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State Innovations in Improving Access to Care for Adults with Complex Needs in Rural Communities

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TAKEAWAYS

- States have a timely opportunity to improve access to care for people with complex needs in rural communities, building on recent federal investments and state-level innovations that address longstanding barriers.
- This brief highlights Medicaid policy and financing strategies that can help improve access to care for rural older adults, people with disabilities, and others with complex health and social needs.
- Promising approaches from California, Missouri, North Dakota, South Dakota, and Virginia offer program design and implementation lessons for other states seeking to target investments that improve access to care in rural communities.

States have a critical opportunity to improve access to care for people with complex health and social needs living in rural communities. Recent federal investments, including the Rural Health Transformation Program, along with innovation at the state and local levels, have created momentum for states to address longstanding challenges and expand access to promising solutions.

States can use Medicaid policy and financing tools to strengthen rural delivery systems, expand provider supports, invest in care coordination infrastructure, and deepen partnerships with community-based organizations (CBOs). These strategies can better integrate medical, behavioral health, long-term services and supports (LTSS), and social services for populations with complex needs, including older adults and people with disabilities, and better align services around their goals and preferences.

This brief, made possible with support from The SCAN Foundation, examines approaches in **California**, **Missouri**, **North Dakota**, **South Dakota**, and **Virginia** that have demonstrated opportunities to improve access to care for people with complex needs living in rural areas.

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Drawing on CHCS' previous work to identify options for improving rural care access,[1] CHCS conducted a literature review, interviewed program representatives, and convened national subject matter experts to explore three promising strategies:

1. Establishing care coordination entities

2. Strengthening provider capacity

3. Expanding transportation options

By highlighting effective strategies across these three approaches, this brief offers state policymakers insights to inform program design and implementation, guide policy decisions, and target investments to improve access to care in rural communities.

Across the three focus areas, four common factors emerged as critical to successful design and implementation: (1) trusted local champions; (2) strong community collaboration; (3) flexible program design; and (4) supportive payment structures.

Factors Supporting Successful Replication of Rural Access-to-Care Approaches

Through CHCS' analysis and interviews, four common factors emerged that can help states build sustainable solutions that improve access to care for people with complex needs in rural communities. These factors, described below, reflect the need to respond to unique characteristics of rural areas, including smaller populations, limited provider availability, geographic isolation, and strong social networks.

- **Trusted local champions**. In rural settings, relationships and reputations carry significant weight. Residents may be more likely to engage with services when they are introduced or endorsed by someone they trust, such as a local clinician, community health worker, or faith leader. These champions can also help bridge cultural and logistical gaps between external programs and local realities, ensuring that interventions are not perceived as imposed from outside, but instead as community-driven solutions.
- **Strong community collaboration**. Rural areas often have fewer providers and services than urban settings, making cross-sector coordination across physical health care, behavioral health care, social services, schools, and community organizations essential. Smaller populations and shared cultural values often contribute to the close-knit nature of rural communities.
- **Flexible program design**. Due to wide variation in population density, workforce availability, infrastructure, and cultural norms, what works in one rural community may not translate to another. Programs that allow for local tailoring — such as adapting staffing models, using telehealth, or modifying service delivery locations — are better able to meet people where they are. Flexibility also allows programs to evolve over time as community needs change, which is crucial for sustainability.
- **Supportive payment structures**. Traditional payment models often do not account for the additional time, travel, and coordination required to deliver care in rural areas. Payment approaches that support care coordination, team-based care, telehealth, and non-clinical services help offset these challenges and support programs' financial viability. When funding mechanisms align with the realities of rural care delivery, providers are more likely to adopt and sustain innovative models.

Taken together, these factors can help states design rural access-to-care strategies that are responsive to local needs and sustainable over the long term.

