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Pennsylvania Department of Human Services

HEALTH TRANSFORMATION (RHT) PROGRAM

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Pennsylvania Department of Health

Pennsylvania Department of Aging

Pennsylvania Department of Community & Economic Development

Pennsylvania Insurance Department

Pennsylvania Department of Drug and Alcohol Programs

LEAD: DEPARTMENT OF HUMAN SERVICES

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Acronym List

Acronym	Definition	Acronym	Definition
ADRC	Aging and Disability Resource Center	LIFE	Living Independence for the Elderly
AHEC	PA Area Health Education Center	MATP	Medical Assistance Transportation Program
API	Application programming interface	MCO	Managed-care organization
BHIP	Behavioral Health Integration Project	MFM	Maternal fetal medicine
CBOs	Community-based organizations	MHTMS	Mental health training management system
CEU	Continuing education units	MOUDS	Medication for opioid use disorders
CHCs	Community health centers	MRC	Medicaid Research Center
CHWs	Community health worker	NEMT	Non-emergency medical transportation
CINs	Clinically Integrated Networks	NOFO	Notice of funding opportunity
CMS	Centers for Medicare & Medicaid Services	OB	Obstetrics/Obstetrician
CoCM	Collaborative Care Model	P3N	Pennsylvania Patient and Provider Network
CPS	Certified peer specialists	PA	Pennsylvania
CRS	Certified recovery specialists	PACE	Program of All-Inclusive Care for the Elderly
DHS	PA Dept of Human Services	PACHC	PA Community Health Center
DPP	National Diabetes Prevention Program	PCPs	Primary care providers
DOH	PA Department of Health	PMPM	Per member per month
EDs	Emergency departments	PREP	Partnerships for Regional Economic Performance
EHR	Electronic health record	PSAPs	Public safety answering points
EMS	Emergency medical services	QIP	Quality Investment Program
FHIR	Fast Healthcare Interoperability Resources	RBHC	Remote Behavioral Health Consultation
HAP	The Hospital and Healthsystem Association of PA	RCC	Rural Care Collaboratives
HIE	Health information exchange	RHTP	Rural Health Transformation Plan
HRSA	Health Resources and Services Administration	SUD	Substance use disorder
HTE	Health Tech Ecosystem	TiPS	Telephonic Psychiatric Services
IUP	Indiana University of PA	USCDI (v3)	United States Core Data for Interoperability
L&D	Labor and delivery	WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Rural Health Needs and Target Population

Pennsylvania (PA) is home to the third-largest rural population in the nation[1], with nearly 1 in 5 (19%)[2] residents living in Health Resources and Services Administration (HRSA)-defined rural areas. These communities face substantial health challenges driven by geographic isolation, workforce shortages, hospital and service line closures, and limited access to specialty care. Rural communities experience higher rates of chronic disease, maternal and infant health challenges, behavioral health needs, and aging-related conditions that require coordinated solutions. Because of these challenges, the Shapiro Administration, upon taking office, began to address these issues across state agencies through statewide rural health convenings and strategic planning summits focused on maternal health, aging, behavioral health, Emergency Medical Services (EMS) and transportation, the health care workforce, and digital infrastructure. This combination of urgent need, proven capacity for change, and robust public input makes Pennsylvania well positioned to transform rural health, improve outcomes, and create sustainable models of care that strengthen the vitality of rural communities.

Population Health:

Pennsylvania's rural population is aging and in poorer health than their urban counterparts. Higher rates of major health conditions such as coronary heart disease (9%), obesity (36%), and diabetes (12%)[3] underscore the critical need for rural health investment as these health indicators are key to community vitality. While rural overdose rates are lower, suicide deaths in rural Pennsylvania are significantly higher than in urban areas (15 vs 12 per 100k)[4]. Inadequate prenatal care (8% of pregnancies in rural vs. 6% in urban areas)[5], reflects the lack of local maternal health providers and significant transportation challenges. Over 300,000 Pennsylvanians, 13% of the rural population, live more than 30 minutes from the nearest hospital and 32% are more than 30 minutes to the closest labor and delivery unit.[6]

Pennsylvania Rural Population Snapshot

- 2.4 million rural residents in HRSA areas
- 52 of 67 counties in Appalachian region
- Lower educational attainment, higher poverty (13.3%), higher unemployment rates (5.5%)
- Older (21% over age 65) with more than 20% with a disability

Rural Health Care

Although Pennsylvania is home to world-class health systems, rural access to medical and dental care remains limited. Despite serving nearly 20% of the population, only 10% of Pennsylvania's physicians, 6% of dentists, and 10% of the state's hospital beds are in rural counties.[7,8] Between 2020 and 2023, eight acute care hospitals closed, and nearly half of rural hospitals operated at a loss in 2023.[9] These trends threaten the sustainability of rural health infrastructure. Three rural hospitals closed their labor and delivery units in just the past year,[10] creating new and larger maternity care deserts.

Target Counties and Populations

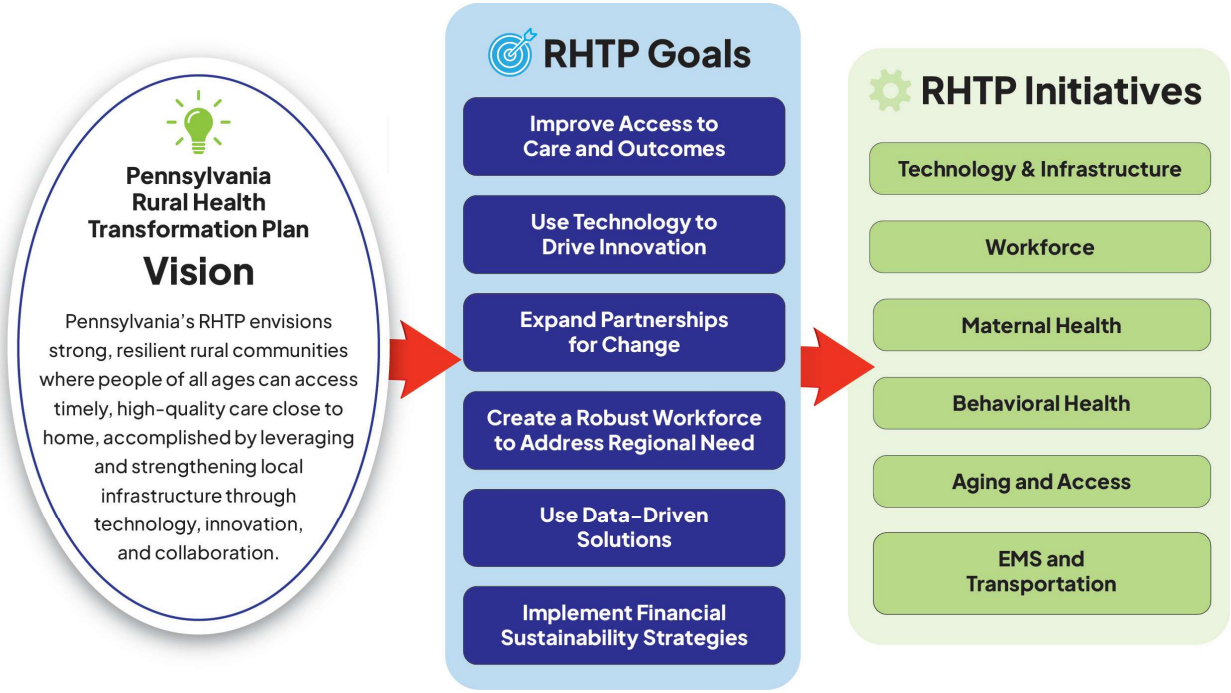
The Rural Health Transformation Plan (RHTP) is designed to deliver direct supports to residents, reinforce community anchors – including hospitals, clinics, and schools – and cultivate collaboration with local businesses that promote rural well-being. Pennsylvania classifies counties by population size (class 1-8).[11] This RHTP will focus on all counties class 6-8 and counties 2a-5 containing HRSA-defined rural census tracts. Target populations include older

adults, individuals with disabilities, veterans, pregnant women, residents with behavioral health and chronic disease needs and preventive initiatives to keep children and adults healthy.

Rural Health Transformation Plan: Goals and Strategies

Vision: *Pennsylvania's Rural Health Transformation Plan envisions strong, resilient rural communities where people of all ages can access timely, high-quality care close to home, accomplished by leveraging and strengthening local infrastructure through technology, innovation, and collaboration.*

Figure 1: PA RHTP

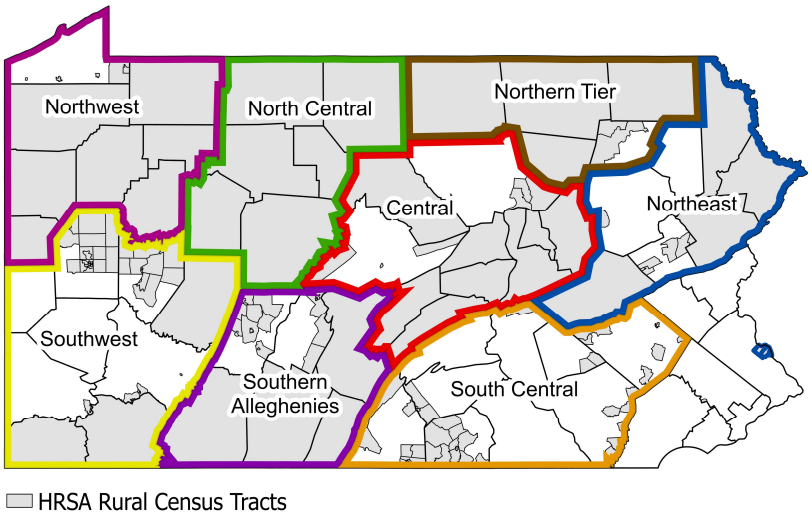


Pennsylvania's RHTP is informed by extensive stakeholder input over the past two years, including governor's roundtables, listening sessions, regional rural health summits, and more than 300 public responses and comments. The plan establishes a rural health framework for reform that emphasizes access, outcomes, workforce development, technology, innovation, and sustainability. The plan focuses on investments that create lasting infrastructure, strategic partnerships, and human capital.

Pennsylvania's rural health transformation strategy is grounded in a balance of statewide coordination and regional leadership and collaboration. Pennsylvania's "Health Hub" state agencies (Human Services, Health, Aging, Insurance, Drug and Alcohol Programs), and other partner agencies will establish clear strategic priorities focusing on access, workforce, maternal health, aging, behavioral health, EMS and infrastructure. Pennsylvania will leverage statewide technical expertise, evaluation, and financial oversight and support. Strong regional rural care collaboratives will be composed of a roster of regional stakeholders that prioritize local needs, develop effective local sustainable solutions, and leverage existing resources and assets.

Pennsylvania will leverage established regional entities that coordinate regional economic development. These Partnerships for Regional Economic Performance (PREP) organizations are long-standing, quasi-governmental organizations that convene regional stakeholders, administer federal and state grants, collect local data, report outcomes, and catalyze public and private partnerships for regional economic development. They bring established governance structures, convening power, and a track record of successful cross-sector collaboration. PREPs (Figure 2) will convene regional stakeholders to create Rural Care Collaboratives (RCCs) to align initiatives with regional economic planning and development – making the RHTP investments sustainable and promoting long-term partnerships.

Figure 2: PREP Regions



Combining statewide vision with regional implementation enables Pennsylvania to move quickly to stabilize access in the near term while building collaborative, sustainable systems in rural communities over time. RCCs will include health care providers directly delivering care in that region alongside other key local stakeholders such as local officials, business leaders, patients, educational institutions, foundations, and community-based organizations (CBOs). Local hospital leadership will participate in the RCC, even if that hospital is part of a larger system, to maximize local impact. RCCs will have a statewide steering committee to allow for collaboration and learning communities across regions and coordination of cross-regional projects (e.g., access to highly specialized care). With statewide support, and access to technical experts, RCCs will be charged with identifying and implementing key initiatives and prioritizing investments and activities based on meeting their local rural health needs. As such, not every RCC will implement all the activities noted in the narrative below.

Recognizing the urgency of challenges rural communities face today, Pennsylvania will launch a short-term Rapid Response Access Stabilization Program in Years 1 and 2, subject to permissible use of funds. Pennsylvania has clear statutory authority to administer the Rural Health Transformation Program through Act 45 of 2025, Article II-H, which establishes the program within the Department of Human Services and authorizes the Department to distribute funding, oversee implementation, and monitor compliance with State and Federal requirements. If any portion of RHTP funding is used for short-term stabilization activities, DHS will apply this statutory authority to ensure that participating facilities are accountable for measurable outcomes consistent with the federally approved application. Under Act 45, DHS may allocate funding to qualified entities, monitor and audit their performance, and withhold or recover funds for noncompliance. DHS will use these oversight tools, together with CMS performance and

reporting requirements, to ensure that any stabilization funding is tied to defined deliverables and produces measurable improvements in rural health system performance. Administered directly by the Commonwealth, this program will target key near-term investments such as preserving essential hospital and EMS capacity and making foundational investments in technology and workforce to catalyze RHTP initiatives.

As RCCs mature, they will take the lead in setting priorities and guiding implementation of statewide initiatives in their regions. This dual structure, statewide vision with regional implementation ensures Pennsylvania can move quickly to stabilize access in the near term, while building local, collaborative, sustainable systems in rural regions to accomplish key goals.

1. **Improve Access to Care and Outcomes:** Expansion of maternity care, modernization of EMS systems, investment in non-emergency transportation, and deployment of mobile health clinics and digital health infrastructure. Across initiatives, Pennsylvania expects to improve key health outcomes such as prevention and treatment of chronic disease, use of the 988-suicide prevention line, substance use disorder treatment engagement and collaborative care arrangements for subspecialty care. Measures are further described in the Metrics and Evaluation Plan section.
2. **Use Technology to Drive Innovation:** Invest in tailored, sustainable community telehealth infrastructure, digital solutions to improve primary and specialty care access, technology enabled prevention and chronic disease management strategies, health information technology interoperability through the Pennsylvania Patient and Provider Network (P3N) and AI-enabled tools to relieve workforce burden.
3. **Expand Partnerships for Change:** RCCs in each of the eight PREP regions[12] will build and sustain regional partnerships. A funding allocation formula will be used for regions (see budget narrative) based on the size of the rural population in HRSA-defined rural census tracts and other regional measures adapted from the Centers for Medicare and Medicaid Services (CMS) Notice of Funding Opportunity (NOFO) for this RHTP opportunity (i.e., rural facility and population score factors).
4. **Create a Robust Workforce to Address Regional Need:** Workforce strategies include support for training rural medical, dental, pharmacy, and nursing students, including clinical rotations, residencies, and rural fellowships (e.g. dental residencies, family medicine fellowships in OB and psychiatry). The RHTP will support these strategies through workforce pipeline and training infrastructure (clinical sites, staff, short-term housing, and faculty educational time). RHTP funds will provide educational awards for trainees who meet financial eligibility standards, tied to 5-year service commitments. We will also support the development of training programs for new models of *credentialed* providers that can extend the impact of clinical teams (e.g. dental hygienists, midwives, nurse aides, doulas, and a new Primary Care Medic[13] model). Recruitment for all levels of the health care workforce will prioritize students born and raised in rural areas, while retention will be supported through service obligations.
5. **Use Data-Driven Solutions:** Modernize statewide health data infrastructure in alignment with the CMS Health Tech Ecosystem (HTE) model and adopt technology solutions for population health management. RCCs will also focus on developing regional data tracking in partnership with our evaluation partner to measure program key performance indicators.
6. **Implement Financial Sustainability Strategies:** This RHTP is built on lessons learned from the Center for Medicare and Medicaid Innovation (CMMI) PA Rural Health Model,[14,15]

where financial incentives alone did not lead to delivery system transformation or financial stability. The PA Rural Health Redesign Center is funded to convene payers and providers to develop new alternative payment methodologies that may be proposed as a "Next Generation" Rural Health Model to help sustain rural health facilities. Because that is an ongoing funded process, it is not included in this proposal, which focuses on regional delivery system reform and sustainability. In addition, Pennsylvania's Department of Human Services (DHS) has an overarching strategy described in "Attachment A. Value Based Purchasing," focused on alternative payment models. Many of the initiatives outlined in our proposal are focused on bringing care closer to home using technology and strengthening sustainable health care partnerships which will yield more success in future alternative payment models.

Pennsylvania has taken major actions to identify causes (i.e., cause identification) of financial distress and prevent the closure of rural hospitals. The state makes targeted direct investments in rural hospitals through state funds appropriated specifically for supplemental fee for service payments to designated rural and critical access hospitals that meet defined criteria. Despite these investments, over half of Pennsylvania's rural hospitals have negative operating margins and the rest have margins close to zero.[16] Many rural hospitals have high fixed costs and low patient volumes worsened by local residents bypassing hospitals – the bypass rate for elective surgery in rural Pennsylvania averaged nearly 60% between 2016 and 2022 with a steady increase over time.[17] We believe that the RHTP will stabilize rural hospitals through support for workforce apprenticeship programs, rural residencies, digital technology investments, stronger regional collaboration with local community health centers (CHCs), CBOs, and formal collaborative care and flexible financial arrangements for subspecialty care with tertiary care hospitals.

Program Key Performance Objectives

By 2031, the RHTP will deliver a sustainable, digitally connected, and community-anchored rural health system that improves access, strengthens the workforce, modernizes infrastructure, and addresses some of the root causes of poor health. Success will be measured through improvements in access, digital infrastructure, workforce capacity, care quality, population health, and system sustainability across our eight regions (see Table 1).

