiative.

Survey the Existing Infrastructure in Rural Areas of the State

Care coordination requires a number of key resources to succeed: qualified providers with whom to connect patients, trained care coordinators to help patients navigate and bridge systems of care, and supports like HIT tools that facilitate information sharing. In rural areas in particular, finding new resources with which to build an initiative from scratch may be challenging. States with successful care coordination strategies often have opted to build on existing infrastructure in rural areas. However, states must also identify gaps in rural infrastructure and take action to address them.

Identify and build on previous collaboration and care coordination experience in rural areas. States and rural areas in particular may have unique strengths, from existing relationships

to information technology infrastructure. Policy-makers in Montana saw an opportunity to integrate organizations and providers that were already dedicated to serving the underserved at the local level, building on a robust FQHC network in the state. As one state official shared, "FQHCs are uniquely positioned to do primary care, so by attaching this program [HIP] to them, they already had the mission in mind that we were looking for."

New Mexico built upon care coordination requirements that had previously applied only to a long-term care managed care program; under Centennial Care, this approach has been expanded to the entire Medicaid population. The Medicaid agency has helped to disseminate to other Centennial Care MCOs the lessons learned about coordinating care for rural beneficiaries by the former long-term care MCOs. The new Centennial Care MCOs are contractually obligated to link their care coordination efforts with existing infrastructure in the state. This includes collaborating with core service agencies, including community mental health centers, in many rural areas that focus on meeting behavioral health needs but work to coordinate a broader array of services for beneficiaries.[24]

Other states also built on existing community-based organizations or relationships as they designed new care coordination strategies. Colorado formed its RCCOs out of a "hodge-podge" of organizations ranging from former health plans to community-based organizations without experience with government contracting. The connection to the community and to providers enjoyed by these organizations is an asset, particularly in rural areas where one informant suggested they make care coordination "…easier because the relationships are so tight." The Community Care Networks of North Carolina grew out of efforts to support rural providers by sharing care management resources across PCPs serving Medicaid patients under a PCCM program.

Consider incremental implementation and practice support services to accommodate care coordination staffing needs in rural areas. Promoting care coordination in rural areas requires providers to serve those regions, as well as personnel who can connect patients to needed resources and help patients experience continuity of care across settings. A more sparse rural workforce may require contingency plans for staff vacancies, as the loss of even a single care coordinator could temporarily leave multiple rural counties without coordination services. States hoping to reach rural areas with their care coordination strategy may need a more specific plan for workforce development because of the importance of developing new skills needed for care coordination.

Primary care provider recruitment was a priority in the first year of Colorado's initiative. The Medicaid agency allowed RCCOs to use a phased rollout to allow sufficient time for provider recruitment, including in rural counties. This ensured the RCCOs were prepared to meet beneficiaries' needs. State officials cited this decision to allow time for a ramp up of the program as a key success factor in extending care coordination services to rural areas of Colorado. Similarly, New Mexico built a year-long readiness review into its implementation plan for Centennial Care, dedicating an entire year before the launch of the new MCOs to training the MCOs on care coordination and ensuring that each organization was prepared to discharge its coordination responsibilities, including having appropriate care coordinator staffing levels.

Participating providers may need additional supports to implement a state's care coordination strategy, particularly rural providers who may lack resources for the model chosen by the state. Vermont has practice facilitators working in each Blueprint practice to help integrate CHTs into the practices' workflows. These facilitators also assist practices with quality improvement, data collection, and implementation of evidence-based guidelines for care delivery and coordination. Each facilitator works with 8 to 10 practices and is funded through a line item in the state budget, which is supported by savings achieved under the state's 1115 waiver.[25]

Montana, on the other hand, found that its FQHCs had little trouble finding qualified care coordinators, despite specific state requirements. For example, coordinators must have a chronic care professional certification in addition to being a registered nurse, licensed practical nurse, or behavioral health professional. Within three to six months of the HIP launch, all participating FQHCs were staffed to provide the care coordination services. Before settling on a PMPM approach to financing the care coordinators in FQHCs, the state had expected the HIP would be financed through grants to participating FQHCs. The state solicited grant proposals from FQHCs and, though the grant approach to financing was abandoned, the officials credit the request for proposal process with helping health centers to think through and plan their approaches and staffing needs.

Recognize that gaps in rural HIT may need to be addressed before implementation of care coordination models. Technology to support information sharing across care settings and analysis of patient data, described by one informant as "the most complicated and frustrating part" of care coordination strategies, is key to the success of these models. In a more coordinated system, care providers must have the right patient information at the right time, and care coordinators need patient information to target their services. HIT supports this real-time information sharing between providers, as well as analysis of administrative data to identify high needs patients. Each state strategy explored below relies on new HIT tools to facilitate and enhance care coordination.