1. Establishing Care Coordination Entities

Accessing providers and services in rural communities can be challenging for many individuals. For people with complex needs — who often have multiple chronic medical and behavioral health conditions, disabilities, and health-related social needs — navigating limited provider networks and services is often even more difficult. Entities that can coordinate and help people navigate care and services can play a critical role in connecting people in rural areas to needed care.

Care Coordination Models

To support people with complex needs in rural areas, states can consider two care coordination models informed by their managed care landscape:

- **Health plan-led care coordination**: States with Medicaid managed care programs that cover LTSS and behavioral health services can require managed care organizations (MCOs) to establish care coordination approaches tailored to members living in rural communities. For people who are dually eligible for Medicare and Medicaid, states with statewide managed care can use contracts with Medicaid MCOs and dual eligible special needs plans (D-SNPs)* to require integrated models that coordinate care and services across both payers (Medicaid and Medicare). For example, states can require affiliated Medicaid MCOs and D-SNPs to operate statewide, including in rural areas.
- **Provider- and CBO-led care coordination**: States with limited or no Medicaid managed care can consider care coordination models that position different types of providers or CBOs as the care coordination hub. States with managed care may also consider provider- and CBO-led models, as an alternative to working with health plans to coordinate care for populations with complex needs. For example, some states use the Medicaid Health Homes model to provide enhanced care management for people with chronic conditions.[2] Under this model, designated providers receive additional payment for certain care coordination activities. The Program of All-Inclusive Care for the Elderly (PACE) is another provider-led model that delivers and coordinates medical and support services for adults age 55 and older with complex needs who require a nursing home level of care.[3] Other models may use providers that broadly serve the community, such as hospitals or community health centers, to establish a care coordination hub.[4]

*D-SNPs are a type of Medicare Advantage plan that only enroll dually eligible individuals. D-SNPs were originally authorized by the U.S. Congress in 2003 and made a permanent part of Medicare Advantage in 2018. D-SNPs are required to hold contracts with the state Medicaid agency in each state in which they operate, and those contracts must contain at least certain minimum elements.

States have used these care coordination models to help people access and navigate health care and social support across various settings. However, states will need to consider several factors when adapting and implementing these models in rural communities, as described later in this brief.

Program Examples

Following are programs that use different care coordination models to support people with complex needs in rural communities. Exhibit 1 provides an overview of three programs: (1) South Dakota Care Connect; (2) California Redwood Coast PACE; and (3) the Missouri Transformation of Rural Community Health (ToRCH) Program.

While these programs are not rural-specific, they have been implemented successfully to serve populations with complex needs in rural communities.

Exhibit 1. Care Coordination Hub Program Examples

Program	Location	Model Summary	Population Served
South Dakota Care Connect (Medicaid Health Home)[5]	South Dakota, statewide	Community-based providers (e.g., primary care physicians, federally qualified health centers or rural health clinic providers, community mental health center providers) offer a set of core care management services to Medicaid members with certain chronic conditions. South Dakota does not have managed care for any Medicaid population.	People enrolled in Medicaid with certain chronic conditions such as asthma, COPD, diabetes, heart disease, hypertension, obesity, substance use disorder, mental health conditions, pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression, and musculoskeletal and neck/back disorders.
California Redwood Coast PACE[6]	Humboldt County, Northern California	Redwood Coast PACE is a comprehensive health plan and provider of all medical and social support services. PACE organizations receive capitated payments from both Medicare and Medicaid.	People age 55 and older, who are eligible for nursing home level of care, can safely live in the community with the help of PACE services, and reside in the Redwood Coast PACE service area.
Missouri ToRCH Program[7]	Central and western counties in Missouri	Using a primary care case management model, participating rural hospitals receive Medicaid funding from the state as regional care coordination hubs to address medical and social support needs of local residents receiving Medicaid coverage. The hospitals use a virtual community information exchange platform to administer referrals for social support services. While Missouri has Medicaid managed care, older adults, people with disabilities, and dually eligible individuals are excluded.	Medicaid members residing in regions with participating hospitals.