Table 1: Key Objectives

Key Objective	Baseline	Target	Source
Access to Care	% rural residents able to get a routine primary care appointment within two weeks and urgent appointment within one week. (TBD)	> 85% can get a routine PC appointment within 4 weeks and urgent appointment within 1 week	Appointment access via secret shopper studies
Digital Connectivity and Telehealth	% of rural hospitals and clinics with telehealth and broadband (TBD)	>85% of rural hospitals and clinics with broadband and telehealth functionality >50% rural hospitals and clinics connected via FHIR	Qualitative interviews and quantitative surveys to baseline needs, current system capacity, and measure progress over time

Key Objective	Baseline	Target	Source
	% with FHIR adoption and interoperable systems, record sharing (TBD)	and actively sharing records	
Workforce Adequacy	Rural hospital vacancy rates: PAs and MAs (23%), RNs (21%), NPs (18%) Nurse Anesthetists (29.6%). Number of rural training programs such as medical rotations, dental residencies, partnerships with FQHCs and rural hospitals (TBD)	Reduce rural hospital vacancy rates by 10% for key direct care roles Three new rural training programs.	DOH Office of Primary Care; Labor & Industry stats, HAP hospital survey, PACHC, RCC reports. New collection by RCCs; Accreditation bodies.
System Sustainability	% rural hospitals partnering with local CHCs (TBD)	> 60% partnered with rural CHCs for specialty care	PHC4 data HAP and PACHC data PA Navigate data
Health Outcomes	7.9% of pregnant women living in rural areas with inadequate prenatal care	20% reduction of pregnant women living in rural areas with inadequate prenatal care	Dept of Health – health statistics
Rural Care Collaboratives (RCCs)	Few formal partnerships or collaborative care arrangements, no regional health planning	Eight RCCs engaged in regional planning, partnerships, and collaborative care	Surveys and key informant interviews conducted by evaluation team

Strategic Goals Alignment: Table 1: CMS Goal Alignment in Attachment B: Initiative/Activity Summary Tables summarize the initiatives and activities planned and alignment with each of the five CMS RHTP strategic goals. Across all initiatives, Pennsylvania plans to address all five strategic goals.

Legislative or Regulatory Action: Pennsylvania state policy actions, policy baselines, and data driven factors are summarized in Table 2.

Table 2: Pennsylvania State Policy Actions and Data Driven Factors

Policy	State Commitment and/or Policy Baseline
C.3. Certificate of Need	Current Cicero Institute Score = 0 (100 points)
D.2. Licensure Compacts	Physicians - Yes (100 points) Nurses - Yes (100 points) EMS - Yes (100 points) Psychology - Yes (100 points) Physician Assistants – Proposed legislation - SB 1051, HB 1961 (50 points); **Pennsylvania commits to policy change (expected 2026).**
D.3. Scope of Practice	Physician Assistants (0 points) Nurse Practitioners (50 points) Pharmacists (0 points) Dental Hygienists (50 points)
E.3. Short-term, limited duration insurance	STLDI insurance plans not restricted in PA (100 points)

Policy	State Commitment and/or Policy Baseline
F.1. Remote care services	Medicaid payment for live video – Yes (100 points) Medicaid payment for Store and Forward – No Medicaid payment for Remote Patient Monitoring – Yes (100 points) In-State licensing requirement exception – Yes (100 points) Telehealth license/registration process – Yes (100 points)
Data-Driven Factor	**Result**
A.2. Certified Community Behavioral Health Clinics	Eight clinics (see Attachment C. CCBHC List)
A.7. Number of hospitals that received a Medicaid DSH payment	151 hospitals, 68% of PA's hospitals (see Attachment D: Medicaid DSH Payments)
E.2. Individuals dually eligible for Medicare and Medicaid	Duals contact - Yes Integrated plans offered - Yes Integrated plan enrollment = 54%
F.2. Data infrastructure	T-MSIS state grade = 66.7

Technology and Infrastructure Initiative

This transformation strategy emphasizes strategic capital investments in digital technology that directly improve patient care by enabling innovative delivery models and stronger connections between health care and community resources. These upgrades foster prevention, address risk factors for chronic disease, enhance care coordination across providers, and extend the capacity of front-line rural providers while relieving workforce burden. By building shared, interoperable digital infrastructure, the investments create the foundation for sustainable, long-term transformation of rural communities. This will build capacity for providers to participate in value-based care and alternative payment models that incentivize better health outcomes and empower providers to manage risk sustainably for population health impact.

Data Innovation and Information Exchange to Strengthen Pennsylvania's Care Network

Pennsylvania will modernize our statewide health data infrastructure in alignment with the CMS HTE model, a national framework designed to enable secure, consent-based, API-driven data exchange across payers, providers, and patients. Pennsylvania's initiative will transform our existing health information exchange network, the P3N, into a CMS-Aligned Network, ensuring compliance with federal interoperability mandates and creating a foundation for all future health transformation efforts. Data interoperability and digital services modernization are pillars of our approach to transformation.

Under the HTE model, Pennsylvania will expand and build three core statewide services: (1) an Identity and Trust Service that extends Keystone Login to a CMS-approved IAL2/AAL2 level, ensuring verified digital identities for all Fast Healthcare Interoperability Resources (FHIR)-based exchanges; (2) a FHIR Endpoint Directory synchronized with CMS's National Directory of Healthcare, enabling real-time discovery and connection between payers, providers, and digital health applications; and (3) an Authorization and Audit Utility, modeled after CMS's Developer Portal, to issue secure access tokens, manage consent, and maintain auditable transaction logs.

These shared services will allow Pennsylvania to "build once, use many times," thereby reducing redundant integrations, supporting AI-enabled care coordination, and establishing a secure digital backbone that every public and private health program in the state can rely on. By modernizing the P3N framework to fully participate in the CMS HTE, Pennsylvania will enhance accountability for value-based outcomes and position itself as a national leader in AI-ready health interoperability.

By using a phased, standards-driven methodology anchored in CMS's HTE, Pennsylvania will be able to meet the needs of our care network now and in the future. We will begin with a Discovery & Current State Assessment to inventory provider systems, electronic health records (EHRs), HIOs, payer platforms, and digital applications across the state for FHIR readiness, data models such as United States Core Data for Interoperability (USCDI v3) or beyond, consent frameworks, identity management, and connectivity gaps. While many systems are FHIR-capable in isolation, they remain disconnected, under-governed, and lacking shared services or unified identity. Following discovery, in a design and integration phase, we will align Pennsylvania's infrastructure with CMS HTE categories, using the following:

- CMS Aligned Network: We will require the CMS Interoperability Framework, incorporating clinical and claims data exchange, responding to requests from patients, providers, and payers, and demonstrating compliance throughout.
- EHR & Providers: We will require participating EHRs and provider systems to expose both structured data (FHIR) and unstructured clinical artifacts (e.g. notes, imaging, attachments) in accordance with USCDI v3 (or later). Provider workflows must support near real-time event notifications (e.g. outpatient, inpatient) to the aligned network (within 24 hours).
- Payers: We will engage public and private payers to expose claims data via Patient Access Application programming interfaces (APIs) (as mandated under CMS) and require them to provision claims access to the CMS Aligned Network upon patient or provider request.
- Patient-Facing Apps: We will encourage adoption of secure, consent–based apps that verify identity (via IAL2/AAL2 or equivalent mechanisms), integrate with CMS Aligned Networks, and support use cases such as "Kill the Clipboard" (patient at check-in sharing demographic and history via FHIR) or Conversational AI tools.

Implementation will proceed through pilot hubs, selecting a region or subset of providers (e.g. rural hospitals, CHC networks, behavioral health systems) to test integration with identity services, the FHIR directory, and the authorization/audit hub. These pilots will validate connectivity, governance, consent flows, API performance, event-notification timing, and patient app onboarding. We will use findings to iteratively refine the architecture, policies, and technical standards before scaling statewide. This approach ensures Pennsylvania's infrastructure is fully aligned with CMS mandates and priorities, embraces the full spectrum of our health tech ecosystem roles (providers, payers, networks, apps), and positions the Commonwealth as a leader in health data interoperability and digital innovation. Pennsylvania also has an opportunity to pursue three implementation strategies:

- Extend P3N: Pennsylvania's Health Information Exchanges (HIEs) are well-positioned to serve as operational partners. Each would enable FHIR APIs for quality and clinical data exchange, integrate with statewide identity and authorization services, and demonstrate live consented FHIR transactions between health plans and providers as proof of readiness. These activities can be supported through updated participation agreements or funded contracts.

- Clinically Integrated Networks (CINs): Rather than mandating participation, CINs affiliated with managed care organizations (MCOs) will be tasked with operationalizing the statewide network within all beneficiaries served by their clinically integrated networks. MCOs will align their FHIR endpoints and Provider Access APIs (required by CMS-0057 by January 1, 2027) with Pennsylvania's standards. This creates a unified ecosystem that launches with existing Medicaid, Medicare Advantage, and ACA payer mandates, but allows for all payers to access the same backbone for value-based care programs and AI-enabled patient engagement.
- Point-to-Point Demonstrations: Pennsylvania will facilitate at least one demonstration project partnering with an AI-powered health application. This will showcase how to seamlessly aggregate clinical and claims data through secure FHIR endpoints for purposes such as conversational AI apps, digital check-in tools, or chronic disease prevention services. This transformation strategy emphasizes strategic capital investments in digital technology that directly improve patient care by enabling innovative delivery models and stronger connections between health care and community resources. These upgrades foster prevention, enable improvements in chronic disease management, and enhance care coordination across providers. By building shared infrastructure and collaboration, the investments create the foundation for sustainable, long-term transformation in rural communities. It builds capacity for providers to participate in value-based care and alternative payment models that incentivize better health outcomes and empowers providers to manage risk sustainably for population health impact.

In alignment with these goals, Pennsylvania will support adoption and modernization of EHRs among high-need providers in behavioral health, intellectual disability and autism, long-term care, and CHCs to facilitate interconnectivity through P3N.

Digital Infrastructure and Next-Generation AI to Improve Access, Quality and Experience

Pennsylvania will: a) Expand digital infrastructure to bring specialty expertise directly to the bedside while empowering peer-to-peer consultation and collaboration across the care team; b) Expand models of workforce relief such as virtual nursing and other technology-enabled solutions; and; c) Ensure that rural providers benefit from rapid advances in AI and software platforms to transform care and meet the needs of frontline health care providers.

Digital infrastructure offers a powerful lever to address patient access and workforce strain. Tele-specialty care models allow specialists such as a neurologist, psychiatrist, or obstetrician to be virtually present at the patient's bedside, providing timely expertise that can avoid unnecessary transfers and improve outcomes.[18,19] Virtual nursing models can relieve bedside nurse of repetitive tasks like admissions, discharges, documentation, and patient education, directly addressing burnout and outcomes.[20] Secure peer-to peer collaboration tools and eConsult platforms allow rural providers to consult with specialists asynchronously, expanding local capacity and strengthening provider collaboration and capabilities.[21,22] These strategies are important for increasing access, decreasing the need for in-person referrals, and integrating care in primary care settings, particularly in communities where there are geographic barriers to accessing specialty care.[23] Other software-driven models focused on chronic care management linked to a remote workforce (e.g., 24/7 nurse lines) can supplement frontline workforce. Promising models have been deployed by the Hospital and Healthsystem Association of

Pennsylvania in pilot hospitals with positive preliminary results – better outcomes achieved through technology and innovative staffing.

Emerging AI-enabled tools such as ambient clinical documentation, predictive analytics for patient deterioration, and intelligent workflow support improved efficiency, accuracy, and staff satisfaction. Early evidence on the implementation of ambient AI demonstrates large reductions in provider burnout – a recent study at two large academic medical centers demonstrated a more than 20% reduction in burnout.[24] However, rural hospitals are at a disadvantage, lacking the resources and internal capacity to evaluate, implement, and manage AI-enabled tools independently.[25] Other AI-enabled tools focused on population health management – specifically chronic disease management and prevention – have become more widespread and show great promise in risk stratifying populations for intervention.[26] Importantly, there are proven examples that demonstrate this vision is achievable:

- The University of Colorado's Virtual Health Center[27] serves as a hub for tele-ICU, virtual nursing, and specialty consults, connecting 12 hospitals across Colorado to real-time expertise. In Pennsylvania, the Guthrie Clinic's Pulse Center has pioneered a similar approach, using centralized digital monitoring and support to improve care coordination, ease staff workload, and achieve reductions in nurse turnover and hospital costs.[28]
- The Permanente Medical Group implemented ambient AI and demonstrated large reductions in workload through reduced documentation hours, a driver of provider burnout.[29]

What is missing for Pennsylvania's broader rural provider network is the capital, technical assistance, and organizational structure to scale these innovations. We propose a Regional Hub Model supported by shared statewide technical expertise. This Regional Hub Model will be nested within RCCs. Each region will identify a hub organization to work locally and utilize statewide and national knowledge and expertise.

- Regional Hubs will be anchored by health systems, health information exchanges, or other organizations positioned to lead regional digital technology and AI adoption. The hubs will provide direct support to local hospitals and providers, including technical assistance, workflow redesign, staff training, and mentoring.
- Spoke facilities (rural hospitals, CHCs, clinics, and long-term care providers) will gain access to vetted digital tools, implementation support, and virtual care models and in collaboration with the hub, determine the suitability of technology solutions for rural facilities.
- Shared statewide technical assistance resources will provide centralized vendor vetting, training, and evaluation, improving efficiency and consistency.

This approach balances local leadership with shared statewide support and builds on lessons from recent AI local capacity building initiatives and the Regional Extension Center model of the federal HITECH Act, which accelerated adoption of EHRs.[30,31] HITECH demonstrated that small and rural providers need more than just financial support to adopt complex digital tools. Pennsylvania will direct funds to three main categories:

1. Capital investments: Software and telehealth equipment (e.g., carts, tablets or retrofitted televisions).
2. Implementation and training: Regional hub staffing (e.g., workflow redesign, on-the-ground technical assistance) and statewide technical assistance (technology, evaluation, contracts).

3. Innovation fund: Pilot and early implementation costs for provider adoption.

Mobile and Digital Health That Reaches Every Community

Rural and hard-to-reach communities face persistent barriers like isolation, limited broadband, and provider shortages, restricting access to even routine primary care. Expanding digital health technology offers a powerful solution, but no single strategy will work in every community. A hybrid regional approach ensures flexibility by combining mobile health units, community-based telehealth hubs, digital kiosks, and broadband access points. This model allows regions to tailor a mix of digital health strategies based on their local geography, existing assets, and population needs, while benefiting from shared infrastructure and technical assistance at the state level.

Plan and Implement Regionally: Each RCC will designate a regional hub entity to lead planning, engage stakeholders, and prioritize resources, while a central state team assists with technology standards, compliance, workforce training, and data reporting. This ensures solutions are tailored to local, rural providers but delivered with consistency and cost efficiency without imposing centralized governance. In most cases, this will be the same entity focused on building digital infrastructure and AI capacity among rural health care providers (described above). The hub will prioritize investments to deploy mobile units, kiosks, telehealth hubs, and patient-level hotspot access that avoids duplication and maximizes reach by building on existing community assets.

Deploy Mobile Health Units with Telehealth Capacity: Mobile units will be deployed to communities geographically isolated from health care facilities. Mobile units will be outfitted with telehealth equipment (with broadband connectivity) that links to specialty centers, portable diagnostic equipment, and nurses or other appropriate health professionals and focuses on prioritized regional needs (e.g., maternal health, dental care, chronic care management, etc.). Units will rotate on a fixed schedule to create predictable access points for communities. These strategies have been demonstrated to eliminate critical logistical barriers for populations with limited access, decrease wait times, increase use of preventive and chronic disease focused care, and serve as an important resource during local emergencies (i.e., natural disasters).[32,33] There is a "business case" for mobile units that creates both upstream and downstream sources of revenue for sponsoring health care organizations. Start-up grant funding will help organizations overcome financial barriers prior to achieving a sustainable business model.[34]

Create A Community Telehealth Hub: Each region will identify trusted community locations such as libraries or local public health centers that can accommodate a telehealth access hub that assures privacy, broadband access, secure connectivity, and an onsite navigator to assist residents. These hubs will be uniquely valuable to residents who lack reliable home broadband access and/or digital devices. Regions will also consider opportunities to install self-service kiosks in high-traffic sites such as grocery stores and pharmacies that would include basic diagnostic tools (e.g., blood pressure cuffs) and user-friendly digital interfaces. Pharmacies offer a unique opportunity to create new access points in co-located spaces with pharmacists that may facilitate direct improvements in chronic disease management.[35] Regions will also consider patient-level hotspot access for remote patient monitoring programs as well as patient-facing app technology that links community members to health care resources. Community telehealth access can increase access to care, improve health outcomes, and address geographic barriers.[36]

Pennsylvania Rural Health Transformation Plan – Project Narrative

Community Wellness Hubs to Improve Health and Catalyze Collaboration

Community Wellness Hubs will anchor regional health, vitality, whole person care, and local connection across rural Pennsylvania. Rooted in trusted local organizations and supported by statewide infrastructure, these hubs coordinate access to resources, wellness activities, and healthier living close to home, while strengthening links between health care providers and community resources. Building on PA Navigate[37], Pennsylvania's statewide closed-loop referral platform, the hubs expand its reach and functionality and advance RHTP goals: strengthen rural health, expand prevention and wellness, and support residents to thrive locally.

As regional conveners and connectors, Community Wellness Hubs will apply lessons from proven models: strong backbone organizations, inclusive governance, and centralized tech and administrative functions. Key functions include:

- Wellness Navigation and Connection: Act as a trusted organization where residents can find support with nutritious food access, transportation, child and family supports, workforce programs, and wellness activities. Use PA Navigate to send referrals from hospitals and clinics to community-based organizations for further support, ensuring a closed-loop process that confirms connections were successful and reports back outcomes in accessing programs and resources. The Maternal Health Hub model described in the next initiative may be nested within a regional Community Wellness Hub.
- Wellness Promotion and Prevention: Coordinate evidence-based programs that advance preventive screenings, nutrition, physical activity, maternal and family health, behavioral health, and chronic disease self-management. Expand access to evidence-based programs such as cancer screenings[38], National Diabetes Prevention Program (DPP)[39], and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)[40].
- Integration with Health Care Providers: Serve as a bridge between health care and community life, ensuring that physicians and hospitals can connect people to practical supports that help them stay well or recover. Provide feedback to clinicians on referral completion, closing the loop between medical care and community wellness.
- Regional Collaboration and Capacity Building: Convene a network of CBOs, hospitals, public health centers, and payers to align resources and strengthen regional wellness strategies. Provide training and technical support so that smaller community partners and additional resources such as job training programs can confidently use PA Navigate and expand their ability to serve residents. Support contracting and payment models for CBOs.
- Data, Reporting, and Accountability: Track participation in wellness programs, confirmed connections through PA Navigate, and participation in prevention and wellness programs.

