For nearly 900,000 Kansans, home is a rural community. Health care is the heart of these communities; those without local access to primary care services experience declining populations and shrinking economic opportunities for those who remain. The fight to maintain services, therefore, is literally a battle to preserve these communities. With significant stakeholder engagement, the State has developed an ambitious Rural Health Transformation Plan (the "Plan") aligned with existing initiatives with the vision that rural Kansas communities will thrive as residents lead healthier lives and have ready access to high-quality, well-coordinated, and comprehensive health care services.

I. Rural Health Needs and Target Population

Rural Demographics

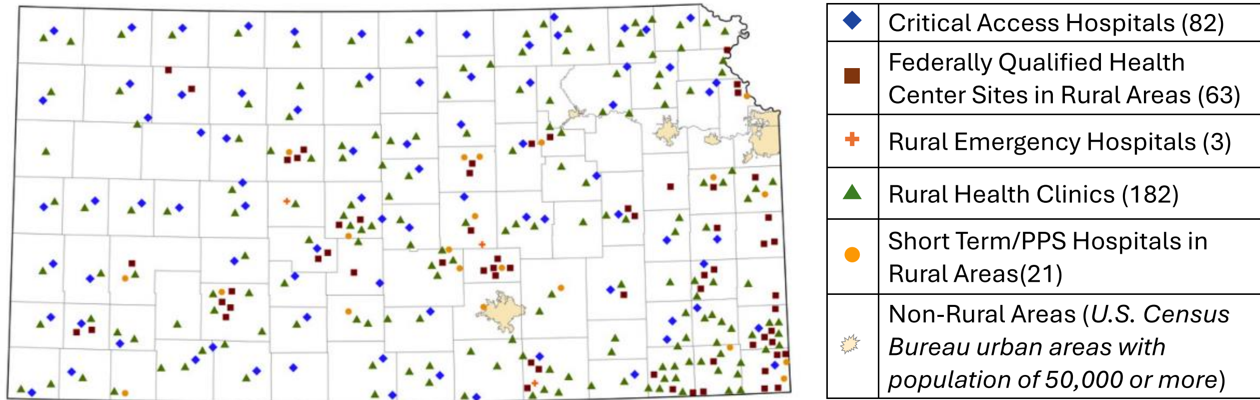
Population Size and Density	Kansas has 105 counties with a total population just under 3 million.[i] Of that population, about 860,000 (29.2%) reside in one of Kansas' 85 rural counties (i.e., those outside a metropolitan statistical area).[ii,iii] Nearly two-thirds (61) of rural Kansas counties are not adjacent to an MSA and 50 counties have urban populations of fewer than 5,000.
Income Levels	According to the most recent data, Kansas' rural population has a per-capita income of $55,677, compared to a state average of $66,115 and an urban per-capita income of $70,423. The poverty rate is 12.7%, compared to a state average of 11.2% and an urban poverty rate of 10.6%.[iv]
Employment Sectors	Rural Kansas' employment sectors include agriculture, healthcare, and manufacturing with secondary sectors in transportation and logistics, retail and hospitality, and government and education. In small communities, healthcare and government are among the largest employers. The agricultural sector, which employs just under 7% of rural Kansans, includes grains, beef production, and related industries. The manufacturing sector, which employs nearly 15% of rural Kansans, supports agriculture and the transportation and manufacturing industries.[v]
Unemployment	The unemployment rate in rural Kansas counties ranges from 3.2% to 6.1%,[vi] while the average rate in urban areas is 3.8%.[vii]
Educational Attainment	One in ten rural county residents aged 25 and older never graduated from high school compared to an urban county rate of 7.3%. Only 24.2% have earned a bachelor's degree or higher, compared to the state average of 35.2%.
Health Insurance Coverage	The uninsured rate for all Kansans aged 0-64 is 10.2%. For rural counties, however, the rate is 11.8%, while only 9.6% in urban counties.[viii] Among Kansas Medicaid enrollees, 34% live in a rural area.[ix] Enrollment in Medicare Advantage in rural Kansas is significantly below national averages. Blue Cross Blue Shield of Kansas controls about 85% of the commercial market in Kansas.[x]