Factors Supporting Effective Implementation

While each program highlighted in this section uses a different care coordination approach, interviews with program representatives and input from national experts identified several common factors for states and local partners to consider. These factors can help states build on existing rural infrastructure, align medical and social supports, and sustain care coordination for people with complex needs.

- **State agency leadership can support program reach and sustainability**. In South Dakota, the Medicaid agency supports the administration of the Care Connect health home program and uses a variety of strategies to promote statewide availability of health home services. For example, South Dakota Medicaid conducts semiannual targeted outreach to all primary care clinics that already participate in the state's basic primary care case management program about the opportunity to also become a health home provider if they are eligible. In Missouri, the legislature and Medicaid program partner to support the design and implementation of ToRCH, a model that builds on existing relationships with hospitals and health systems to support and sustain services in rural communities.
- **Trusted local organizations can anchor care coordination in the community**. In California, the well-established senior center, Humboldt Senior Resource Center, administers Redwood Coast PACE. The senior center offers a range of services widely used by the community, including transportation and in-home support services. The senior center and PACE staff actively focus on building trust within their local community, including through consistent outreach and engagement with local providers and CBOs. In Missouri, ToRCH partners with rural hospitals, which are integral to the provider and economic landscapes of rural communities. Through ToRCH, hospitals not only provide medical care, but also become the hubs for connecting individuals to support services as well.
- **Existing provider relationships can support program adoption**. In South Dakota, Care Connect builds on the state's primary care case management infrastructure to support care coordination. Through Care Connect, the state provides additional payments to eligible local providers to become health home providers and coordinate services for people with complex needs. In California, Redwood Coast PACE works closely with local hospitals to streamline and support care planning by coordinating follow-up medical and social services for PACE enrollees being discharged from the hospital. The program also works with nearby graduate schools, including Cal Poly Humboldt and the College of the Redwoods, to provide opportunities for pre-med and nursing students to fulfill training requirements, while also learning about the care and support needs of people in rural communities.

- **Care coordination programs can help fill local service gaps**. In California, Redwood Coast PACE uses Medicare and Medicaid capitated payments and support from the Humboldt Senior Resource Center to provide a range of person-centered support services that may otherwise be limited in the community. For example, when the only community lab stopped offering same-day lab testing, Redwood Coast PACE established its own laboratory to maintain access to lab testing for its enrollees. The PACE center also established its own transportation and in-home support services in response to a shortage of local providers.
- **Incentive payments can support care coordination models and strengthen community partner capacity**. A key challenge to building rural community provider capacity is the limited economies of scale in rural settings. In Missouri, ToRCH supports hospitals' financial stability by encouraging them to serve as local care coordination hubs.[8] Hospitals receive Medicaid primary care case management payments and additional funding allocated by the state legislature to support the provision and coordination of social support services. To support the coordination capacity of hospitals and CBO partners, all participating entities use a single technology platform to coordinate services. The state also requires participating hospitals to direct a portion of state funding to CBOs to support organization capacity-building activities and address unmet health-related social needs in the community.[9] In South Dakota, Care Connect addresses limited economies of scale by offering incentive payments to small, rural clinics — those with 15 or fewer patients in their caseload — to participate as health home providers.

Key Considerations for States

The care coordination programs featured in this section could be adapted by states to increase access to care in their rural communities. States may want to consider how each program's scope of services, provider and member eligibility rules, geographic reach, and infrastructure may impact replication.