The Community Wellness Hub model directly supports the RHTP's mission to transform health in rural communities:

1. **Prevention:** Locally embedded hubs promote nutrition education, physical activity programs, maternal and child wellness, and behavioral health supports that reduce the onset of chronic disease and promote long-term health.
2. **Chronic Disease Management:** Hubs can serve as regional accelerators of evidence-based programs to address conditions like heart disease and cancer.
3. **Nutrition:** Hubs can serve as a foundation for "food is medicine" infrastructure, linking to fresh food and produce prescription programs and local food providers in collaboration with health care providers, public health centers, and insurers.

4. **Strengthening Local Systems:** Aligning health care providers, payers, and community partners through PA Navigate, hubs reduce fragmentation, improve accountability, and strengthen the foundation for thriving communities.

Table 3 and 4 summarize our Technology and Infrastructure Initiative alignment with RHTP goals and outcome metrics.

Table 3: Technology and Infrastructure Initiative Summary

RHTP Element	Description
Main strategic goal:	Tech Innovation
Use of funds:	A, B, D, F, H, and K.
Technical score factors:	B.1, B.2, C.1, F.1, F.2, and F.3.
Key stakeholders:	Patients, hospitals, CHCs, long term care facilities, behavioral health providers, home health agencies, HIOs, community-based organizations (e.g., libraries, YMCA, faith-based organizations), pharmacies and pharmacists, broadband offices, community action agencies, and health care payers. Potential hubs/anchors (e.g., regional HIOs, academic medical centers, health systems); Organizations with AI/IT expertise.
Impacted counties:	All rural counties (see Attachment G: PA RHTP Eligible Rural Counties) will be included in an RCC. Each RCC will have a Technology and Infrastructure initiative but will align activities to regional need.
Estimated required funding	$241.5 M

Table 4: Infrastructure Initiative Outcomes

Metric and Metric Type	Rationale	Baseline and proposed goal by end of grant period	Geography	Source
Program adoption & technology adoption: % with FHIR adoption and interoperable systems, record sharing (TBD)	HIE participation improves patient care coordination and reduces costs.[41,42]	Baseline: TBD, 77% of rural hospitals participate in P3N (2025); FHIR baseline TBD. Goal: >50% rural hospitals and clinics P3N connected via FHIR and actively sharing records.	county	Existing data (P3N). Updated annually.
Access: # of rural residents more than 30-minute drive to the closest health facility, including digital and mobile access points	Greater distance from health facilities lowers health care utilization.[43] Community mobile/tele-health strategies decrease distance.	Baseline: 331,624 (2024) Goal: <250,000	PREP Region	Existing data (CMS facility) & new collection (RCCs). Updated annually.
Program adoption & technology use: % of rural facilities adopting at least one community facing and one inward facing digital health strategy	Digital health strategies like telehealth improve outcomes for patients and increase staff retention.[44]	Baseline: TBD Goal: 80% of CHC and hospital facilities have adopted at least one digital health strategy	PREP Region	New collection by RCCs. Updated annually.

Metric and Metric Type	Rationale	Baseline and proposed goal by end of grant period	Geography	Source
Program adoption & technology use: # of referrals completed through PA Navigate	Electronic community referral systems provide connections to prevention and wellness supports that improve patient health and wellbeing.[45]	Baseline: 503,934 searches on PA Navigate in rural areas (6-month period in 2025). Goal:775,000 rural searches on PA Navigate in a 6-month period.	PREP region	Existing data (PA Navigate) Updated annually.

Maternal Health Initiative

Pennsylvania's maternal health crisis has been marked by 38 closures of labor and delivery units since 2005, and OB/GYN shortages that leave nearly half of rural women more than 30 minutes from the nearest birthing hospital.[46] According to the Pennsylvania and Philadelphia Maternal Mortality Review Committee Reports, in 2021, 42 women died from pregnancy-related causes, nearly all preventable, with behavioral health conditions (including overdose and suicide) as the leading drivers of mortality.[47]

Comprehensive Maternal Health Hubs

Pennsylvania will create regional rural Maternal Health Hubs to serve as a centralized access point for comprehensive, coordinated maternity care. Each hub will link hospitals, community providers, behavioral health partners, and CBOs to ensure that every pregnant and postpartum woman has access to a full spectrum of services. The Maternal Health Hubs will function as regional coordination and service centers that connect patients to care, support providers and drive continuous improvement in the maternal health system. Rather than duplicating existing care, the hubs will augment and integrate the work of hospitals, obstetric and primary care practices, behavioral health providers, and CBOs by centralizing functions that are difficult to sustain at the practice or hospital level. They will create regional efficiencies in care delivery and foster regional clinical integration. Hubs will include the following core functions:

- Provide comprehensive care management and navigation for patients from preconception through 12 months postpartum and for babies during their first year of life. Hubs will recruit and manage multi-disciplinary teams based on regional needs (e.g., nurse care managers, doulas, community health workers, peer recovery specialists, social workers, behavioral health coordinators). Teams will facilitate access to face-to-face, telemedicine, and community-based visits for obstetrical, mental health, oral health, substance use, and primary and specialty care prior to, during, and after pregnancy. PA Navigate will be used to ensure closed-loop referrals for community resources to address key health-related social needs.
- Integrate behavioral health by embedding behavioral health screening and referral into prenatal and postpartum care and coordinating tele-behavioral health, mobile outreach, and peer-to-peer perinatal consultation through DHS' Perinatal Telephonic Psychiatric Services (TiPS) line.
- Lead regional quality improvement and maternal health innovation, such as remote patient monitoring programs. This includes providing technical assistance to area providers on workflow redesign, data tracking, and patient engagement and participation with the statewide Perinatal Quality Collaborative. The shared infrastructure will facilitate regionalization of programs such as remote monitoring.

- Develop regional infrastructure strategies for maternal health focused on building the maternal health workforce: OBs and Family Physicians trained in OB (see Attachment F: Workforce Examples), along with midwives, doulas, etc., access to adequate pre-and postnatal risk screening, labor and delivery, birth centers, and digital and mobile health technology deployment. The hub model is valuable in rural areas, where patients often face long travel distances, workforce shortages, and fragmented care systems. The hub will augment the capacity of existing providers by centralizing key activities and expanding services where gaps exist.

The Maternal Health Hubs will be organized by the RCCs to address each region's unique needs and expand access to comprehensive prenatal and postpartum care. Each RCC will identify local priorities and determine how funding is allocated, ensuring that investments reflect regional challenges and opportunities. Each hub will maintain a physical location that will serve the full region, although care and coordination will occur virtually or by telephone. In some regions, the Maternal Health Hub may be co-located or integrated with the Community Wellness Hub to promote efficiency and continuity of services.

Maternal Health Hubs will initially be funded through per-member-per-month (PMPM) payment to support essential services not otherwise reimbursable from other sources. As hubs demonstrate measurable improvements in access, quality and outcomes, they will transition to value-based payment arrangements with regional insurers and providers. This phased financing approach allows the hubs to build operational capacity, build strong regional partnerships, generate evidence of impact – laying the groundwork for long-term financial sustainability and local ownership.

Maternal Health Hubs will also incorporate a suite of technological, workforce and capacity building activities that are listed in Table 5: 1) Consumer-facing app; 2) Remote psychiatric and substance use disorder (SUD) consults (as described in detail in the behavioral health section; 3) Remote patient monitoring; 4) Labor and delivery access (birth center expansion, reopen labor and delivery units where feasible, expanding Family Medicine OB training (see Attachment F: Workforce Support); and, 5) Hub and spoke telehealth (as described in detail in infrastructure section)

Table 5: Suite of Maternal Health Technological, Workforce, and Capacity Building Activities

Activity	Description
Consumer-facing new mom app	The Commonwealth was a partner in the development of an app for new moms that can serve as a patient and engagement and education tool with the maternal health hub. The app integrates PA-specific resources and other support tools and ensures that mothers receive actionable, credible information while also connecting them to local providers, community resources, and telehealth services as needed. This digital layer strengthens the hub's commitment to accessible, patient-centered education and engagement to improve outcomes. Funding will be used for app implementation and dissemination.
Remote psychiatric and SUD consults – Perinatal TiPS program:	This peer-to-peer consultation service will extend the hub's behavioral health capabilities by providing immediate, expert consultation to frontline providers. Through rapid-response (<30 minutes) telephonic and telepsychiatry services, TiPS equips obstetric, family medicine, and community health clinicians and non-clinicians with specialized support for perinatal mood disorders and substance use conditions. High-risk mothers benefit from earlier diagnosis, coordinated care, and bridge therapy while

Activity	Description
	awaiting community-based treatment. Please refer to the Behavioral Health initiative that follows this section for greater detail on the TiPS program. Funding will be used to establish the program infrastructure while peer consultation will be billed to insurance when it is a covered service.
Remote Patient Monitoring	This activity expands the hub's ability to manage chronic disease, high-risk pregnancies and postpartum complications across rural areas. Beginning with blood pressure tracking for hypertensive disorders, patients will be equipped with devices that transmit daily readings to hub-based tele-RNs. Abnormal results will prompt immediate intervention, linking patients to tele-maternal fetal medicine consults or local care. By embedding remote monitoring in the hub infrastructure, rural women gain access to proactive, continuous oversight, reducing preventable complications and improving maternal and infant outcomes. Shared monitoring infrastructure across a geographic region will generate regional efficiencies. In addition, there are opportunities to leverage the consumer facing app described above for direct engagement with patients to prompt measurement and transmission. RHTP funding will be used for start-up funding for equipment, training, and staffing.
Labor & Delivery Access	Access to OB and family physicians trained in OB, along with reopening labor and delivery (L&D) units in selected underserved regions will restore a vital spoke of the hub's clinical network. By connecting reopened L&D units with tele-MFM (maternal fetal medicine) specialists, integrated behavioral health, and coordinated referral protocols, the hub ensures safe, local delivery options while minimizing patient travel burdens. Hubs will work in concert with the RCC to identify high-value strategic opportunities to re-open hospital-based L&D units. Regional criteria for investment will generally include but are not limited to a) one-time and/or non-recurring investments to allow a hospital to overcome a critical financial barrier to reopen labor and delivery; b) concurrent RHTP workforce and technology initiatives to address key sustainability challenges; and, c) regional collaboration in place to develop appropriate triage and access to remote specialty care. Expanding birth centers as midwifery-led spokes in the hub model is another important strategy for expanding access to L&D services for low-risk pregnancies. The hub will work with the RCC to develop a grant program to support start-up costs for birth centers including retrofitting space, staff training, and staff start-up costs. The hub will prioritize opportunities that leverage existing infrastructure and foster partnerships with comprehensive health care access such as a nearby rural hospital or community health center. The hub will work with regional providers to develop safe transfer protocols and collaborative care models for pregnancies where transfers are indicated. (See Attachment F: Workforce Examples - FM-OB Fellowship)
Hub-and-Spoke Telehealth	The hubs will leverage investments in community-based telehealth access points and peer-to-peer consultation as described in the infrastructure section to improve access in regions with limited face-to-face options. This will facilitate reliable access to comprehensive care closer to home. See infrastructure section for more detail.

Table 6 and 7 summarize our Maternal Health Initiative alignment with RHTP goals and outcome metrics.

Table 6: Maternal Health Initiative Summary

RHTP Element	Description
Main Strategic Goal:	Make Rural America Healthy Again
Use of funds:	A, B, C, E, F, G, H, I, J, K
Technical score factors:	B.1, B.2, C.1, D.1., E.1, F.1, F.2, F.3
Key stakeholders:	CHCs, Family Medicine, Obstetrical Practices, Maternal Fetal Medicine programs, Primary Care Practices/Clinics, Hospital Clinics, Rural and Referral Hospitals, Birthing Centers, Pharmacies, Emergency Medical Services, Mental

	Health/SUD providers, County Mental Health/SUD agencies, and Community-Based Organizations.
Impacted counties:	All rural counties (see Attachment E: PA RHTP Eligible Rural Counties) will be included in an RCC. Each RCC will have a Maternal Health initiative but will align activities to regional need.
Estimated required funding:	$186.4 M

Table 7: Maternal Health Outcomes

Metric & metric type	Rationale	Baseline and proposed goal by end of grant period	Proposed geographic unit	Data source,
Program adoption & access: # of providers and facilities participating in Maternal Health Hubs	Maternal hub model improves access to specialists in rural areas.[48]	Baseline: no hubs Goal: Two Maternal hubs launched by 2028 Regions with a hub will have at least 25% of births engaged with the hub.	PREP region	New collection by RCCs. Updated semi-annually. Claims data from PHC4
Program adoption & access: # of PREP regions with at least one facility participating in the hub	Maternal hub model improves access to maternal care in rural areas.[49]	Baseline: No region has a hub Goal: every PREP region will have at least one hospital and multiple outpatient providers within the hub.	PREP region	New collection by RCCs. Updated semi-annually.
Program implementation & technology use: # of downloads of new moms app	Mobile health apps educate patients and improve maternal health outcomes[50]	Baseline: In year zero, app has been downloaded 50 times. Goal: app will have been downloaded 2000 times.	Determining feasibility of sub-state collection.	New collection by app developer. Updated annually.
Program implementation & access: % of births without prenatal care before the third trimester.	Telehealth expands access for rural expecting and new moms [5152]	Baseline: 8% in rural areas (2024). Goal: Reduce by 25%.	Determining feasibility of sub-state collection.	Existing data (vital registry). Updated annually.

Behavioral Health Initiative

Rural Pennsylvanians experience high rates of mental illness and substance use disorder, which are exacerbated by limited access to care. Nearly a quarter of rural residents live in areas with shortages of addiction treatment providers, and Pennsylvania ranks 42nd nationally in 988 crisis line utilization, based on the July 2025 Vibrant Broad State Metrics Report[53] and population data. Workforce shortages, siloed care, and limited broadband compound these barriers. The behavioral health initiative includes efforts to: a) expand crisis services through 988 awareness campaigns and staffing, b) increase access to care through remote behavioral health consultation via TiPS, collaborative care model (CoCM) adoption, and a telehealth bridge clinic for same-day SUD treatment, and, c) expand the rural behavioral health workforce through educational awards for peer and recovery specialists and develop a statewide training management system. Funding will cover salaries, training, technology, and technical assistance. The overarching goal is to expand service capacity, reduce reliance on emergency departments (EDs), and improve clinical

outcomes for a variety of mental health and SUD issues, with grant funded activities designed to directly benefit rural Pennsylvanians.

988 Expansion & Education

Pennsylvania's 988 expansion & education initiative will utilize advertising and community partnerships to increase knowledge of 988 services specifically in rural areas while expanding capacity to respond to 988 contacts. The initiative will target rural Pennsylvanians using messaging that resonates with rural audiences and through channels most likely to be utilized by rural Pennsylvanians. The initiative will seek to reduce stigma and encourage individuals to access mental health care resources when needed and in the longer term reduce Pennsylvania's elevated rates of rural suicide.[54] Grant-funded outreach and advertising will focus on rural counties and rural-serving organizations. With increased public awareness of the service, more capacity will be needed to respond to 988 contacts. 988 initiative activities are described in Table 8.

Table 8: 988 Crisis Line Program Expansion

Expansion Activity	Description
Research and Message Development	Utilize media contract vendor to message test
Public Awareness Campaign	Expand campaign through existing partners
Real-time Quality Improvement	Measure clicks, conversions, utilization data, crisis services utilization, surveys
Integration	Continue integration between 988, crisis providers, and other community partners
Evaluation	Annual evaluation with adaptation for subsequent year

Remote Behavioral Health Consultation (RBHC)

Description: The RBHC initiative consists of two components: A TiPS program that provides telephonic peer-to-peer behavioral health clinical consultation between a psychiatrist and a requesting licensed provider, and the implementation of the CoCM between primary care practices and behavioral health providers.

TiPS is an initiative designed to increase the availability of peer-to-peer child and adult psychiatry consultation to rural primary care providers (PCPs), obstetricians, licensed behavioral health mid-level providers, other medical specialists, EDs paramedics, pharmacists, and nursing homes for mental health and substance use disorders. The program will provide real-time access to consultative advice for children and adults with behavioral health concerns. TiPS providers will have dedicated teams to provide consultation, care coordination, and training/education of providers in rural areas. RHTP funds will expand access to TiPS to a broader range of rural providers, rural EDs, EMS paramedics, and 988 responders to facilitate rapid and efficient triage and placement to outpatient and inpatient levels of care for mental health and substance use disorder (see program details in Table 9). Grant-funded TiPS services will be available to providers practicing in rural counties or clinics with majority rural patient panels.

Table 9: TiPS Program Description

Team Members	Services (telephonic/video)	Potential Response to Calls (maximum 30 min response time)
Psychiatrists Licensed therapists Care coordinators Administrative personnel	Consultation (peer) Care coordination Training and education Direct care (if needed)	1. Answer provider question 2. Referral to care coordinator to identify local care resources 3. Real-time referral to team therapist for transitional care services while awaiting local care 4. Referral to team or local psychiatrist for psychopharmacologic or diagnostic consultation

The TiPS team will educate and train providers on key issues such as: a) safe use of psychotropic medications for appropriate indications; b) guidance on medication assisted treatment for SUD; c) use of screening tools in clinical practice and diagnostic guidelines; d) recognizing and triaging behavioral health urgent/emergent situations; and, e) developing a referral resource for local behavioral health services. The training and technical assistance will enable all providers to expand their scope of practice with appropriate psychiatric specialty back-up.

Pennsylvania has a strong and proven foundation to expand TiPS services. Currently there is a statewide Pediatric TiPS for children covered under Medicaid and CHIP with an existing reimbursement model in place for peer-to-peer consultation.[55] TiPs will be expanded to include all children, obstetrical patients, and all adults in rural areas. For adults, a special focus will be on pregnant/postpartum and geriatric patients living within the community and long-term care facilities. The TiPs teams will also provide peer to peer consultation for those living with intellectual disabilities and autism and coordinate a continuum of crisis management with 988 and EDs as needed. TiPS teams will also provide consultation to EDs and EMS/paramedics to help improve diagnosis, treatment and placement as needed for children and adults.