Vermont relies on its statewide health information exchange and a centralized registry to support communication between providers and CHTs. The state has found that this communication capacity has strengthened care networks, particularly in rural areas. Montana uses information technology tools to target the top five percent of utilizers within the Medicaid program. Predictive modeling software purchased by the state and implemented specifically for the HIP draws from claims data to assign a risk score to all Medicaid beneficiaries in the state based on utilization

patterns. Without this software, community health centers would not have this data analytic capacity and would be unable to systematically identify beneficiaries most in need of care coordination services.

Recognizing that participating PCPs, including those in resource-strapped rural areas, would lack internal data analytics capacity, Colorado made the creation of a statewide data analytics contractor a key component of its Accountable Care Collaborative. RCCOs and PCPs can take advantage of user-friendly portals to access patient data and claims collected and analyzed by the contractor. As part of its analysis of utilization data, the contractor provides predictive modeling support to help the RCCOs and providers identify and target care coordination services to high-risk beneficiaries.[26]

In New Mexico, the MCOs are contractually required to make their Centennial Care health information available to the New Mexico Health Information Exchange (HIE) and to financially support the New Mexico Health Information Collaborative as the operator of the HIE. The MCOs must also develop a delivery system improvement project to increase the use of EHRs by providers and to increase the number of providers who participate in the exchange of electronic health information using the HIE. At least one MCO is exploring reimbursement models to incentivize rural providers in particular to adopt EHRs and participate in the HIE.

Design the State-Level Policy Structures that Will Govern the Program

Regardless of whether a care coordination initiative is exclusive to rural areas, rural considerations will be important to its success. States must establish an overarching policy framework for these initiatives that explicitly encompasses rural considerations or leaves room for the entities administering the program to respond to local needs.

Identify existing Medicaid policy to build on and new policies needed to govern the initiative. Programs within Medicaid may leverage existing policy, such as waivers. Montana, Alabama, and North Carolina each built upon existing PCCM infrastructure in the state because a degree of care coordination responsibility is implicit in PCCM. While North Carolina and Alabama ultimately transitioned to using a Medicaid state plan amendment, each of the three states initially amended an existing 1915(b) freedom of choice waiver to create enhanced PCCM programs. The process of developing these waiver amendments impressed upon officials in these states the importance of incorporating sufficient time for development, and federal review and approval of waivers.

Other states may find that entirely new policies are needed to implement their strategy. Vermont's Blueprint traces its genesis to an executive initiative launched in 2003. In 2005, the program was included in a new 1115 Demonstration waiver awarded to Vermont's Medicaid program, and the Blueprint was codified by the passage of state legislation in 2006. Colorado's ACC emerged from the recommendations of a Blue Ribbon Commission in the state and, like North Carolina, required approval of a new Medicaid state plan amendment.

Other policy decisions can also dictate the success of a care coordination strategy or initiative. Decisions influencing provider participation are particularly significant in rural regions of a state where even a small number of non-participating providers could cripple a care coordination initiative's effectiveness
To encourage more providers to participate in its initiative, Colorado deliberately incorporated flexibility into its medical home standards. For instance, one official shared that a poll of rural PCPs had revealed relatively limited EHR capacity. Strict requirements for EHR use in the state's medical home qualifications would have led to a much more limited primary care network for the ACC in rural areas. As a result, Colorado allows RCCOs to help rural PCPs to build medical home capacity instead of requiring it upfront as a condition of participation. In addition to requiring Centennial Care's MCOs to cover telehealth which helps to connect PCPs, specialists, and patients who may be far apart geographically, New Mexico has moved to promote the use of telehealth by relaxing regulatory requirements. The Medicaid agency removed restrictions on the services that can be provided using teleheath and eliminated requirements that telehealth be confined to frontier areas.

Consider early on methods and resources for assessing impact on a regional or rural basis. Officials in several highlighted states identified tracking the impact of their initiatives as a particularly important consideration for states. However, many states may find assessing impact of care coordination strategies challenging. States that have struggled with this aspect of program design identified a need for upfront money to support a method for collecting assessment and evaluation information, as well as robust systems for collecting administrative data. Despite these challenges, some states have incorporated an impact assessment into their programs.

For instance, Colorado's ACC focuses on impact assessments, tying RCCO incentive payments to high performance on key indicators on well-child visits, emergency room visits, 30-day hospital readmissions, and medical imaging. Because effective care coordination will support appropriate utilization of these services, performance on these metrics offers insights on the impact of the coordination. The state also tracks financial impact closely and submits annual reports to the legislature that detail cost savings, as the initiative is designed to be cost neutral.
The RCCOs in turn report to the state on a quarterly basis, detailing key components of care coordination strategies like the relationships they have created with non-medical resources like food and housing services.

Vermont benefits from the existence of an all payer claims database that compiles administrative data from payers and can be used to examine expenditure and utilization data to gauge the impact of the Blueprint. These data, along with process measures

that examine care delivery, have been key to Vermont's strategy for demonstrating impact since the launch of the Blueprint; the most recent annual report on the Blueprint found improvements in quality and evidence that payer investments in the Blueprint's PCMHs and CHTs were more than offset by reductions in health care spending.[27] Under New Mexico's Centennial Care managed care contracts, 1.5 percent of MCOs' capitation amounts are contingent upon the MCO meeting annual delivery system improvement targets. For 2014, the MCOs have four improvement targets, one of which is increasing specialist interactions using telehealth in rural and frontier areas by at least 15 percent. Each 2014 improvement target is worth 25 percent of the total withheld amount.