- **Provider eligibility requirements may limit which rural organizations can participate**. States have the flexibility to designate what types of entities (e.g., physicians, clinical group practices, rural health clinics, community health centers, federally qualified health centers (FQHCs)) are eligible to be Medicaid health home providers. If considering health homes as a mechanism to improve care coordination in rural settings, states may want to designate provider types that most frequently serve rural communities. In South Dakota, Care Connect designates health home providers as those who practice as a primary care physician, (e.g., family practice, internal medicine, pediatrician, OB/GYN), physician assistants, certified nurse practitioner who are working in an FQHC,

rural health clinic, Indian Health Service Unit or clinic group practice; or a mental health professional working in a community mental health center.[10]

- **Population eligibility may limit the reach of some models**. PACE is not available to all populations with complex needs in rural areas. Federal statute limits PACE enrollment to adults age 55 and older who meet the state's nursing home level of care criteria and can live in the community with the help of PACE services. Establishing a new PACE center can also be costly for provider organizations and requires state support and oversight.[11]
- **Local care coordination entities may be limited in connecting people to certain services**. States may want to consider the types of entities providing care coordination, particularly for populations with complex needs who often require a range of support services. For example, local hospitals that act as the coordination hubs in rural communities may not be as familiar with different types of in-home support services that people with complex needs require to remain in the community. While the participating hospitals in ToRCH offer coordination across several social support needs in the community, they are not typically involved in administering certain home- and community-based services (HCBS), such as in-home supports.
- **Care coordination programs can offer states opportunities to avoid more costly service use**. Costs associated with the design and implementation of expanding care coordination models into rural areas are a key consideration for states. Therefore, care coordination programs that demonstrate savings can help states build the case for launching, expanding, or sustaining such programs. A South Dakota representative reported approximately $16 million in savings to the state as a result of Care Connect reducing costly care for members with complex needs. The representative attributed these savings to coordination supported through the program's quality incentives and enhanced payments.

2. Enhancing Provider Supports

Provider shortages[12] are a major barrier to accessing care in rural communities. Individuals with complex needs rely on an array of providers for primary and specialty care, behavioral health care, HCBS, and social services. Rural communities struggle to attract and retain providers for a variety of reasons, including limited infrastructure and lower pay. As a result, residents in rural communities often face long travel or extended wait times to receive care or may go without needed care and services altogether.

Provider Support Models

States have opportunities to enhance provider access and capacity by implementing policies or models that focus on strengthening provider supports in rural communities:

- **Enhanced payments**: States can consider using enhanced payment methodologies to encourage providers to work in rural areas by making care delivery more financially sustainable and professionally viable. Payment methodologies, like differential or enhanced payment rates, loan repayment, and incentives tied to rural service, can help attract and retain a range of provider types.[13] Differential rates pay higher rates to providers for working in less desirable conditions or locations, such as in hard-to-access rural areas. Enhanced payment rates include higher payments to account for common challenges in rural communities, such as increased costs related to smaller patient volume, long travel times, and high administrative burden.
- **Community-based workforce**: CBOs are often deeply trusted and embedded within their communities, positioning them well to address individuals' health-related social needs, such as transportation, food insecurity, housing instability, and care coordination.[14] States can consider policies that support these organizations to train staff to serve as community health workers (CHWs) or similar roles. These approaches can help local health care and support service systems to extend their reach without solely relying on limited licensed providers. Supporting the community-based workforce also enables clinical staff to practice at the top of their license.
- **Provider training and capacity building**: States can consider establishing policies and programs that expand access to continuing education, networking, and mentorship opportunities to help build a more flexible, skilled, and sustainable rural health care workforce. For example, states can support programs that cross-train medical providers in rural areas to expand community access to specialty care, strengthen partnerships across rural health care systems, and maximize limited resources.

Program Examples

The programs below use different approaches to strengthen provider supports in rural communities. Each program has implemented rural-specific strategies to serve people with complex needs in rural settings. Exhibit 2 provides an overview of three programs: (1) North Dakota Rural Differential Rates for HCBS Providers; (2) South Dakota Community Health Worker Services; and (3) Project ECHO.