The **Collaborative Care Model (CoCM)** is an evidence-based approach in which PCPs, behavioral health managers, and psychiatric consultants form a team to deliver coordinated, measurement-guided treatment.[56,57] The CoCM improves outcomes for depression, anxiety, and substance use disorders and saves $6 in health care costs for every $1 invested.[58] The CoCM will be implemented by the Behavioral Health Integration Project (BHIP) Consortium that leverages academic expertise, statewide reach, and local knowledge from Penn State, the University of Pennsylvania, UPMC, and statewide partners such as the PA Office of Rural Health. The team has extensive experience sustainably integrating behavioral health in primary care. For example, Penn State College of Medicine's Project ECHO (Extension for Community Healthcare Outcomes) implements tele-mentorship and learning communities to support rapid and scalable adoption across rural practices.[59] BHIP offers a turnkey solution, combining training, technical assistance, and learning networks with billing, EHR integration, and sustainability guidance. BHIP strengthens workforce supply, reduces barriers to implementation, and supports long-term viability of CoCM programs. The Consortium positions rural practices to expand beyond CoCM to other pressing priorities such as suicide prevention, opioid use disorder treatment, and maternal behavioral health.

BHIP, in partnership with the RCCs, will implement the CoCM in rural clinics, including primary care providers, CHCs, obstetric practices, hospital clinics, and EDs, by providing psychiatric consultative support. Grant resources will support implementation in rural practices

and rural hospital-based clinics. This coordinated effort, in conjunction with TiPS teams' broader peer-to-peer consultations, will expand behavioral health access, enhance provider effectiveness, and improve patient and family outcomes. By aligning both programs and using data monitoring to avoid redundancy, implementation of the CoCM will build a sustainable, statewide system that transforms behavioral health care delivery across rural Pennsylvania.

Educational Awards for Peer and Recovery Specialist Certification (CPS, CRS)

Description: By providing educational awards for the completion of training and certification, this program will increase the number of certified peer specialists (CPS) and certified recovery specialists (CRS) in rural communities across Pennsylvania. This will expand employment pathways and increase access to timely intervention when individuals are transitioning between levels of care in the behavioral health care system. SAMHSA has highlighted several benefits of peer specialist services including improved client engagement and retention, enhanced service offerings, stronger connections to community supports and the recovery community, and enhanced access to additional resources such as short-term housing, transportation and social connection.[60]

There are currently 2,043 active CRSs and 1,300 CPSs in Pennsylvania (internal data). The costs to obtain certification ranges between $900-$1,400 per applicant. In addition to the initial training, certification and an optional specialty endorsement, renewals and continuing education must be completed every two years. Specialty endorsement for peer specialists to acquire greater capacity to support individuals with intellectual disabilities and autism is currently under development.

The educational award program will consist of:

- Collaboration with the PA Office of Vocational Rehabilitation, county social service agencies, county drug and alcohol programs/single county authorities and recovery hubs to establish and/or expand educational award programs for eligible CRS/CPS applicants serving rural communities.
- Educational awards of up to $1,200 per applicant for an initial certification and up to $600 per applicant for a renewal based on documented need, with eligibility limited to applicants serving rural communities.
- Tracking process to ensure each successful CRS/CPS candidate maintains certification and a minimum of five years of work and/or volunteer experience in a rural community in Pennsylvania.

Statewide Bridge Clinic for SUD

Description: Bridge clinics serve to reduce barriers by "bridging" gaps in behavioral health care delivery, particularly for SUD. Studies demonstrate that bridge clinics are highly effective in providing immediate access to care.[61,62] Telemedicine models improve availability of medications for opioid use disorder (MOUD) and reduce overall treatment costs.[63] Urgent telehealth evaluation through these clinics can deliver rapid MOUD treatment, facilitate effective care navigation, cut wait times, and increase follow-up, especially in rural areas. This can contribute to lower overdose rates and reduced costs associated with untreated opioid use.

This initiative will use existing 988 and 1-800-662 (GET) HELP lines – to facilitate a "no wrong door" approach for individuals residing in rural communities seeking SUD services. Call staff from all programs will be trained to immediately connect a caller to appropriate help, whether

that is to a bridge clinic for MOUD, other SUD resources, 988 (suicide prevention and crisis support), or local social services. The bridge clinic will be overseen by addiction medicine specialists who can provide immediate help through phone-based evaluations, prescribe MOUD, and make handoffs to local providers, single county authorities, or other resources to support long-term follow-up care, with grant-funded services targeted to rural residents and rural providers.

Mental Health Training Management System (MHTMS)

Description: The MHTMS will expand Pennsylvania's existing training management system, which currently covers only SUD and intellectual and developmental disabilities trainings, to add training modules for mental health professionals, community advocates, peer specialists and their families, and nontraditional professionals (police, judges, others) to improve system-wide therapeutic and trauma-informed responses to people suffering with behavioral health issues. This greatly enhanced system will coordinate, track, and assess training, streamline workforce development, help individuals maintain regulatory compliance, and respond to evolving rural behavioral health needs. Because MHTMS is inherently a statewide platform, grant dollars will support system enhancements that prioritize rural impact including rural-focused curricula and learning pathways along with targeted rural outreach and technical assistance. Through structured, evidence-based modules, MHTMS will enhance Pennsylvania's training and management system to support the mental health workforce and peer specialist development and ensure trainings and certifications meet standards set by DHS' Office of Mental Health and Substance Abuse Services. Following user testing and vendor coordination, the upgraded MHTMS will launch as a public, statewide resource with expanded training opportunities.

Use of Grant Funds: Collectively, the behavioral health activities described above are structured so that grant-funded impact is overwhelmingly rural. Direct service delivery, practice transformation supports (e.g., TiPS and CoCM), 988 outreach and education, CPS/CRS educational awards, bridge clinic services, and related technical assistance will be targeted to rural counties and rural providers. At the same time, the grant will support select statewide infrastructure investments, such as enhancements to the MHTMS that are inherently statewide in scope but will be promoted and monitored to ensure that rural providers and communities receive the greatest benefit.

Table 10 and 11: Behavioral Health Initiative alignment with RHTP goals and outcome metrics.

Table 10: Behavioral Health Summary

RHTP Element	Description
Main Strategic Goal:	Sustainable Access
Use of Funds:	A, B, D, E, G, H, I, J, K
Technical Score Factors:	B.1, C.1, C.2, D.1, F.1, F.2.
Key stakeholders:	CHCs, Primary Care Practices/Clinics, Hospital Clinics, Obstetrical Practices, Birthing Centers, Rural Hospitals/EDs, Pharmacies, Emergency Medical Services, Rural Long-term Care Facilities, Mental Health/SUD providers, County Mental Health/SUD agencies, and CBOs. PA DDAP: 1-800-GET HELP Now contact centers; 988 contact centers; local drug and alcohol program administrators/single county authorities; recovery hubs; local health care organizations; rural PA, local human service agencies, faith communities, schools, and other community partners; veterans' organizations.

RHTP Element	Description
Impacted Counties:	All rural counties (see Attachment E: PA RHTP Eligible Rural Counties) will be included in an RCC. Each RCC will have a Behavioral Health initiative but will align activities to regional need.
Estimated Required funding:	$60.6 M

Table 11: Behavioral Health Outcomes

Metric & metric type	Rationale	Baseline and proposed goal by end of grant period	Proposed geographic unit	Data source
Program implementation & workforce: # of people who complete training for peer and recovery specialists	Peer recovery specialists can increase capacity of BH providers[64]	Baseline: To be collected. Goal: Increase # of individuals completing training, goal TBD.	PREP region	New collection by RCCs. Updated annually.
Quality & health outcomes: % of bridge clinic patients with SUD with a MOUD Rx fill or claim	Bridge clinics support MOUD initiation and continuity of care[65]	Baseline: To be collected: Goal: increase in % of individuals with OUD who received a bridge clinic service receiving MOUD, TBD	PREP region	New collection by RCCs. Updated annually.
Program adoption & workforce: # of mental health trainings offering continuing education units (CEUs)	Continuing education can increase access to high quality, evidence-based behavioral health treatment [66]	Baseline: No existing trainings currently incorporate CEUs. Goal: 35 training opportunities offering CEUs	Determining feasibility of sub-state collection	New collection by RCCs. Updated annually.
Technology use & access: # of consultations with rural providers via TiPS	Tele-consults can improve access to specialty care for rural patients.[67]	Baseline: To be collected Goal: Increase in # of consultations, TBD	PREP region	New collection by RCCs. Updated annually.
Program adoption & access: # of practices recruited to implement the CoCM model of care	CoCM improves outcomes for depression, anxiety, and substance use disorders and saves $6 in health care costs for every $1 invested.[68]	Baseline: 0 Goal: 30 practices with formal CoCM arrangements.	All PREP regions (combined)	New collection by RCCs, reporting from BHIP team.

Aging and Access Initiative

Pennsylvania's aging rural population faces workforce shortages, fragmented navigation, and poor care transitions. To address these challenges, we will implement activities to reduce re-admissions, build the nurse aide workforce, improve infection control, and simplify access to long-term care services statewide, with grant-funded activities designed to primarily benefit rural older adults and the rural providers who serve them.

Hospital-to-Home Community Paramedicine

Description: This program will build on lessons learned by private in-state health care organizations and will offer coordinated, structured, home-based follow-up care by trained paramedics to rural Pennsylvanians. This model has been utilized by health care organizations around the country and in more urban areas of Pennsylvania with successful results. For example, Lancaster EMS expanded their patient pool from 100 in their inaugural year to approximately 1,000 patients per month today, a testament to the positive reception within their community.[69,70] The Home-to-Home Paramedicine model has been shown to reduce readmissions, ED utilization, and avoidable nursing home placements.[71] Pennsylvania's rural communities have not had the resources to implement the model. With startup funds from the RHTP, and new rural EMS paramedicine training sites, down-time readiness of EMS systems can be leveraged to support community paramedicine training and services. Beyond transitions to home, services can be expanded to include other preventive support visits focused on chronic disease management, fall risk assessments, wellness checks, and other health screenings with referrals as needed to essential community services. Paramedics will implement emergency diversion protocols by triaging non-emergent 911 calls on scene and redirecting patients to appropriate care settings. This approach supports the broader vision to make rural America healthy again by creating new access points and fostering rural innovation.
Pennsylvania will leverage the PA Department of Health's (DOH) existing EMS funding channels and support community paramedicine activities that fill payer gaps such as post-discharge follow-up, health coaching, chronic disease management, and in-home care where not otherwise billable and will require facility/agency attestations and quarterly billing screens to confirm non-duplication with Medicare/Medicaid and commercial reimbursement. Funding will flow through the DOH Bureau of EMS using established mechanisms (e.g., the EMS Operating Fund and fireworks-tax-supported grants) with RHTP grant dollars directed to rural EMS agencies, while the state pursues a durable reimbursement pathway potentially modeled on EMS law similar to that in Minnesota. These could include codifying Medicaid coverage for community paramedic services via a state plan amendment or aligning managed care agreements and payment for defined, quality-tied interventions delivered by credentialed EMS and community paramedics.[72,73,74,75,76]

Long Term Care Quality Investment Program (QIP)

Description: Pennsylvania will support long-term care communities by funding targeted quality initiatives through the QIP, modeled after successful programs in states that link facility-level investments to measurable quality improvements.[77,78,79,80] Building on Pennsylvania's federally funded Quality Investment Pilot that demonstrated strong returns on investment, this next phase will be jointly administered by the PA Department of Human Services, Department of Aging, and the Department of Health's Long-Term Care Transformation Office, consistent with the state's Aging strategy. QIP will enhance care quality, workforce stability, and clinical infrastructure through Nurse Aide Training Hubs and retention supports[81,82,83]; infection-prevention training and air-quality improvements; EHR and telehealth implementation[84]; and resident/family engagement technologies. Funding will be provided to selected rural long-term care communities based on readiness and need, with performance expectations tied to measurable gains in resident safety, inspection outcomes, including lower agency staffing dependence, improved Nurse Aide retention, fewer deficiencies and citations, higher CMS star ratings, reduced hospital transfers, and expanded access to care through telehealth. This will

position facilities to succeed under value-based reimbursement models anchored in quality performance.[85,86]

Nurse Aide Training Hub Expansion

Description: To address the workforce challenges of rural direct care workers, we propose to launch a Nurse Aide Training Hub to expand opportunities for education training, and case management of direct care workers – a core recommendation of the state's "Aging Our Way, PA" strategic plan. This model connects schools, employers, and community supports to build a sustainable pipeline of direct care workers by establishing incentives for nurses to become Nurse Aide educators, expanding clinical training sites, and creating new entry-level training pathways to LPN and RN programs.[87,88,89,90]

The Nurse Aide Training Hub model will reduce hospitalizations and emergency visits through early detection; lower overall care costs by improving workforce retention and decreasing reliance on staffing agencies; alleviate family caregiving burdens; strengthen long-term care financial stability; expand access to care for rural seniors and individuals with disabilities; and attract, train, and advance rural workers within health care career pathways. Grant-funded hubs, clinical training slots, and case management supports will focus on rural long-term care facilities, home- and community-based providers, and rural residents seeking direct care careers.

Increase and Expand Integration for Dual Eligible Rural Pennsylvanians

Description: Pennsylvania will expand the Program of All-Inclusive Care for the Elderly (PACE) to underserved rural counties in northeastern PA. These counties have high concentrations of aging adults, limited health care infrastructure, and fragmented care pathways.[91] Pennsylvania's national PACE program, known as Living Independence for the Elderly (LIFE), offers a proven, fully integrated, person-centered model that delivers comprehensive, wraparound services – medical, social, and long-term care – designed to help older adults age in place safely and with dignity.[92] Pennsylvania has been a leader in the implementation and expansion of the PACE/LIFE program, serving 10% of the nation's enrollment which is third highest in the U.S.[93] The expansion of the PACE/LIFE program to rural counties in northeastern Pennsylvania advances the goal to increase access to fully integrated care for individuals who are dually eligible for Medicare and Medicaid.

Additionally, we propose a technology-forward expansion of integrated behavioral health services and telehealth-enabled care at existing PACE/LIFE centers across Pennsylvania. This strategy supports aging in place and reduces avoidable hospitalization through person-centered, data-driven innovation. RHTP funds will support establishing PACE/LIFE centers or satellite hubs in strategically selected and RCC prioritized regions of the state, and will focus on deploying mobile health units and telehealth-enabled care that reaches isolated seniors in rural communities, partnering with community-based organizations and local providers to deliver interdisciplinary, whole-person care and using adult day health centers as anchors for integrated care teams that support preventive and proactive care. This initiative will be linked to the infrastructure initiative on community-based telehealth access.

The expansion will leverage existing infrastructure and partnerships to ensure continuity of care, reduce stigma, and improve access to behavioral health services for aging populations in rural communities. Once the expansion into the underserved northeastern counties occurs, and by

virtue of this expansion, there will be increased education to those community members about the benefits of full dual integration options for care and services. Pennsylvania will continue to use the Independent Enrollment Broker to provide information to long-term care applicants on integration options through enhanced educational materials and options counseling.

Redesign of Pennsylvania's Aging & Disability Resource Center (ADRC)

PA Link is Pennsylvania's front door to aging and disability services—a statewide ADRC network that streamlines access to long-term services and supports through person-centered navigation.[94] By linking Area Agencies on Aging, Centers for Independent Living, and community partners, PA Link reduces handoffs and delivers a consistent experience across the state. Pennsylvania is implementing a "no wrong door" system; ADRCs operationalize this approach locally while the "no wrong door" framework aligns access statewide. Funding will establish cross-agency governance anchored by Medicaid, aging, and disability services with meaningful consumer participation; scale core navigation capacity; and build durable infrastructure for data-sharing, training, and continuous quality improvement, supported by diversified financing. PA Link delivers information and referral, assessment, counseling, service coordination, outreach, case management, transitions, crisis intervention, and specialized supports. Because PA Link is inherently a statewide platform, RHTP funds will support enhancements that are available statewide but explicitly prioritized for rural impact – for example, by expanding navigation capacity in rural Area Agencies on Aging and Centers for Independent Living, tailoring outreach and training for rural communities, and improving connections to rural health and social service providers. This investment will produce measurable results: faster access to long-term services and supports, reduced duplication and avoidable costs, improved consumer satisfaction, and a reliable, integrated system that lets residents and caregivers focus on care. The approach is summarized below:

- *Statewide Call Center (PA Link Line):* Strengthen the toll-free PA Link call center by introducing technology to improve customer service practices and quality. The call center is designed to provide intake, information, assistance, and referral to the broader aging and disability resource network.
- *Training and Technical Assistance – PA Navigate*: Expand training and technical assistance to enhance the use of PA Navigate, Pennsylvania's closed loop referral platform (see Infrastructure Initiative). Engage community partners in using the system to navigate resources, refer individuals to community organizations, and close the loop on referrals. Priority will be given to rural providers to reduce fragmentation in rural service networks.
- *Training and Technical Assistance – Service Navigation Training Series*: Develop and deliver statewide training series to strengthen the capacity of local staff as service navigators, extending beyond traditional aging and disability information and referral functions. Training slots will be targeted to staff serving rural communities.
- *Workforce – Volunteer Coordination:* Support a structured volunteer program focused on community outreach, education, and navigation that expands local engagement and service. Rural volunteers and rural outreach activities will be emphasized.
- *Fostering collaboration – Academic Detailing:* Implement a targeted academic detailing program to engage rural health care providers through one-on-one educational outreach, promoting awareness of PA Link, PA Navigate, and related community-based programs.

Across these aging initiatives, RHTP grant resources are structured to produce predominantly rural impact. Direct service innovations (e.g., community paramedicine, PACE/LIFE expansion),

workforce investments (e.g., Nurse Aide Training Hubs and QIP supports), and navigation improvements (e.g., PA Link enhancements) funded under this grant will be targeted to rural counties, rural long-term care facilities, and rural-serving organizations. For infrastructure that is inherently statewide, grant funded enhancements will be configured, promoted, and monitored to ensure rural older adults and rural providers are the focus.

Table 12 and 13 summarize our Aging and Access Health Initiative alignment with RHTP goals and outcome metrics.