Consider the Balance of State and Local Needs Within Care Coordination Strategies

While the state-level policy structures governing the initiative will outline the contours of care coordination strategies, some decision-making authority will be left in the hands of the entities closer to the on-the-ground implementation of care coordination strategies. The PMPM payment structures that many state care coordination strategies use lend themselves to the provision of a diverse array of services and supports tailored to local needs. States will need to decide how much flexibility to build in at the policy level to allow local entities responsible for care coordination to respond to rural challenges. Greater local autonomy will come at the expense of standardization of care coordination approaches.

Identify entities responsible for arranging or delivering care coordination services in rural areas and the population served. Determining which entities will be responsible for delivering or securing care coordination services is a key design decision for policy-makers.

- Alabama and North Carolina's approaches rely on nonprofit community-based networks. The two states' networks differ in their targeted populations. Alabama's networks are aimed at health home-eligible individuals with chronic conditions, while North Carolina's networks serve all Medicaid beneficiaries in their geographic areas.
- Vermont's CHTs are a critical component of the Blueprint model and help to bring cohesion to rural areas of the state, which often have more dispersed primary care practices. A state official emphasized their importance, suggesting that, "the secret sauce, the magic, is the coordination that we have—the way the teams have come together," particularly in rural areas.
- Montana chose its network of FQHCs as the locus of care coordination for Medicaid beneficiaries in the state. In developing regulations to govern the HIP, Montana Medicaid adopted a philosophy of flexibility to ensure that the FQHCs have latitude to meet the needs of rural communities as they see fit.
- Colorado placed responsibility for care coordination in the hands of its seven RCCOs. These organizations not only help to coordinate care for patients across settings, they also serve primary care practices, offering administrative support and clinical tools for practice transformation.
- New Mexico is relying on MCOs to develop appropriate care coordination strategies for enrollees across the state. Specific care coordination activities that must be conducted by MCOs based on the level of care coordination needed, as determined by a comprehensive needs assessment, are spelled out in contracts. While the state has deliberately avoided being over prescriptive, care coordination is a critical piece of the service package MCOs offer.

Grant local entities autonomy to develop tailored care coordination strategies. The recognition that communities face differences in service availability and physical geography is an important part of designing health programs, whether statewide or concentrated in particular areas. As a state official in Montana said of the FQHCs that administer the HIP, "they know their resources and the people—it works best to let them do it." The result is that in many initiatives, the role of the state has been to design a broad policy framework in which local entities charged with coordinating care can flourish, developing individualized strategies for care coordination in response to local challenges, including challenges unique to rural environments.

Under Vermont's Blueprint, the CHTs identify and address gaps in service delivery and care coordination at the local level, often in consultation with health care providers, hospitals, and human services. The varying challenges faced by rural areas of the state were addressed by moving care coordination planning to the local level. As a result, various strategies—such as nurse coordinators or mental health social workers being "rented out" to Blueprint practices by a mental health agency—have emerged at the local level.

Colorado's RCCOs perform gap analyses of their regions and explore options for building "medical neighborhoods" to meet enrollees' medical and non-medical needs. Different RCCOs have designed different strategies for supporting rural populations based on local relationships, resources, and needs. RCCOs may also delegate care coordination responsibilities to PCPs when appropriate. This regional approach has resulted in unique local care coordination strategies. One region uses community-based teams to coordinate care, another focuses on partnering mental health centers with primary care practices to build shared resources for coordination, while yet another provides care coordination services in the home and partners with firefighters to focus on patients who frequently call 911.

Similarly, care networks in Alabama and North Carolina use internal data analytics to determine the needs of the local population. The networks then tailor approaches to meet the needs identified. For instance, Alabama's PCNAs can contract with specialists as they see fit, while in North Carolina network

psychiatrists provide support to the networks, PCPs and care managers for services (i.e., quality improvement and consultation) that not covered by fee for service.

Conclusion

The experiences of Alabama, Colorado, Montana, New Mexico, North Carolina, and Vermont facilitating care coordination in rural environments offer lessons for states considering similar approaches. Officials in these states are proud of their successes to date in meeting the needs of rural populations, yet many were also able to identify several areas in which improvements are still underway. Such areas for improvement include developing strategies for engaging specialists and using them more efficiently, new approaches to addressing provider shortages in rural areas, additional supports for providers extending their after-work hours, and integration of behavioral health with primary care. By engaging key stakeholders and partners in rural areas, leveraging existing rural infrastructure, and balancing state-level policy structures with local needs, states are addressing care coordination in rural areas. These states' decision points, considerations, and action steps provide a platform upon which state policy-makers can build to better coordinate care in rural areas.

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