Exhibit 2. Provider Support Program Examples

Program	Location	Model Summary	Population Served
North Dakota Rural Differential Rates for HCBS Providers[15]	North Dakota, statewide	Increased payments for HCBS providers and family caregivers who meet the state's Qualified Service Provider standards and travel 21 or more miles to provide personal care and respite services. Providers are not paid for the time they drive to or from an individual's home; the rural differential rate may only be used for the time spent providing services.	Individuals accessing Medicaid HCBS.
South Dakota Community Health Worker Services[16]	South Dakota, statewide	Medicaid fee-for-service payment for CHW services, including health system navigation and resource coordination, health promotion and coaching, and health education to teach or promote methods and measures that have been proven effective in avoiding illness and/or lessening its effects. The state works with the CHW Collaborative of South Dakota as the organizing entity that supports CHWs statewide, including by providing training, certification, and support for sustainability.	Medicaid populations with a chronic condition or at risk for a chronic condition who are unable to self-manage the condition or for people with a documented barrier that is affecting the person's health with social support needs.
Project ECHO[17]	Launched in New Mexico; available in every state	Mentorship model that supports providers and builds local workforce capacity by virtually connecting community-based care teams with specialists — often located in academic medical centers or larger health systems — to share evidence-based strategies for delivering care.	Rural populations accessing specialty care.

Factors Supporting Effective Implementation

Interviews and input from national experts identified factors that can help states implement the models highlighted in this section to expand rural workforce capacity, support provider participation, and adapt payment and training strategies to local conditions.

- **State leadership can support provider participation in rural areas**. In North Dakota, the state has championed the differential rates for rural HCBS providers to encourage provider participation in rural areas as it indirectly covers the extra resources needed to travel longer distances. Supported through the state's Medicaid state plan personal care services and 1915(i) home- and community-based state plan option, the state has administered the higher rate for the past 15 years to support qualified service providers, including eligible family caregivers, who are willing to travel to deliver personal care and respite services. State engagement also helps ensure that efforts like the rural differential rates are part of a broader strategy to strengthen rural health infrastructure. The state noted that HCBS providers participating in state surveys report that the differential rate has increased access to HCBS in rural areas. Some case managers reported that without the increased rate, many providers would not be willing to travel into rural areas.
- **Organizing entities can ensure consistent standards among a community-based workforce**. CHWs often serve as trusted connectors among community members, health care providers and systems, and social services. The CHW Collaborative of South Dakota is the statewide organizing entity that provides shared standards, training, peer learning, and collective advocacy to strengthen consistency and quality of services for people with complex needs. The Collaborative also supports the state by administering a standard certification process for all CHWs to ensure that they are eligible for Medicaid reimbursement.
- **Embedding CHWs in local CBOs can expand rural service capacity**. In South Dakota, CHWs play a central role in working with local CBOs to connect people living in rural areas to health care and social supports. The state uses broad criteria for the types of organizations that qualify to staff CHWs through Medicaid. In addition to traditional medical provider organizations, local CBOs can bill for CHW services delivered to South Dakota Medicaid members if the CBO has become a CHW agency through Medicaid.[18] Embedding CHWs within local organizations expands the capacity of rural providers who may lack the time or staffing to provide comprehensive supportive services. In addition to allowing a range of organizations to qualify as CHW providers, South Dakota allows flexibility in where CHWs can bill for delivered services, such as during transportation to appointments.

- **Existing training models can strengthen rural provider capacity**. Project ECHO offers a strong model for connecting rural providers and CBOs to multidisciplinary specialty care. Through the model, rural providers can connect with an ECHO hub that offers virtual access to specialty expertise and training, enhancing workforce capacity in rural areas and reducing the need for community members to travel long distances to access specialty care. Several states have supported rural providers' access to Project ECHO through several mechanisms, including state funding and leveraging Medicaid managed care contract requirements. For example, New Mexico requires Medicaid MCOs to contract with the state's Project ECHO hub at the University of New Mexico Health Sciences Center that support ECHO programs for providers statewide.[19]
- **Flexible payment models can account for rural geography and travel time**. In North Dakota, providers are eligible to access the rural differential payment rates if they travel 21 miles or more to provide services in a person's home, but the rate is calculated based on the time spent providing services. Providers can access the increased rates for each person they serve, even if a provider drives 21 miles or more to one individual and then serves another person nearby or even in the same home. This approach recognizes the efficiencies gained when providers can coordinate visits — reducing the financial burden associated with long travel distances and helping providers remain financially viable. The state also recently updated its policy to offer differential payment to rural HCBS providers who travel longer distances to serve populations in more populated areas.