Table 12: Aging and Access Initiative Summary

RHTP Element	Description
Main strategic goal:	Sustainable Access
Use of funds	A, B, D, E, F, G, H, I, K
Technical Score Factors:	B.1., B.2., C.1., C.2., D.1., E.1., F.1., E.2., F.2.
Key Stakeholders:	EMS agencies, community-based organizations, health systems and ambulatory clinics, PA DOH's Bureau of EMS, acute health care facilities, long-term care communities, community organizations that support long term care communities and other community needs, educational institutions, county/local human services agencies and leaders, FQHCs and rural health clinics, AAAs, Centers for Independent Living, rural health care providers.
Impacted counties:	All rural counties (see Attachment E: PA RHTP Eligible Rural Counties) will be included in an RCC. Each RCC will have an Aging and Access initiative but will align activities to regional need. The PACE program expansion will occur in rural counties in northeastern Pennsylvania.
Estimated required funding:	$77.1 M

Table 13: Aging and Access Outcomes

Metric & metric type	Rationale	Baseline and proposed goal by end of grant period	Proposed geographic unit	Data source
Program adoption & quality: # of facilities participating in QIP	Participation in quality improvement programs can improve service delivery and patient outcomes,[95]	Baseline: In year zero, 25 facilities participated in QIP. Goal: 100 facilities will participate in QIP	PREP region	Existing data. Updated annually.
Program implementation & quality & outcomes: # of deficiencies/ citations among QIP participating facilities.	Participation in quality improvement programs can improve service delivery and patient outcomes,[96]	Baseline: # deficiencies/citations before QIP participation, TBD Goal: reduction in deficiencies/citations after QIP participation, TBD	PREP region	Existing data. Updated annually.
Program implementation & workforce: # of nurse aide trainings completed (and # of participants)	Increase capacity of nurse aide workforce[97][98][99][100][101][102]	Baseline: 93 cohorts nurse aide trainings were completed, serving 750 participants. Goal: 465 cohort trainings will be held, serving 3,750 participants.	Determining feasibility of sub-state geography	Existing data. Updated annually.
Program implementation & access: # of individuals in rural	PACE can improve health outcomes for participants[103]	Baseline: 2,175 individuals receiving PACE/LIFE (2024)	PREP region	Existing admin data and new data collection.

Metric & metric type	Rationale	Baseline and proposed goal by end of grant period	Proposed geographic unit	Data source
areas receiving PACE/ LIFE services		Goal: By 2031, 3,654 individuals in rural areas will be receiving PACE/ LIFE services		Reported annually.

EMS and Transportation Initiative

EMS is the frontline of care in rural communities, yet agencies struggle with outdated fleets, underfunding, and workforce instability. The Medical Assistance Transportation Program (MATP) – PA's Non-Emergency Medical Transportation (NEMT) program – is under-resourced, while innovative models like paramedicine and mobile health are not yet scaled to meet rural needs. To address these gaps, PA proposes a coordinated strategy to a) modernize EMS infrastructure, b) stabilize the workforce, and c) expand access to care through rural paramedicine training programs and more flexible MATP/NEMT. Investments in EMS will improve readiness and response capacity, while expanded MATP/NEMT flexibility will ensure residents can access preventive and routine care. Scaling paramedicine and mobile health programs will extend care into homes and communities, strengthening continuity and reducing costly hospitalizations. Together these initiatives will build a more sustainable rural health system capable of meeting immediate needs and supporting long-term resilience.

Modernize EMS Infrastructure

Without targeted investment, rural EMS agencies face service reductions or closure, undermining timely access to essential care. This initiative will strengthen PA's rural EMS system through investments in infrastructure, workforce, and operational efficiency by:

- Equipping ambulances with 12-lead electrocardiogram machines, providing lift and moving support to reduce worker injury, and purchasing Advanced Life Support licensed ambulances to enhance clinical capability.
- Stabilizing and supporting EMS as a professional provider workforce, as opposed to "ambulance services." PA will conduct targeted recruitment campaigns, create rural service bonuses, offer tuition reimbursement tied to a five-year service commitment in a rural community or county, career advancement opportunities through paramedic trainings and tuition reimbursement, and mental health mentorship programs to promote retention and resilience among EMS professionals.
- Developing a regional triaging system in partnership with county Public Safety Answering Points (PSAPs), ensuring that resources are dispatched based on clinical guidance to enable efficient dispatch of the most appropriate level of care.

These activities will strengthen response times, improve workforce retention, and secure reliable, high-quality rural emergency care.

Rural Paramedicine and Mobile Health Programs

The Rural Paramedicine program is described in detail in the Aging Initiative section of this proposal (see page 22). Mobile health programs are described in the Infrastructure Initiative section of this proposal (see page 7).

Increase Reliable Nonemergency Transportation

MATP is a critical lifeline for rural residents, connecting them to preventive, specialty, and chronic care. A statewide study[104] identified transportation as one of the most consistent barriers to accessing health care in Pennsylvania's rural regions, especially for specialist and behavioral health services. Long distances to care and rigid ride policies create barriers, particularly for families with small children who must supply and reinstall car seats for each trip. Current MATP policy limits flexibility for children to accompany caregivers to appointments, contributing to missed well-child visits, prenatal and postpartum care gaps, and increased ED use for preventable conditions. RHTP initiatives will modernize and strengthen MATP services by expanding car seat access, updating policies to allow children to accompany caregivers, and improving routing and fleet capacity by maximizing paratransit consumer usage. These targeted investments will reduce missed appointments and improve maternal and child health outcomes.

Table 14 and 15 summarize our EMS/Transportation Initiative alignment with RHTP goals and outcome metrics.

Table 14: EMS/Transportation Summary

RHTP Element	Details
Main strategic goal	Sustainable access
Use of funds	B, E, G, I
Technical score factors	B.1., C.1., C.2., D.1., F.1.
Key stakeholders	EMS agencies, EMS regional councils, FQHCs, rural health clinics, primary care clinics, Pennsylvania Emergency Health Services Council, PSAPs, rural hospitals and health systems, training institutions, high schools, shared ride transportation providers, transit authorities, 56 county MATP administrators.
Impacted counties	All rural counties (see Attachment E: PA RHTP Eligible Rural Counties) will be included in an RCC. Each RCC will have an EMS/Transportation initiative but will align activities to regional need.
Estimated required funding	$86.0 M

Table 15: EMS/Transportation Outcomes

Metric & metric type	Rationale	Baseline and proposed goal by end of grant period	Proposed geographic unit	Data source
Program adoption & access: # of EMS agencies with a paramedicine program	Paramedicine units increase health care access for rural residents.[105]	Baseline: In year zero, 4 EMS agencies have a paramedicine program Goal: 10 EMS agencies will participate in paramedicine programs.	county	New collection by RCCs. Updated annually.
Program implementation & technology use: # PREP regions with at least one modernized ambulance	Modernized ambulances with advanced life support can improve patient outcomes.[106]	Baseline: to be collected Goal: 8	PREP region	New collection by RCCs. Updated annually.
Program adoption & access: # car	Providing car seats can remove a barrier to	Baseline: No car seats for MATP	county	New collection by RCCs.

Metric & metric type	Rationale	Baseline and proposed goal by end of grant period	Proposed geographic unit	Data source
seats available for MATP participants	attending health care appointments.[107]	Goal: 10 car seats will be available per county		Updated annually.
Program implementation & workforce: # of individuals certified for EMS	EMS units increase health care access for rural residents.[108]	Baseline: In year zero, 17,000 certified EMS individuals are active in the state (rural TBD). Goal: 1,000 additional in rural areas.	county	Existing data (EMS registry). Updated annually.

Workforce Initiative

PA's rural communities face an existing and growing health care workforce crisis. Although nearly one in five Pennsylvanians live in a rural area, only 6.6% of the state's health care workforce serves these regions, resulting in widespread shortages, in primary care, behavioral health, maternal, oral, and allied health fields.[109] According to PA licensure data, only 6% of PA's dental graduates practice in rural areas, with 9 counties having > 5,000 population to dentist ratios.[110] Rural hospitals report double-digit vacancy rates,[111] with more than one-third at risk of closure within the next 2-3 years. Without targeted investment, these shortages will continue to erode access, quality and stability across rural health systems.

To address these challenges, PA will invest in coordinated strategies to strengthen and modernize the rural health workforce: a) recruiting and preparing rural students for health careers, b) expanding training and clinical rotations in rural communities, and c) supporting innovative, team-based care models that make rural practice attractive and sustainable. Other workforce initiatives are described in sections (Maternal Health, Behavioral Health, Aging, EMS). These efforts will build a durable pipeline of providers, stabilize rural health infrastructure, and ensure that rural residents can access the high-quality whole person care they need close to home. These one-time investments are designed for sustainability; they will yield long-term benefits by embedding training programs, partnerships, and workforce pipelines in rural communities. Funding will support durable infrastructure such as rural training sites, short-term housing, and mentorships networks that will be maintained through health system and educational partnerships. These efforts will increase rural recruitment and retention, reduce vacancy rates, and strengthen the long-term viability of rural hospitals and clinics. Their success will be measured by increased metrics of access and numbers of rural patients served. Attachment F: Workforce Examples, provides additional detail on workforce activities.

Recruiting Rural Students into Health Care

Rural students are the best hope for the future of rural health care in PA. Many studies have validated the predictiveness of a rural upbringing to working in rural health care.[112,113,114,115] Unfortunately, the number of rural students applying and being accepted to health professions schools is declining or stagnant.[116,117] PA will invest in its rural learners through entry level training, upskilling, health professions preparation support, and attractive apprenticeships ("earn while you learn"). The state needs an immediate and ongoing infusion of a variety of health professionals across rural regions of PA. We will build on existing evidence-based programs and develop new innovative workforce models to "Grow Our Own" through health career exploration programs, pathway programs, and educational award programs. Table 16 describes a

suite of approaches and tools we will employ to recruit, support, and retain students in health care careers. We will work with RCCs to tailor strategies in different regions of the state based on community assets and needs.

Table 16: Recruiting Rural Students into HealthCare

Model	Key Focus	Core Elements
Health Career Exploration Programs	Build interest in rural health careers from K-12 through college	Career exploration ("see it to be it") in rural schools and colleges
Emerging Pathway Model: Pre-Apprenticeship	Provide early hands-on preparation for front-line health care roles	Approved curriculum, hands-on and simulated training (e.g., virtual reality), supportive services (e.g., transportation), links to registered apprenticeship programs for nurse and medical assistants, EMTs, behavioral health aides
Innovative Model: Apprenticeship Degree Programs	Provide employment-based job-embedded college degrees for front-line, direct care staff	Wages/benefits while completing college credits, flexible/remote delivery to retain workers in rural posts, partnerships between rural health employers and degree-granting institutions, technical assistance from National Center for the Apprenticeship Degree. PA recently launched a registered doula apprenticeship.
Tailored Rural Pre-Med and Pre-Dental Student Support	Increase medical and dental school entry of rural students by offering needed supportive services	Services offered include medical and dental entrance exam preparation, application coaching, clinical shadowing, mentoring, recommendation letters.

An array of **educational award programs** linked with five-year service commitments can meet shorter- and longer-term rural health professional needs in rural communities. HRSA and the Commonwealth have several federal and state-funded Primary Care Loan Repayment Programs; we will not duplicate or supplant any of the loan repayment programs Instead, we will invest RHTP funds in community-based service-educational award programs, which hold high potential for local return on investment through the recruitment and support of local students through their training programs. Table 17 describes a suite of new approaches and tools PA will implement to recruit and retain more providers into rural practice. We will work closely with RCCs to tailor workforce investments strategies in different regions based on community assets and needs for specific provider types.

Table 17: Service Linked Educational Award Programs

Model	Key Focus	Core Elements
Service-Educational Award Programs for *licensed* providers (Medical Dental, Pharmacists, RNs, PAs NPs, etc.)	Provide up-front tuition and living stipends to rural PA natives in exchange for rural service (5 years) by addressing a major financial barrier for rural PA students; provides freedom to establish roots in the community.	New educational award programs for tuition, fees, and living stipend through programs managed by rural educational institutions, hospitals and health systems.

Model	Key Focus	Core Elements
Service-Educational Award Programs for *other direct care* providers CHWs, doulas, EMTs, nurse aides, paramedics, and dental hygienists.	Shorter training programs leading to credentialed providers providing support for team-based care – but are also considered to be pipeline programs for health care careers	Provide recruitment and apprenticeship programs and tuition educational awards to rural PA natives for these short-term and pipeline programs in exchange for 5 years of rural service community.

Supporting Rural Clinical Training

PA lags peer states such as Wisconsin, Missouri, Ohio, and Georgia in financially supporting rural clinical training. Ohio funds preceptorships in rural and other community health centers,[118] while Georgia invests more than $2 million annually in housing and rotation management for students training in rural and underserved areas.[119] Limited investment in PA has resulted in only about 3% of medical student graduates and 6% of dental school graduates practicing in rural communities. Most health professional students come from suburban or urban backgrounds with little exposure to rural practice.[120] Studies have consistently demonstrated that students who spend more time in rural training programs are more likely to choose rural health care careers.[121,122,123,124] Currently, PA has several unique opportunities to help launch new rural-specific provider training programs. One example, is a new rural osteopathic medical school at Indiana University of Pennsylvania that will specifically recruit and make educational awards available to eligible students from rural PA, beginning in 2027. Likewise, several PA dental schools are developing rural residency track sites and creating financially sustainable rural postgraduate dental fellowships, along with training for dental assistants and hygienists. These programs will partner with local CHCs and rural hospitals both of which will benefit from the additional clinical revenue, while the educational institutions will benefit from additional tuition revenue. RHTP funds will support start-up funds for program infrastructure, faculty or preceptors, and short-term housing. PA has other opportunities to start or expand rural rotations, residencies, or fellowships. Table 18 outlines several promising and planned initiatives to expand additional rural clinical education and experiential training.

Table 18: Supporting Rural Clinical Training

Model	Key Focus	Core Elements
Rural Training Tracks and Train-in-Place Models	Encourage rural and rurally interested students to train in rural settings by offering clinical training in rural areas and adapting education to include rural health issues to promote interest in rural practice.	Extended training (>12 weeks) in rural areas (e.g. Penn State Rural Health Scholars (≥12 weeks), Temple Dentistry Rural Track (planned 2026), Pitt Dental Regional Centers (planned 26-27), and IUP Osteopathic Medical School (planned 2027).
Rural Clinical Training: Short-term Housing and Support	Provide free/low-cost, safe, short-term housing and additional financial support to preceptors and clinics to address two major infrastructure barriers to rural clinical rotations.	Short-term housing (limit of 6 months) and additional financial support to preceptors and clinics (e.g. Ohio model pays CHCs hourly (up to $50k/year) for teaching; AHEC Community Oriented Rural Education arranges ≥8-week rotations and supports preceptors to prevent overload).
Rural Residency and Fellowship Programs for both Medical and Dental Fellowships	Develop rural residency programs to increase the number of medical, obstetrical, dental, and surgical	Rural residency tracks affiliated with academic medical centers/medical schools. Fellowship programs for family physicians to receive extra training in OB and

Model	Key Focus	Core Elements
	post graduate residents who train in rural settings.	Psychiatry and post graduate rural fellowships in general dentistry.

New and Expanded Workforce Models for Rural Pennsylvania

PA can build on encouraging signs of growing team-based care: 73% of PA hospitals report employing community health workers, 74% employ mental health therapists, and 28% employ doulas,[125] all of which have the potential to add to revenue at rural hospitals and CHCs. These models demonstrate the potential to expand and broaden the rural health workforce while sustainably improving access and patient outcomes. The Commonwealth will invest in innovative, team-based workforce initiatives that make rural health care more attractive, leverage the full range of provider skill sets, and strengthen the long-term sustainability of services for rural residents. Given the severity of rural workforce shortages,[126,127,128,129] it is essential to adopt refreshed workforce models that integrate new roles, shared staffing, and interprofessional collaboration. Table 19 presents a range of possible training options.

Table 19: New and Expanded Workforce Models for Rural Pennsylvania

Potential Component	Key Focus	Core Elements
Primary Care Medics (New PC-Medic model in development)	Provide community-integrated primary and preventive care by targeting rural residents, military medics, EMTs, CHWs, MAs for advanced training	Develop scope, algorithms (behavioral, oral, maternity), and telehealth platform.
Community Paramedicine	Upskill EMTs for non-urgent home visits & chronic care. New regional training programs will be needed to build on PA successful pilot program to meet the needs of PA's rural communities.	Funding for new paramedic training programs, addressing scope/training inconsistencies, and expanding performance and evaluation metrics. Programs associated with reductions in ED visits, hospitalizations, and improved patient experience metrics as noted earlier.
Community Health Workers (CHWs)	Build a rural CHW workforce to address social and health needs and complement clinical care.	Rural-focused CHWs can address social and health needs. Sustainability can be achieved through public and private insurance reimbursement models.
Teaching Health Centers	Increase rural rotations and rural residency programs in community health centers.	Incentivize CHCs to incorporate rural rotations and rural residency programs.
Centralized Nurse Advice Line	Training program in support of developing and staffing a 24/7 nurse line to provide clinical guidance to reduce ED burden.	Modeled after New Mexico program, provides real-time nurse advice and linkage to care.
Family Medicine physicians providing maternity care	Support Family Medicine fellowships in OB and C-sections in rural Pennsylvania.	Build the Family Medicine Obstetrician workforce with OB support to reduce maternity deserts.
Resident Experiential Exchange	Develop rural/urban rotation swaps.	Provide rural rotations to promote clinical skill diversification and rural exposure.
Rural Fellowship in Leadership Advocacy	Train providers in leadership & community health.	Teach skills related to public health advocacy, conflict resolution, community needs assessments, etc.
Project ECHO Expansion	Implement a tele-education hub-and-spoke model.	Rural residents & physicians collaborate to improve their knowledge on a wide variety of health care challenges through a rural lens using case-based studies in high need areas.

Table 20 and 21 summarize our Workforce Initiative alignment with RHTP goals and outcome metrics.

Table 20: Workforce Initiative Summary

RHTP Element	Description
Main Strategic Goal	Workforce Development
Use of Funds	E, G, H
Technical Score Factors	B.1., C.1., C.2., D.1.
Key stakeholders	State health, labor, and economic development departments, Pennsylvania Office of Rural Health, Pennsylvania Area Health Education Center (AHEC), Pennsylvania Coalition for Oral Health, community-based coalitions, school districts, career and technical schools, community colleges, PA State System of Higher Education schools, state-related schools, health-related pre-apprenticeship programs, and health-related apprenticeship programs.
Impacted Counties	All rural counties (see Attachment E: PA RHTP Eligible Rural Counties) will be included in an RCC. Each RCC will have a Workforce initiative but will align activities to regional need.
Estimated Funding	$237.4 M

Table 21: Workforce Initiative Outcomes

Metric & metric type	Rationale	Baseline and proposed goal by end of grant period	Proposed geographic unit	Data source
Program adoption & workforce: # of placement and training programs focusing on licensed/ credentialled rural workforce (e.g. EMTs, midwives, MDs, pharm, Dental hygienists, etc.)	Rural training and placement programs can increase rural workforce retention.[130]	Baseline: To be collected by program type Goal: Three new programs that focus on rural workforce	PREP region	New collection by RCCs. Updated annually.
Program adoption & workforce: # of participants in rural workforce development pipeline programs (medical school, residencies, rotations, etc.)	Rural training and placement programs can increase rural workforce retention.[131]	Baseline: No rural train local-stay local medical school or dental residency programs Goal: One new medical school enrolling at least 30 new rural students; one new rural dental residency program enrolling at least 20 dental residents; one new family medicine-obstetric fellowship program enrolling at least one person/year.	Statewide	Existing data from hospital and dental associations, medical school and dental training partners
Program implementation & workforce: Workforce vacancy rate in rural hospitals	Healthcare workforce shortages are linked to worse patient outcomes.[132]	Baseline: In year zero, average 19% vacancy rate among direct care workers in PAs rural hospital. Goal: 10% reduction in vacancy rate	PREP region	Existing survey data from HAP. Updated annually.

Metric & metric type	Rationale	Baseline and proposed goal by end of grant period	Proposed geographic unit	Data source
Program implementation & access: Appointment availability and wait time for primary and preventative care	Healthcare workforce shortages are linked to worse patient outcomes.[133]	Baseline: to be collected Goal: Increased appointment availability – <4 weeks for routine and <1 week for urgent care appointments	PREP region	New collection by DHS and PA Insurance Department (secret shopper method)

Implementation Plan and Timeline

The PA RHTP will be guided by a robust, multi-level governance and implementation framework designed to support strategic alignment, transparency, and accountability across all participating agencies and partners. The details are summarized in Figure 3, and more information can be found in Attachment G: Governance Descriptions. The Central Governance Committee, composed of leadership from Pennsylvania's Health Hub state agencies, and Governor's Office, with support from the Pennsylvania Office of Rural Health, will provide broad oversight of this plan and review and approve all funded activities to ensure alignment with the overall goals of the RHTP. Supporting this body, the advisory council of subject matter experts and stakeholder representatives will inform implementation, strengthen collaboration, and provide technical guidance. At the regional level, the leadership of the eight PREP regions will form a steering committee to align the program across regions. Implementation, compliance and communication with CMS will be supported by an interagency project team led by DHS with co-leadership from the Health Hub state agencies. Internal staffing based on the proposed budget will include a program director (1) along with program managers assigned to each region (expected 8), a fiscal/contract oversight focused position, and limited FTE support within partner agencies to strengthen interagency coordination, fiscal accountability, and data reporting. A university partner (University of Pittsburgh Medicaid Research Center) will serve as an independent evaluator.

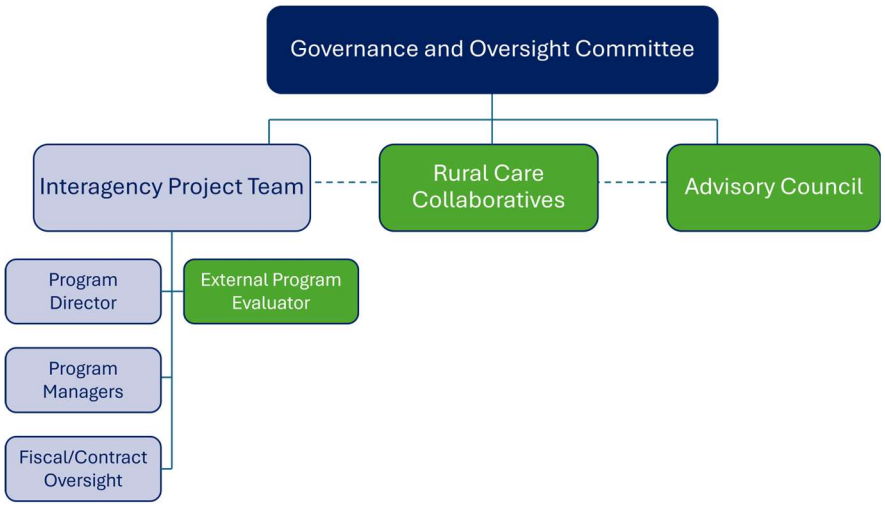


Figure 3: Governance and Oversight Structure

Pennsylvania Rural Health Transformation Plan – Project Narrative

Overall Implementation Timeline (FY26-FY31)

PA's RHTP is transformative and unique. Over the five award periods, PA proposes to use most of the proposed funding to support regional, community-led health care delivery system transformation. Recognizing the urgency of the challenges our rural communities face today, PA will launch a short-term Rapid Response Access Stabilization Program in Years 1 and 2. Administered by the state, this program will target key near-term investments such as preserving essential hospital and EMS capacity and making foundational investments in technology and workforce that will catalyze RHTP initiatives.

Regional RHTP initiatives will be spearheaded by the eight PREP regional organizations that will serve all of PA's HRSA-defined rural census tracts. The PREP regions are multi-county organizations focused on regional economic development and provide services such as business development, grant assistance, and community development in counties. Each PREP organization will stand up a RCC in Year 1, comprised of a prescribed roster of local stakeholders (local county commissioners, healthcare providers, rural hospitals, CHCs and other health care facilities, the business community, local health departments, educational institutions, patient representatives, local foundations, and other key stakeholders). DHS will provide a budget for each region along with a list of approved projects for prioritization based on regional health needs. The state will determine how much of the RCC allotment can be spent annually in each category, but the exact projects to be funded in each region may vary. The Commonwealth will submit quarterly and annual progress reports and annual Non-Competing Continuation applications with updated budgets and metrics per CMS guidance. A full project implementation timeline is presented in the Gantt chart in Figure 4 and the milestones described in Table 22.

Figure 4: PA RHTP Implementation Chart (see next page)

Pennsylvania Rural Health Transformation Plan – Project Narrative

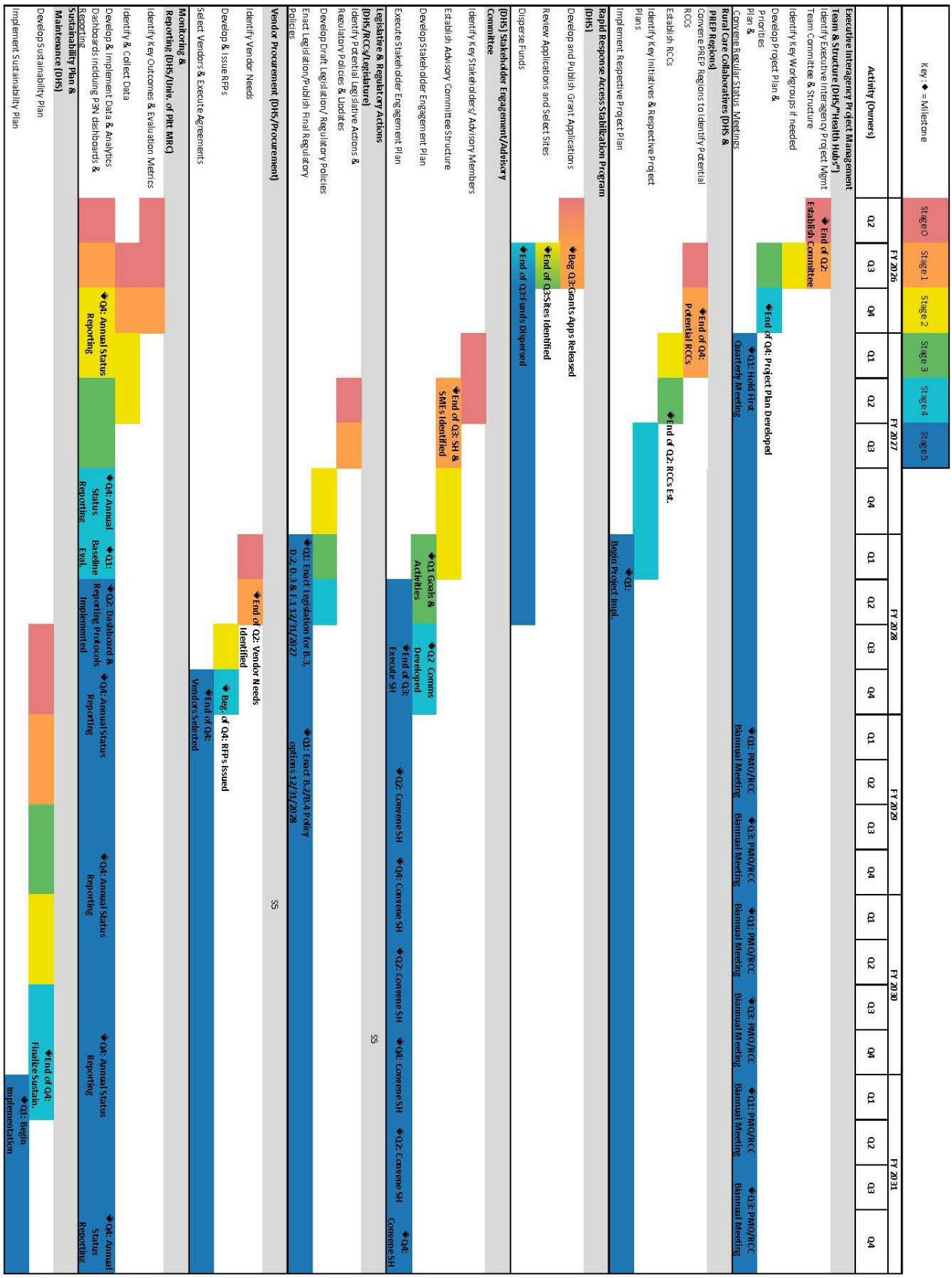


Table 22: Timeline and Milestones

Initiative	Initiative Description	Key Timeline Details
Maternal Health	Comprehensive Maternal Health Hubs expanding prenatal, delivery, and postpartum care through regional RCCs. Integrates behavioral health (Perinatal TiPS), remote monitoring, and workforce development (doulas, midwives).	Launch statewide Maternal Health Hubs (FY26–FY27, Stage 1–2); Expand telehealth and mobile units (FY27–FY28, Stage 2–3); Implement remote monitoring and reopen birth centers (FY28–FY29, Stage 3–4); Fully operational statewide maternal health hub network (FY30–FY31, Stage 5).
Behavioral Health	Suite of initiatives addressing behavioral health disparities in rural PA including 988 Expansion, Remote Behavioral Health Consultation (TiPS & CoCM), Peer/Recovery Specialist Educational Awards, Bridge Clinics for SUD, BH training for nontraditional providers, (courts, police) and providers caring for patients with intellectual disability and autism – MHTMs.	Expand 988 awareness and capacity (FY26–FY30, Stages 0–5); Implement TiPS/CoCM statewide (FY26–FY30, Stages 0–5); Launch Bridge Clinics and CRS/CPS educational awards (FY25–FY30, Stages 0–5); Deploy and maintain MHTMS training platform (FY26–FY30, Stages 0–5).
Aging	Comprehensive rural aging strategy including Hospital-to-Home Paramedicine, Long-Term Care QIP, Nurse Aide Training Hubs, Increase and expand integration for dual eligible rural Pennsylvanians, and ADRC redesign for streamlined long-term services navigation.	Initiate QIP pilots and EMS Paramedicine model (FY26–FY27, Stage 0–2); Expand Nurse Aide Hubs and QIP performance monitoring (FY27–FY29, Stage 2–4); Implement PACE expansion and ADRC redesign (FY26–FY30, Stage 0–5); Achieve full sustainment (FY31, Stage 5).
EMS-Transportation	Modernization of emergency and non-emergency medical transportation systems, including community paramedicine pilots, fleet modernization, and flexible MATP policies improving rural care access.	Launch community paramedicine pilot (FY26, Stage 0–1); Implement EMS modernization and workforce initiatives (FY27–FY28, Stage 2–3); Integrate tele-consults and regional dashboards (FY28–FY29, Stage 3–4); Transition to long-term sustainment (FY30+, Stage 5).
Infrastructure	Investments in digital health and technology infrastructure, including statewide interoperability (P3N), AI-enabled tools, mobile telehealth units, and Community Wellness Hubs integrated with PA Navigate.	Onboard hospitals/FQHCs to HIOs (FY26–FY27, Stage 1–2); Deploy regional hubs for AI, virtual care, and mobile units (FY27–FY29, Stage 2–4); Establish community telehealth and wellness hubs (FY28–FY30, Stage 3–5).
Workforce	Comprehensive medical and dental workforce pipeline and training programs; rural recruitment, training, educational awards, residencies, apprenticeships, fellowships, and new workforce models such as Primary Care Medics, CHWs, and Nurse Aide training.	Implement exploration and apprenticeship programs (FY26–FY27, Stage 0–1); Launch rural medical and dental residencies and training tracks (FY27–FY29, Stage 2–3); Expand innovative workforce models and statewide support programs (FY29–FY31, Stage 4–5).

Pennsylvania Rural Health Transformation Plan – Project Narrative

Stakeholder Engagement

Stakeholder engagement is a cornerstone of PA's proposal, ensuring that the voices of rural residents, providers, payers, and community organizations meaningfully inform implementation at every stage. Since April 2025, five regional rural health summits have engaged providers, patients, and community leaders in identifying regional health challenges and workshopping solutions. These solutions were reinforced through more than 300 proposals submitted to DHS in October 2025 in response to a statewide call for concepts to respond to the RHTP NOFO. This extensive stakeholder input has guided our proposal. The planned RCCs will ensure ongoing stakeholder engagement over the five-year grant period and beyond. The shared governance model for RCCs will include patient and provider representatives seated alongside other community leaders to guide strategy, decisions, and to review results so engagement is continuous, meaningful, and accountable. Table 23 describes additional plans for ongoing stakeholder engagement:

Table 23: Stakeholder Engagement Approaches

Approach	Activities
Regional Engagement	Each RCC will convene quarterly public stakeholder forums.
Statewide Collaboration	The state will host annual learning collaboratives with rural hospitals, CHCs, managed care organizations, and health systems to share lessons and strengthen partnerships.
Consumer and Community Input	Community members including patients, caregivers, and advocates will be engaged through surveys and listening sessions and standing advisory panels (e.g., Medical Assistance Advisory Committee).

To promote transparency, PA will publish annual RHTP progress reports on our Rural Health Website and maintain public facing websites highlighting initiatives and milestones and provide opportunities for public input.

Metrics and Evaluation Plan

Pennsylvania's RHTP initiatives will be independently evaluated by the University of Pittsburgh Medicaid Research Center (MRC) at the University of Pittsburgh. In 2013, DHS initiated an intergovernmental agreement with the MRC to provide research and expertise in support of DHS's administration of the Pennsylvania Medicaid program. Since then, the MRC and DHS have partnered on dozens of quantitative and qualitative analyses, including those focused on rural health care, such as the adoption of opioid use disorder treatment in rural primary care practices and access to hospital services in rural Pennsylvania. The MRC permanent infrastructure includes faculty health policy experts, health economists, qualitative researchers, statisticians, data analysts, and other subject-matter experts.

To evaluate the RHTP initiatives, the MRC will work with the RCCs to 1) monitor implementation and 2) establish and monitor interim milestones in alignment with identified outcomes per initiative, 3) conduct and report on primary data collection, 4) execute data analyses to evaluate the impact of RHTP initiatives on rural health outcomes, and 5) disseminate findings to CMS, DHS, and other stakeholders. For example, the MRC will conduct secret shopper surveys to measure the impact initiatives have on appointment availability, wait times, and distance travelled in rural Pennsylvania for urgent and non-urgent health needs. The MRC

has collected survey and qualitative data in numerous evaluations for DHS, as well as worked with data directly reported by health care organizations, and with large administrative datasets (e.g., Medicaid claims data), all of which will be leveraged for this evaluation. Pennsylvania's proposed metrics for each initiative (at least four measurable outcomes, including one at the community level) are summarized under each initiative. To be determined baselines will be established by the end of FY 2027 to align with the establishment and implementation of the RCCs and the collaboration with the MRC. The findings from the ongoing evaluation will be regularly reported to DHS, allowing us to refine implementation and ultimately meet the goals described in this application.

Sustainability Plan by Initiative

PA's transformation strategy is designed for lasting impact, embedding new programs into existing financing, reimbursement, and operational structures. Sustainability will be achieved by integrating successful initiatives into Medicaid managed care agreements, expanding value-based purchasing, and pursuing Medicare and commercial reimbursement. RCCs will continue convening stakeholders, managing funds, incentivizing regional partnerships, collaborative care arrangements and payment agreements that benefit all parties, along with developing other regional investments and philanthropic opportunities.

Infrastructure and Technology Investments

Rural infrastructure and digital health investments will transition from one-time capital purchases to self-sustaining models supported through reimbursement, subscription-based financing, and integration into routine operations. Hospital, CHCs and other providers will align tele-consult, virtual nursing, and other digital programs with existing billing streams and value-based care arrangements with a goal of reducing unnecessary transfers and bypass behavior and increasing local care capacity. A regional approach to implementation and technology will further promote operational efficiency and long-term cost savings. Sustainability for mobile health units, telehealth access points, and Community Wellness Hubs will be built through modest subscription fees, value-based contracts with Medicaid managed care plans and commercial insurers, and administrative per-referral payments. These shared structures will enable continuous support for prevention, chronic disease management and community care coordination beyond the initial investment period.

Maternal Health

Maternal Health Hubs will transition to ongoing support through PMPM payments embedded in Medicaid managed care agreements, CHIP managed care plans, and commercial plan coverage.

Behavioral Health

Initiatives will be sustained through a blend of reimbursement and partnerships, including the 988 Trust Fund, CoCM reimbursement models through public and private coverage, and MCO PMPM agreements. Counties, providers and educational partners will maintain educational award and training pipelines to strengthen the workforce.

Aging Initiatives

Aging initiatives will transition from grant-supported pilots to codified, reimbursable services within value-based care models, supported by managed care agreements requirements and braided ADRC funding. For example, cost savings from Community Paramedicine programs will build the evidence for a future Medicaid State Plan Amendment.