Key Considerations for States

The provider support strategies highlighted in this section can help states strengthen rural provider access and capacity. States should also consider whether financing, workforce constraints, and provider participation requirements may affect implementation and sustainability of these strategies in their rural communities.

- **Unpaid training time may limit rural provider participation**. While initiatives like Project ECHO play a critical role in strengthening provider access and capacity in rural areas, participating providers are typically not paid for time spent in training, virtual sessions, and case discussions. For rural providers facing staffing shortages, this uncompensated time may limit engagement.
- **Long application processes may be a barrier**. To receive rural differential payments in North Dakota, providers and eligible family caregivers must apply to become a qualified service provider. These application processes can discourage providers from participating if they are lengthy or poorly designed. States can consider administrative burden when designing application processes to encourage provider participation.

3. Expanding Accessible Transportation in Rural Settings

Limited transportation is another key barrier to accessing care in rural communities. Long travel distances to providers and limited public transportation options can make it difficult to attend appointments, especially for people with low incomes and complex needs.

Transportation Models

States and local partners can explore different flexible transportation models and solutions that reflect rural geography, service availability, and community needs:

- **Microtransit**: This on-demand approach includes both publicly financed and private ride-sharing services to support groups of riders traveling in the same direction in shared vehicles, such as vans or small shuttles.[20] Trips can be booked in real time or in advance through a mobile app, website, or call center and can be provided through door-to-door or curb-to-curb options, depending on the program. In rural communities, microtransit can cover larger areas with fewer vehicles and reduce wait times where fixed-route bus service is limited. It can also help riders reach medical appointments, pharmacies, grocery stores, and other needed services when fixed-route transit does not reach their starting point or destination.
- **Mileage reimbursement, including for family caregivers**: Medicaid agencies are required to cover non-emergency medical transportation (NEMT) for members to travel to and from their medical appointments.[21] Under the Medicaid NEMT benefit, states have the flexibility to offer gas or mileage reimbursement to contractors providing this transportation service.[22] In rural areas where there are few NEMT contractors available, family caregivers may be able to become independent contractors and be reimbursed for the mileage used to take members to and from their medical appointments. This reduces access-to-care barriers for individuals whose family caregivers can provide transportation.

Program Examples

Several rural communities have used microtransit and NEMT mileage reimbursement models to improve access to care for their residents. Exhibit 3 provides an overview of the Mountain Empire Transit Program in southwest Virginia, as well as NEMT mileage reimbursement that is available in most states.

Exhibit 3. Accessible Transportation Program Examples

Program	Location	Model Summary	Population Served
Mountain Empire Transit Program[23]	Southwest Virginia	The Mountain Empire Transit Program is part of the Mountain Empire Older Citizens (MEOC) Area Agency on Aging that uses flexible payment strategies and flexible program infrastructures to maintain a public transportation system.	People of all ages and abilities needing access to services and supports.
NEMT Mileage reimbursement[24]	Available in almost every state	The NEMT mileage model provides per-mile reimbursement for transportation using Medicaid-approved drivers (e.g., independent contractors, family caregivers) to get to and from medical appointments.	Medicaid members, including older adults, individuals with disabilities, and people with chronic conditions who lack reliable transportation options.

Factors Supporting Effective Implementation

Interviews and input from national experts identified factors that can help communities build on existing transportation and service networks, align partners around shared access goals, and adapt funding and operations to local needs.