EMS and Transportation

EMS, paramedicine and transportation programs will achieve long-term viability through legislative funding, balance billing reform, or county-level revenue mechanisms. MATP will integrate recurring costs such as car seat replacement, workforce training, and oversight, into Medicaid's existing appropriation and managed care agreements, ensuring stability and scalability. Together, these strategies establish a diversified, durable foundation to sustain critical emergency, transportation, and community-based care services well beyond initial startup investments.

Workforce Initiatives

Each component of the "grow our own" and train-in-place workforce development plan is predicated on its sustainability. Investments are self-sustaining as the early investments include service obligations. Regional dental training centers that partner with CHCs and rural hospitals provide both expanded services and new sources of revenue for those health care facilities. Grantee outcomes will determine which programs may or may not need ongoing state funding when federal transformation funding ends. Outcomes reporting also will help grantees make the case for sustainable local funding through Workforce Development Boards, charitable and community foundations, health care organizations, health insurance companies, economic development agencies, and the business community.

Attachment A: Value-Based Purchasing

Pennsylvania has a long history of incorporating Value Based Payment (VBP) arrangements into its Medicaid managed care programs, with implementation of the first mandatory VBP initiatives occurring in 2015. Pennsylvania's Medicaid program views VBP as a key component of its continued sustainability and efficiency, both globally and specific to the initiatives included in this proposal. Through Medicaid program-wide Strategic Planning efforts, Pennsylvania aims to align the various Medicaid and CHIP programs in approach, objectives, and specific models. We will leverage this work to continue our transition from paying for volume to value, to engage in practice and system transformation efforts, and to incorporate innovation into payment models that incentivize creativity and positive outcomes for individuals, families, and communities.

We are guided by the following principles as we design the next phase of VBP in Pennsylvania Medicaid:

- The promotion of efficient and effective use of taxpayer resources;
- Improved quality of care; and
- Achieving multi-payer alignment where practical.

This Strategy is being developed utilizing population health best practices to make the biggest impacts with the minimum required financial investment. A key aspect of this Strategy is to provide hands-on technical assistance to providers to ensure that they are assuming as much risk as they're prepared for with support to grow and progress. This will ensure that providers remain viable and that they are empowered to use their data in real-time to drive outcomes. Pennsylvania has adopted this approach to help specific provider groups take on risk in VBP initiatives, including the Opioid Use Disorder Centers of Excellence and the Patient Centered Medical Homes, both of which are supported by robust statewide learning networks and data visualizations, as well as concierge technical assistance when needed.

Pennsylvania Medicaid's VBP Strategic Plan aims to promote alternative payment models to sustain innovative approaches to achieving the following goals: prioritizing preventative care, improving care coordination and integration, and making sure people receive care in the appropriate setting. In identifying priorities for this Strategic Plan, we considered the number of consumers we could impact, the room for improvement we had, and the current costs of services. Specifically, we selected priorities that would impact the largest number of people, make the biggest difference in improving outcomes, and address outsized costs. This natural progression from our solid foundation and history of VBP in the Medicaid program will position us to sustain and even grow the initiatives started with seed funding under our Rural Health Transformation Plan.

VBP strategies currently employed in Pennsylvania Medicaid include Performance-Based Contracting, Shared Savings, Shared Risk, Bundled Payments, and Global Payments. Medicaid managed care organizations (MCOs) are required to expend a minimum amount of their revenue in such arrangements. The minimum amounts steadily increased over a years-long implementation runway, and the majority of capitation dollars are now spent in arrangements with providers that seek the most cost effective, highest quality care. MCOs design payment

arrangements within these parameters that test payment model designs. Through ongoing evaluation and assessment of the progress and impact of these models, efforts are made to incorporate successful approaches into the broader managed care program by bringing them to scale and identifying sustainable funding sources.

Examples of specific arrangements and initiatives currently in place in Pennsylvania include:

- A maternity care bundled payment arrangement, which covers all prenatal, labor and delivery, postpartum, and infant healthcare services provided by a maternity care team comprised of varying provider types, including doulas. This bundled payment also includes an opportunity to earn additional incentive payments for performance on various quality measures that indicate positive birth outcomes.
- The Standardized Transitions to Community (TC) Value-Based Purchasing (VBP) model. The TC Model is a structure that standardizes performance measures to better support care transitions from psychiatric inpatient (IP) discharge to community-based services across the entire healthcare system. Requirements include (1) standardized performance measures tied to payment for IP Providers and (2) standardized data collection for outpatient (OP), Behavioral Health Home Programs (BHHP), and Case Management VBP models to link natural pathways of care that can structure standardization of attribution for VBP arrangements.
- MCO and Provider Pay For Performance (P4P) programs, which provide incentive payments and/or penalties linked to performance. Achievement of benchmarks and incremental improvements with respect to various HEDIS, CMS Core Set, and Pennsylvania Performance Measures earn MCOs and providers enhanced payment. If minimum quality standards are not met, offsets are applied. Incentivized measures are selected based on a variety of factors, including the portion of the Medicaid population reflected in the measure, the cost of care for services included in the measure, and the need for improved performance on a specific measure.
- An Integrated Care Plan (ICP) P4P program between the physical and behavioral health MCOs, focusing on improving care for those with serious persistent mental illness (SPMI). The MCOs must collaborate on identifying individuals with SPMI, establish a joint care plan and notify each other of inpatient stays within one business day. If MCOs achieve those process measures, they are eligible for an incentive payment based on their attainment of quality measure benchmarks.
- Accountable Care Organization (ACO) where primary care providers assume risk for the management of members with chronic medical conditions.
- Global budget models for participating hospitals.
- Efficiency adjustments to MCO capitation rates that penalize MCOs for inappropriate utilization (e.g., low-acuity non-emergent Emergency Department visits) and potentially preventable or avoidable hospital admissions and readmissions.
- Performance-based contracting in intellectual disability and autism service delivery for residential and supports coordination providers. Enhanced rates and P4P are available for meeting or exceeding performance measures related to areas such as wellness, clinical capacity, and implementation of technology solutions. In SFY26-27 P4P opportunities will be available for residential providers to expand service capacity in rural areas.
- The Nursing Facility Quality Incentive Program (NFQI). This performance-based contracting program is aimed at improving quality of care in nursing facilities and provides incentives for

meeting or exceeding performance measures or showing incremental improvements year-over-year. Key areas include influenza and pneumococcal vaccinations, falls, use of anti-psychotic medications, rehospitalization after a nursing facility stay, and residents with pressure ulcers.

- DHS is also well positioned to participate in value or outcomes-based arrangements with manufacturers of high-cost or high-impact drugs or biologics and may explore these opportunities in the future.

Attachment B: Initiative/Activity Summary Tables

Table 24: CMS Goal Alignment

Initiative	Activity	A	B	C	D	E
Technology & Infrastructure	Data Innovation and Information Exchange to Strengthen Pennsylvania's Care Network					X
	Digital Infrastructure and Next-Gen AI to Improve Access, Quality and Experience					X
	Mobile and Digital Health That Reaches Every Community		X			X
	Community Wellness Hubs to Improve Health and Catalyze Collaboration	X				
Maternal Health	Comprehensive Maternal Health Hubs	X	X	X	X	X
	Consumer-Facing New Mom App	X				X
	Perinatal TiPS		X		X	X
	Remote Monitoring	X	X		X	X
	Reopen Labor and Delivery and Expand Birth Centers	X	X	X	X	
	Hub-and-Spoke Telehealth	X			X	X
	Train Local Stay Local			X		
Behavioral Health	988 Expansion & Education		X			
	Remote BH Consultation (TiPS/CoCM)	X	X	X	X	X
	Scholarships for Peer and Recovery Specialists			X		
	Statewide Bridge Clinics		X			
	Mental Health Training Management System	X		X		
Aging & Access	Hospital to Home Community Paramedics	X				
	Quality Investment Program		X			
	Nurse Aide Training Hub Expansion					
	Increase and Expand Integration for Dual Eligible Rural Pennsylvanians	X	X			X
	ADRC Redesign		X			
EMS/Transportation	Rural EMS Improvement and Sustainability		X			
	MATP/NEMT Ridership for Preventative Care		X			
	Expanding Paramedic and Mobile Health Programs in Rural Areas	X	X			
Workforce	Recruiting Rural Students into Healthcare		X	X		
	Supporting Rural Clinical Training		X	X		
	New and Expanded Workforce Models for Rural PA			X	X	
Rural Care Collaboratives	Creation and implementation of Rural Care Collaboratives	X	X			

Key: A. Make Rural America Healthy Again; B. Sustainable Access; C. Workforce Development D. Innovative Care E. Tech Innovations

Table 25: Initiative/Activity Technical Score Applicability

Initiative	Activity	B1	B2	C1	C2	D1	E1	E2	F1	F2	F3
Infrastructure & Technology	Data Innovation and Information Exchange to Strengthen Pennsylvania's Care Network	X	X	X					X	X	
	Digital Infrastructure and Next-Gen AI to Improve Access, Quality and Experience	X		X	X					X	
	Mobile and Digital Health That Reaches Every Community	X		X					X		X
	Community Wellness Hubs to Improve Health and Catalyze Collaboration	X	X	X						X	X
Maternal Health	Comprehensive Maternal Health Hubs	X	X	X		X	X		X	X	X
	Consumer-Facing New Mom App		X								X
	Perinatal TiPS	X		X					X	X	
	Remote Monitoring			X					X		X
	Reopen Labor and Delivery & Expand Birth Centers	X		X							
	Hub-and-Spoke Telehealth	X		X							X
	Train Local Stay Local					X					
Behavioral Health	989 Expansion &Education	X		X					X		
	Remote BH Consultation (TiPS/CoCM)	X		X	X				X	X	
	Scholarships for Peer and Recovery Specialists	X			X	X					
	Statewide Bridge Clinics	X		X					X		
	Mental Health Training Management System	X				X					
Aging & Access	Hospital to Home Community Paramedics	X	X	X	X	X	X			X	X
	Quality Investment Program	X				X	X			X	X
	Nurse Aide Training Hub Expansion	X		X		X				X	
	Increase and Expand Integration for Dual Eligible Rural Pennsylvanians	X	X	X		X		X	X	X	X
	ADRC Redesign		X	X				X			
EMS/ Transportation	Rural EMS Improvement and Sustainability				X	X					
	MATP/NEMT Ridership for Preventative Care	X		X		X					
	Expanding Paramedic and Mobile Health Programs in Rural Areas			X	X				X		
Workforce	Recruiting Rural Students into Healthcare				X	X					
	Supporting Rural Clinical Training	X	X	X	X	X					
	New and Expanded Workforce Models for Rural PA	X	X	X	X	X					
RCC	Creation and implementation of Rural Care Collaboratives	X	X	X	X	X			X		

Attachment C: List of CCBHCs

Certified Community Behavioral Health Clinic	Address	Rural
Berks Counseling Center	645 Penn St, Reading, PA 19601	No
Gaudenzia	166 W Main St 2nd floor, Norristown, PA 19401	No
Merakey	620 Germantown Pike, Lafayette Hill, PA 19444	No
Merakey	906 Bethlehem Pike, Erdenheim, PA 19038	No
Mercy Life Center Corp (aka Pittsburgh Mercy)	1200 Reedsdale St, Pittsburgh, PA 15233	No
Northeast Treatment Center	2205 Bridge St, Philadelphia, PA 19137	No
The Guidance Center	110 Campus Dr, Bradford, PA 16701	Yes
WellSpan Health York	1001 South George St, York, PA 17403	No

Attachment D: Medicaid DSH Payments

ID + SL	Medicare ID	Hospital Name
1007691860184	390231	ABINGTON MEMORIAL HOSPITAL
1007544140015	390142	ALBERT EINSTEIN MEDICAL CENTER
1007447680001	390032	ALLE KISKI MEDICAL CENTER
1007705250010	390115	ARIA HEALTH
1007459070002	390163	ARMSTRONG COUNTY MEMORIAL HOSPITAL
1038951580004	390272	AVENUES RECOVERY MEDICAL CENTER AT VALLEY FORGE
1007276220007	391309	BARNES KASSON HOSPITAL
1030413400002	394023	BELMONT BEHAVIORAL HOSPITAL
0019651800002	394049	BROOKE GLEN BEHAVIORAL HOSPITAL
1007354280026	390139	BRYN MAWR HOSPITAL
1007644390002	391304	BUCKTAIL MEDICAL CENTER
1007731600013	390168	BUTLER MEMORIAL HOSPITAL
1007459700009	390151	CHAMBERSBURG HOSPITAL
1000011270106	391313	CHARLES COLE MEMORIAL HOSPITAL
1007276690009	390179	CHESTER COUNTY HOSPITAL
0010207410006	393304	CHILDREN'S HOME OF PITTSBURGH
1007709910056	393303	CHILDREN'S HOSPITAL OF PHILADELPHIA
1002337670005	390093	CLARION HOSPITAL
1029762890001	390110	CONEMAUGH MEMORIAL MEDICAL CENTER
1029763220001	391302	CONEMAUGH MEYERSDALE MEDICAL CENTER
1029763780001	391317	CONEMAUGH MINER'S MEDICAL CENTER
1029989290001	390062	CONEMAUGH NASON MEDICAL CENTER
1007699900022	391308	CORRY MEMORIAL HOSPITAL
1031151300001	390180	CROZER CHESTER MEDICAL CENTER
1031068930001	390081	DELAWARE COUNTY MEMORIAL HOSPITAL
1001257320003	390203	DOYLESTOWN HOSPITAL
1007779290003	390278	EAGLEVILLE HOSPITAL
1027435270001	390329	EINSTEIN MEDICAL CENTER MONTGOMERY
1000027790002	393031	ENCOMPASS HEALTH REHAB HOSPITAL OF MECHANICSBURG
1007676460004	393026	ENCOMPASS HEALTH REHAB HOSPITAL OF READING
1000053130003	393037	ENCOMPASS HEALTH REHABILITATION HOSPITAL OF YORK
1007373060011	391306	ENDLESS MOUNTAINS HEALTH SYSTEMS
1007731510008	390013	EVANGELICAL COMMUNITY HOSPITAL
1019219380001	394038	FOUNDATIONS BEHAVIORAL HEALTH
1007279630007	390217	FRICK HOSPITAL
1012776950001	394008	FRIENDS BEHAVIORAL HEALTH SYSTEM
1007427630011	391303	FULTON COUNTY MEDICAL CENTER
1007740410009	390003	GEISINGER BLOOMSBURG HOSPITAL

ID + SL	Medicare ID	Hospital Name
1007456760006	390001	GEISINGER COMMUNITY MEDICAL CENTER
1007506760004	390048	GEISINGER LEWISTOWN HOSPITAL
1007478860069	390006	GEISINGER MEDICAL CENTER
1007584780002	390270	GEISINGER WYOMING VALLEY MEDICAL CENTER
1007732780004	390066	GOOD SAMARITAN HOSPITAL
1007608230009	393035	GOOD SHEPHERD REHABILITATION HOSPITAL
1001257410007	390057	GRAND VIEW HOSPITAL
1007765470006	390266	GROVE CITY MEDICAL CENTER
1037273860001	390332	GSL HOSPITAL
1000033550174	390036	HERITAGE VALLEY BEAVER
1000033550179	390037	HERITAGE VALLEY SEWICKLEY
1007769210010	390184	HIGHLANDS HOSPITAL
1001264530009	390097	HOLY REDEEMER HEALTH SYSTEM
1007718810081	390004	HOLY SPIRIT HOSPITAL
1001258770069	390111	HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
1007713530001	390173	INDIANA REGIONAL MEDICAL CENTER
1007683760041	390056	JC BLAIR MEMORIAL HOSPITAL
1007443470018	390265	JEFFERSON REGIONAL MEDICAL CENTER
1007703560003	391300	JERSEY SHORE HOSPITAL
1007283700001	394047	KIDSPEACE CHILDREN'S HOSPITAL
1007711750051	390100	LANCASTER GENERAL HOSPITAL
1022567890001	390012	LANSDALE HOSPITAL
1007610520083	390219	LATROBE HOSPITAL
1007660210018	390133	LEHIGH VALLEY HOSPITAL
1007287190004	390185	LEHIGH VALLEY HOSPITAL HAZLETON
1007607250019	390030	LEHIGH VALLEY HOSPITAL SCHUYLKILL (SOUTH)
1007579170002	393038	MAGEE MEMORIAL HOSPITAL
1007354280039	390195	MAIN LINE HOSPITAL LANKENAU
1007521150043	390113	MEADVILLE MEDICAL CENTER
1007306820001	390156	MERCY FITZGERALD HOSPITAL
1007711200008	390198	MILLCREEK COMMUNITY HOSPITAL
1007653100005	390256	MILTON S. HERSHEY MEDICAL CENTER
1007388870002	390147	MONONGAHELA VALLEY HOSPITAL
1007568020011	394033	MONTGOMERY COUNTY EMERGENCY SERVICE
1007466550003	390268	MOUNT NITTANY MEDICAL CENTER
1007607800008	391301	MUNCY VALLEY HOSPITAL
1007654720011	390204	NAZARETH HOSPITAL
1007276960125	392026	NPHS GIRARD
1007354280036	390153	PAOLI HOSPITAL
1007733760004	391312	PENN HIGHLANDS BROOKVILLE
1007740880070	390086	PENN HIGHLANDS DUBOIS