- **Trusted local leadership can help align partners and sustain implementation**. In southwest Virginia, MEOC, which is the local Area Agency on Aging, played a pivotal role implementing the microtransit model. Effective champions help move services from concept to practice by building trust, aligning partners, and maintaining momentum over time. MEOC's program director brought long-standing experience and deep community ties to the role, which helped the organization collaborate with a wide range of stakeholders and respond to local needs.
- **Existing community relationships can support recruitment, coordination, and service integration**. MEOC was well positioned to lead the microtransit program, because it already provided trusted services to the community. Its relationships with faith-based organizations and other CBOs helped recruit drivers, engage volunteers, and coordinate services with existing transit routes. These partnerships helped integrate the microtransit model into the broader community rather than

creating a standalone service. States can also establish partnerships with local transit agencies, CBOs, and independent drivers to provide mileage reimbursement and improve access to transportation in a culturally responsive way in rural areas. NEMT mileage reimbursement creates the opportunity for family and community members to be involved with providing transportation needs and coordinate care for care recipients.

- **Pooled funding can reduce duplication and support efficient use of resources**. MEOC's microtransit model optimizes the resources by "pooling" transportation funding from multiple sources. This approach helps reduce duplication across services and allows resources to be used more efficiently. Flexible program structures and infrastructure can also help transportation programs respond to changing community needs, funding constraints, and operational challenges over time. Pooled funding enables MEOC to provide wraparound transportation services, including, for example, transportation to pharmacies and other community locations, in addition to Medicaid-covered NEMT services for medical appointments.

Key Considerations for States

The transportation models featured in this section offer flexibility for improving access in rural communities. States should also consider whether funding, service capacity, and local demand can support long-term sustainability.

- **Cost sustainability may be challenging without ongoing funding**. While microtransit can be more efficient than fixed-route transit in low-density areas, it is often more expensive per trip than traditional bus service in higher-demand corridors. As a result, microtransit often depends on ongoing public or grant funding, which can make long-term sustainability more challenging. For the NEMT mileage reimbursement model, costs can fluctuate based on fuel prices and travel distances, which can be difficult to plan for within Medicaid budgets.
- **Service capacity may be limited during periods of higher demand**. Some microtransit programs rely on smaller vehicles and shared rides, which limit the number of passengers who can be served at peak times. If demand increases beyond provider capacity, wait times can grow and ride quality can decline.
- **Vehicle accessibility is critical for populations with complex needs**. States considering implementing microtransit models may want to consider the diverse needs of all populations. For example, passenger vans for groups or private ride-share vehicles may not be able to accommodate the needs of some people with disabilities.[25] States may also want to engage disability advocates and relevant professionals to ensure that rural health investments and projects comply with Americans with Disabilities Act requirements.

- **Very low-density areas may limit cost-effectiveness**. In very sparsely populated communities, demand may be too low to achieve efficient ride pooling. This can increase per-rider costs and reduce the microtransit model's overall efficiency.
- **Some models could be administratively burdensome**. Implementing NEMT mileage reimbursement would require trips to be verified for travel distances and medical necessity to ensure quality and prevent fraud. States would need to implement oversight activities to prevent service misuse and ensure long-term sustainability. The application process may also create administrative burden for members or caregivers seeking reimbursement.

Looking Ahead

The federal Rural Health Transformation Program is bringing renewed attention to longstanding challenges facing rural communities and creating opportunities for states to address them. The models and examples presented in this brief offer rural-focused strategies for addressing the persistent access-to-care barriers that rural communities face, including provider shortages, limited funding, and geographic challenges that disproportionately impact populations with complex needs. By combining these approaches with new federal funding, states have an opportunity to strengthen rural health system capacity and help ensure that people with the most complex needs can access high-quality, timely care.

People with complex needs and advocates for their care can play a vital role in shaping the next generation of rural-focused programs. Their lived experiences provide critical insight into what works, what does not, and where gaps remain. By meaningfully engaging these voices in program design, decision-making, and evaluation, policymakers and practitioners can develop solutions that are more responsive to local needs and more feasible to sustain.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

ENDNOTES

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