ID + SL	Medicare ID	Hospital Name
1007292600030	391315	PENN HIGHLANDS ELK
1007297070008	390223	PENN PRESBYTERIAN MEDICAL CENTER
1000049150007	390226	PENNSYLVANIA HOSPITAL
1034413330001	390127	PHOENIXVILLE HOSPITAL
1033608700007	390101	PINNACLE HEALTH MEMORIAL HOSPITAL
1007723970001	390201	POCONO MEDICAL CENTER
1034416920001	390123	POTTSTOWN MEMORIAL MEDICAL CENTER
1028624840001	390070	PRIME HEALTHCARE LOWER BUCKS
1007712640007	390199	PUNXSUTAWNEY AREA HOSPITAL
1002865910069	390044	READING HOSPITAL AND MEDICAL CENTER
1026073290001	390237	REGIONAL HOSPITAL OF SCRANTON
1007412290004	390222	RIDDLE MEMORIAL HOSPITAL
1007706140003	390079	ROBERT PACKER HOSPITAL
1026857910001	390304	ROXBOROUGH MEMORIAL HOSPITAL
1001625200025	390009	SAINT VINCENT HEALTH CENTER
1033772880001	390211	SHARON REGIONAL HEALTH SYSTEM
1025888780001	393309	SHRINERS HOSPITALS FOR CHILDREN PHILADELPHIA
1007552510051	390049	ST LUKES HOSP OF BETHLEHEM
1038163600001	390162	ST LUKES HOSPITAL - EASTON CAMPUS
1037284090001	393307	ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN
1007552060019	390228	ST. CLAIR MEMORIAL HOSPITAL
1007544970057	390096	ST. JOSEPH MEDICAL CENTER
1028092900001	390326	ST. LUKE'S ANDERSON CAMPUS
1032200100001	390330	ST. LUKES HOSPITAL MONROE CAMPUS
1007454700008	390183	ST. LUKE'S MINER'S MEMORIAL HOSPITAL
1007457000001	390035	ST. LUKE'S QUAKERTOWN HOSPITAL
1007731420004	390258	ST. MARY MEDICAL CENTER
1030757500001	390116	SUBURBAN COMMUNITY HOSPITAL
1007351140008	390027	TEMPLE UNIVERSITY HOSPITAL INC
1007508540018	390174	THOMAS JEFFERSON UNIVERSITY HOSPITAL
1007460650003	391314	TITUSVILLE AREA HOSPITAL
1007505780019	391305	TROY COMMUNITY HOSPITAL
1007734000002	391307	TYRONE HOSPITAL
1007630750018	390041	UNIONTOWN HOSPITAL
1007278290085	390073	UPMC ALTOONA
1007460470003	390117	UPMC BEDFORD
1033557810001	390058	UPMC CARLISLE
1007347990059	393302	UPMC CHILDREN'S HOSPITAL OF PITTSBURGH
1027265440001	390328	UPMC EAST
1007286570033	390063	UPMC HAMOT
1007282360025	390178	UPMC HORIZON

ID + SL	Medicare ID	Hospital Name
1000021890007	390016	UPMC JAMESON
1007457740004	390104	UPMC KANE
1033600840001	390068	UPMC LITITZ
1007711570045	390114	UPMC MAGEE WOMEN'S
1007643400014	390002	UPMC MCKEESPORT
1001380890017	390028	UPMC MERCY HOSPITAL OF PITTSBURGH
1007757910056	390091	UPMC NORTHWEST
1001913350005	390107	UPMC PASSAVANT
1000025630043	390067	UPMC PINNACLE
1007440330006	390233	UPMC PINNACLE HANOVER
1000019040029	390164	UPMC PRESBYTERIAN SHADYSIDE
1002086660009	390039	UPMC SOMERSET
1007599200016	390102	UPMC ST. MARGARET
1000037670010	391316	UPMC WELLSBORO
1007548350019	390045	UPMC WILLIAMSPORT
1007284970027	390146	WARREN GENERAL HOSPITAL
1030055690001	390150	WASHINGTON HEALTH SYSTEM GREENE
1007389110009	390042	WASHINGTON HOSPITAL
1007383590002	390125	WAYNE MEMORIAL HOSPITAL
1007464680006	390225	WELLSPAN EPHRATA COMMUNITY HOSPITAL
1007590180008	390065	WELLSPAN GETTYSBURG HOSPITAL
1007720000016	394020	WELLSPAN PHILHAVEN
1007277200094	390050	WEST PENN-ALLEGHENY GENERAL HOSPITAL
1007277200082	390267	WESTERN PENN HOSP-FORBES REGIONAL CAMPUS
1007277200061	390090	WESTERN PENN HOSPITAL
1007748470028	390145	WESTMORELAND REGIONAL HOSPITAL
1001965470059	390046	YORK HOSPITAL
1007277200146	390334	AHN WEXFORD HOSPITAL
1039628500001	390336	PENN STATE HEALTH HAMPDEN MEDICAL CENTER
1040395160002	390339	PENN STATE HEALTH LANCASTER MEDICAL CENTER
1039786260001	390335	ST LUKES HOSPITAL CARBON CAMPUS

Attachment E: RHTP Eligible Rural Counties

County	PREP Region	Class		County	PREP Region	Class
Adams	South Central	5		Juniata	Central	7
Armstrong	Southwest	6		Lancaster	South Central	2a
Bedford	Southern Alleghenies	6		Lawrence	Northwest	5
Berks	South Central	3		Lebanon	South Central	5
Blair	Southern Alleghenies	5		Luzerne	Northeast	3
Bradford	Northern Tier	6		Lycoming	Central	5
Bucks	Northeast	2a		McKean	North Central	6
Butler	Southwest	4		Mercer	Northwest	5
Cambria	Southern Alleghenies	4		Mifflin	Central	6
Cameron	North Central	8		Monroe	Northeast	4
Carbon	Northeast	6		Montour	Central	8
Centre	Central	4		Northumberland	Central	5
Clarion	Northwest	6		Perry	South Central	6
Clearfield	North Central	6		Pike	Northeast	6
Clinton	Central	6		Potter	North Central	8
Columbia	Central	6		Schuylkill	Northeast	4
Crawford	Northwest	6		Snyder	Central	7
Cumberland	South Central	3		Somerset	Southern Alleghenies	6
Dauphin	South Central	3		Sullivan	Northern Tier	8
Elk	North Central	6		Susquehanna	Northern Tier	6
Erie	Northwest	3		Tioga	Northern Tier	6
Fayette	Southwest	4		Union	Central	7
Forest	Northwest	8		Venango	Northwest	6
Franklin	South Central	4		Warren	Northwest	6
Fulton	Southern Alleghenies	8		Washington	Southwest	4
Greene	Southwest	6		Wayne	Northeast	6
Huntingdon	Southern Alleghenies	6		Westmoreland	Southwest	3
Indiana	Southwest	6		Wyoming	Northern Tier	7
Jefferson	North Central	6				

Attachment F: Workforce Examples

Surgical Obstetric Fellowship for Family Medicine Physicians (FM-OB)

Description: A **s**tructured 12-month post-residency fellowship training programs, where a board-certified family physician receives specialized training in OB including surgical obstetrics and cesarean sections, to expand maternity care access in rural Pennsylvania. The fellowship objectives include:

- Provide hands-on training in cesarean sections and other obstetric procedures to increase OB and surgical capacity in rural areas.
- Prepare fellows to lead quality improvement and patient safety initiatives in maternal and neonatal care while strengthening interdisciplinary collaboration and supporting comprehensive care.
- Build skills in population health and rural healthcare delivery through partnerships with local health departments and rural hospitals.
- Ensure competency in labor management and prenatal care and cesarean delivery through direct observation and procedural logs. Completion of at least 100 deliveries, with at least 50 cesarean sections providing eligibility for the ABPS FMOB Surgical Board Exam upon graduation.

Rationale: Pennsylvania's rural hospitals have experienced over a dozen maternity unit closures in the last decade; nearly 1 in 3 counties in Pennsylvania are considered maternity care deserts. Establishing Family Medicine-OB fellowships (FM-OB) will offer advanced obstetric training to family physicians, which would benefit both patients and resident learners. The fellowship would supply laborists for the OB/GYN departments, bolster Family Medicine obstetrics teaching, and encourage more Family Medicine graduates to practice obstetrics. Importantly, family medicine residents often remain in the areas where they train. The 2023 AAMC Report on Residents showed that 66.5% of family medicine residents trained in Pennsylvania stay in the state to practice. Given this data, we anticipate that regional-based OB fellowships would help expand the number of surgical OB providers in the region, offering a sustainable solution to the rural maternal health crisis.

RHTP Funds: Funding will be used to support fellow salaries (estimate of $77,000 per year with benefits) and faculty stipends for a fellowship director and obstetrical attending preceptors. Additional costs will support program coordination, housing support, and a CME budget for required courses.

Sustainability: The long-term impact and sustainability of the program will be reinforced through billable revenue for services provided by trainees and retention incentives alongside service obligations.

A New Rural Medical School: Indiana University of Pennsylvania College of Osteopathic Medicine (IUP COM)

Description: IUPCOM will be the first public osteopathic medical school in the state of Pennsylvania and the *only* medical school in the Commonwealth with a mission focused on addressing the health care needs of rural Pennsylvania in the Appalachia region. A core strategy is support for rural pipeline programs and sustainable pathways connecting rural communities to medical education, ensuring students from Pennsylvania's medically underserved areas have the support needed to access medical careers. More information on the IUP COM and its vision can be found at: IUP's Proposed College of Osteopathic Medicine - IUP.

Rationale: Pennsylvania is in an acute healthcare crisis due in large part to a lack of primary care physicians (PCPs). This situation is more pressing in rural PA where many PCPs are nearing retirement, creating an anticipated shortage of 1030 PCPs in PA by 2030.

Status: IUP COM is on track to matriculate its first class in 2027. Since 2024, they have hired a transformative dean, clinical leadership, and developed an extensive network of partnerships, GME funding, and clinical training sites, including with DHS's state hospitals. They have achieved credentialing approval from the American College of Osteopathic Medicine.

RHTP funds: In collaboration with the Hospital & Healthsystem Association of Pennsylvania (HAP), IUP COM proposes a $20 million rural workforce initiative to recruit its first cohort. RHTP funding can be leveraged to accelerate and sustain the impact on rural Pennsylvania.

Year 1: Outreach and recruitment to rural students *($3 million)* - Capitalizing on the Pennsylvania State System of Higher Education (PASSHE) public university system, IUP COM will build a rurally based statewide outreach campaign and pipeline program to recruit and train students to become physicians practicing in rural Pennsylvania.
Year 2: Infrastructure development including faculty and curriculum development *($5 million)*- Develop rurally focused medical curriculum.
Year 3: Rural-focused scholarships based on financial need *($6 million)* - Providing scholarships for 30 students from rural areas who demonstrate financial need. In return, recipients will practice medicine for 5 years in rural Pennsylvania.
Year 4: Clinical training *($3.5 million)* - Build infrastructure for a sustainable clinical training program including program staff salaries, preceptor stipends, program administration, and financial assistance for temporary housing for medical trainees.
Year 5: Implementation/follow-up: *($2.5 million)* - Providing direct support for graduate medical education/new medical residency training opportunities in rural areas. This phase will include staffing infrastructure and tracking/monitoring of student scholarship.

Sustainability: The program will be sustainable as demonstrated by the significant increase in rural medical student trainees and graduates who will be practicing (with 5-year service commitments) in rural Pennsylvania (tracked annually through alumni data).

Regional Dental Training Centers: An Innovative and Sustainable Solution to the Dental Workforce Crisis

Description: The University of Pittsburgh School of Dental Medicine (UPSDM) proposes to build Regional Training Centers (RTCs), a multidisciplinary educational and patient care initiative structured to directly address the dental workforce shortages and improve rural oral health. They are built on strong partnerships with Federally Qualified Health Centers (FQHC) and/or rural hospitals. Each RTC will bring 16 new dental providers to a region: three GPR residents, six dental assistant trainees, five dental hygiene students, one faculty dentist, and one faculty hygienist. These providers can significantly improve access to care in the region.

Rationale: Pennsylvanians face many oral health challenges including access to care, availability of dental specialists, and insurance coverage. These challenges are compounded for rural residents and exacerbated by the shortages in dentists, dental hygienists, and dental assistants. In Pennsylvania, 149 areas are categorized as dental health professional shortage areas. Additionally, there has been a 2% loss in dental hygienists since 2015 and a 15% loss in dental assistants since 2019. Graduating dentists from PA dental schools are also choosing jobs in urban areas over rural communities.

Status: UPSDM has initial contracts in 3 rural counties and with startup funds can launch 3 additional rural dental training centers in the next 2 years (2026/2027). Based on a successful pilot, they project that each RCT will provide training through a new rural hybrid track of the UPSDM hygiene program and a Dental Assistant Training Program and the General Practice Residency Program (GPR).

RHTP funds: An initial investment of ~ $1,000,000 (depending on current equipment) is required to furnish each dental center (in an FQHC or regional hospital) with the required operatory, sterilization, radiology, and simulation lab equipment.

Sustainability: After the initial start-up cost, the RTC becomes sustainable.

- The UPSDM will receive expanded tuition from dental hygienists and assistants
- FQHCs will be able to expand their scope of practice and be reimbursed for dental procedures
- Rural hospitals, in addition to new GME funds, will have dental faculty and residents who can help alleviate the strain that oral health issues place on an emergency department by being on-call for oral health emergency issues.

PC-Medic: Expanding the rural primary care workforce

Description: The **Primary Care Medic (PC-Medic)** initiative is an innovative workforce training program designed to expand team-based, whole-person primary care by creating and integrating a new certificate-level health care role. Based on the proven U.S. military "medic" model and the civilian EMT paradigm, PC-Medics will be **trained** to deliver high-quality primary and preventive care under supervision of a licensed provider.

Rationale: In Pennsylvania, rural communities have less than half as many primary care providers per 1,000 residents as their urban counterparts. This disparity is compounded by transportation barriers, geographic isolation, the closure of local medical facilities, and an aging population with a disproportionate burden of chronic medical and mental health conditions. Traditional efforts to expand the primary care workforce have not addressed gaps.

Current Status: We are conducting a data-driven evidence-based **Curriculum Design,** which includes defining a new scope of practice for the PC-Medic model. We will conduct a focused review of epidemiological data, public health reports and existing models of care in rural Pennsylvania. We will identify and adapt evidence-based guidelines and protocols from sources like the VA/DOD Clinical Practice Guidelines. We will then develop training modules focused on chronic disease management (diabetes, hypertension), preventive care, behavioral health (anxiety, depression), oral health, and maternity care.

RHTP funds We estimate that $2,000,000 will cover the five-year project period (FY26-FY31) to achieve the following**:**
Year 1: Stakeholder Engagement in rural areas with severe access challenges in primary, behavioral, oral, and maternity care. We will work with the PREP/Rural Care Collaboratives to conduct focus groups with potential learners (e.g., transitioning military medics, EMTs) and employers (e.g., rural FQHCs, clinics) to refine the curriculum and scope of practice.
Year 2: Telehealth Platform Selection & Adaptation - We will modify the Penn State SAFE-T System, a secure, HIPAA-compliant care delivery platform already being used in rural Pennsylvania. This platform will integrate the PC-Medic training modules and clinical practice algorithms that include clinical decision-support tools, and secure video for real-time provider consultation, and workflows for secure documentation.
Year 3: Pilot Study, evaluation, module refinement and certification - Following development, we will launch and evaluate a **Clinical Pilot** in Pennsylvania's largest FQHC network. Results will be used to pursue **legislative and regulatory changes** to achieve formal recognition of the PC-Medic certification and scope of practice.
Years 4 and 5: Recruitment, implementation, and sustainability of the PC-Medic Program. We will embed the training program within Penn State Extension community colleges network and develop an "earn-while-you-learn" apprenticeship model. We will proactively engage with public and private payers to establish PC-Medic services as reimbursable, either through new billing codes or as part of value-based care arrangements.

Attachment G: Governance Descriptions

Table 26: Operational Structure

Governance Entity	Roles/Description
Governance and Oversight Committee	Representation from state "Health Hub" agencies (Departments of Human Services, Health, Aging, Insurance, Drug and Alcohol Programs), Governor's Office, and PA Office of Rural Health **Role**: This committee will meet monthly to provide strategic oversight, policy direction, and accountability for all aspects of RHTP. They will ensure alignment with statewide goals, approve major programmatic and financial decisions, monitor performance against milestones, coordinate cross-agency collaboration, resolve implementation challenges, and maintain compliance with federal and state requirements.
Interagency Project Team	Representation from state "Health Hub" agencies (Departments of Human Services, Health, Aging, Insurance, Drug and Alcohol Programs), Governor's Office, and PA Office of Rural Health **Role**: This team will perform the day-to-day interagency coordination and communication around strategic initiatives as well as serve as the project and fiscal management staff.
Advisory Council	Subject matter experts in each of the key initiatives and areas (e.g., digital technology/infrastructure, maternal health, behavioral health, aging, workforce development, EMS/transportation, and prevention and chronic disease) as well as clinical and financial payment models. It also will include other stakeholder representatives (e.g., hospitals, payers, providers, and representatives from drug/treatment courts behavioral health programs, and Areas on Aging representatives, and other key partners). The PA Rural Health Redesign Center is currently funded to provide technical assistance to rural hospitals on alternative payment models. **Role**: This body will advise the Health Hub Leadership and RCCs on RHTP initiatives, implementation, stakeholder engagement, and activity sustainability. They will meet monthly in the first year and then at least quarterly and as needed.
Rural Care Collaboratives (RCC) Steering Committee	One Representatives from each of the eight PREP/RCC regions **Role**: This committee will meet quarterly to coordinate joint activities across regions and share lessons learned across regions.
Rural Care Collaboratives (RCCs)	Representatives from local government (County Commissioners, police, fire, EMS, courts, etc.), the business and economic development community, Community Health Centers, local community-based organizations addressing social determinates of health, patients, payers, and local health care providers, including clinical and financial leadership from each rural hospital, even if that hospital is part of a larger system, as well as other key stakeholders identified by regional leaders **Role**: The RCCs will convene regional stakeholders, forge regional partnerships, prioritize initiatives, tailor strategies locally, manage initiatives and funds, report data on program performance, collaborate with the evaluation team and the interagency project team, align rural health transformation with regional economic development and develop regional strategies for long-term sustainability.

Table 27: Project Governance

Project Teams/Partners	Roles/Description
State Agencies	Department of Human Services (Lead) Departments of Health, Aging, Insurance, Drug and Alcohol Programs, Governor's Office, and other agencies as necessary.
Staffing Plan Program Director Program Managers Fiscal/Contracts Oversight Additional partner agency positions as determined	 Overall project management, performance, CMS liaison Day-to-day management of initiatives, RCC engagement and compliance Procurement and fiscal management
External Partners PREP/RCC Regional Organizations Evaluation Partner PA Office of Rural Health	 Launch/lead RCCs, lead regional implementation, prioritize strategies, regional stakeholder engagement University of Pittsburgh Medicaid Research Center (MRC) Penn State University

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