Health Outcomes

Chronic Conditions	56.5% of Kansas adults report having at least one chronic condition, compared to 54.3% nationally. 10.3% of Kansas adults have three or more chronic conditions, compared to 10.1% nationally.[xi] Kansas adults experience obesity and hypertension at a higher rate (35.9% and 34.7%) than the national average (34.3% and 34.0%).[xii]
Behavioral Health	According to Mental Health America's 2025 State of Mental Health in America report, Kansas ranked 30th overall in adult measures of prevalence and access.[xiii]
Pediatric Health Outcomes	Kansas children die at a rate of 52 per 100,000 compared with 49.8 per 100,000 children nationally. Kansas teens aged 15-19 are dying by suicide at an alarming rate of 17.8 per 100,000 compared to the national rate of 10.5 per 100,000.[xiv]
Limited Access to Healthy Foods	6% of the general U.S. population have limited access to healthy food. This percentage is 8% for Kansans and 10.32% for rural Kansans.[xv]
Smoking	13% of U.S. adults smoke, 15% of Kansans smoke, and 17.52% of rural Kansans smoke.[xvi]
Life Expectancy	Life expectancy in rural Kansas counties is 75.28 years, compared to 76.4 years for the state as a whole and 77.1 years nationally.[xvii]

Healthcare Access. Most rural Kansas counties are designated as primary care shortage areas (the numbers on the map below are each designated county's primary care HPSA score). All rural Kansas counties are designated as mental health shortage areas.[xviii] Over 46% of Kansas women live in a maternal care desert and 41% of Kansas counties do not have maternity care services. An increasing number of Kansans have to travel up to 60 miles for low-risk prenatal/postpartum and labor and delivery care.[xix]

The map below depicts the distribution of rural health care facilities throughout the state based on HRSA data current through July 2025.



Nearly all rural health clinics are affiliated with the local hospital, and there are very few independent physician practices in rural Kansas. Less than 25% of rural Kansas counties have an FQHC; those FQHCs in rural counties are mainly satellite clinics with limited services and operating hours.[xx] Because Kansans value local ownership and control, fewer than 10% of the state's rural hospitals are owned or managed by large health systems.

Rural Facility Financial Health. Kansas' rural hospitals (78 CAHs and 25 rural PPS hospitals) face significant financial challenges placing enormous stress on their communities. A recent study commissioned by the Kansas Hospital Association (KHA) ranked Kansas rural hospitals' performance across key financial indicators against the performance of other states' rural hospitals using 2023 Medicare cost report data, the most current and complete data available.[xxi] As demonstrated by this chart summarizing the results of that study, Kansas rural hospitals rank near the bottom on nearly every metric:

Ranking of 2023 Median Financial Metrics to U.S. States
Lower Score Better

		Kansas	
	Metric	PPS - Rural	CAH
1	Total Margin	43	43
2	Operating Margin	39	43
3	Return on Equity	39	43
4	Current Ratio	45	21
5	Net Days in Patient A/R	34	37
6	Equity Financing Ratio	38	30
7	Cash Flow to Total Liabilities	28	37
8	Average Age of Plant	10	39
9	Occupancy Rate	43	29

According to the Chartis Center for Rural Health's 2025 Rural Health State of the State report, Kansas has the second highest number (46) and third highest percentage (47%) of rural hospitals vulnerable to closure.[xxii] Since 2015, six rural Kansas hospitals have closed, the most recent in October 2023.[xxiii] Two of the now-closed hospitals were owned by an out-of-state not-for-profit health system unwilling to invest in local communities. The other four closed after years of financial difficulties and low patient volumes.

While most rural Kansas hospitals have experienced multiple years of negative operating margins, they are strongly supported by the communities they serve in the form of tax levies to sustain local services. Few states have as many local jurisdictions actively contributing tax revenue directly to hospital operations. Internal analysis of inpatient and outpatient hospital services claims data collected by KHA also reflects these communities' commitment to local hospitals, as the data shows minimal patient outmigration for services available in the community. Stated another way, Kansans do not drive past their local hospital if the service they require is available at that hospital.

In the near future, however, our state's rural hospitals will no longer be able to rely on local tax revenue to fill the gap between operating costs and patient care revenue, as their communities struggle with other rising costs. Rural hospital leaders, therefore, understand the transformation

imperative. But with negative operating margins, hospitals lack the ability to make the investments necessary for regional collaboration, clinical integration, and technology solutions. Targeted initiatives funded by the RHT Program will empower rural Kansas providers to abandon our current reactive “sick care” model in favor of a proactive and sustainable delivery system that enables every rural Kansan to live their healthiest lives possible.

Target Population. Kansas’ Plan will leave no one behind: its impact will extend to all residents of our state’s 85 rural counties. All rural providers – including hospitals, RHCs, FQHCs, CCBHCs, physician clinics, local health departments, nursing facilities, and EMS – will have opportunities to participate.

II. Rural Health Transformation Plan: Goals and Strategies

Foundation for Transformation. Any plan to transform rural health will place significant demands on resource-strapped rural providers, *e.g.*, participate in trainings, overhaul workflows, implement technologies, collect and report data. Unlike other states, Kansas has an existing statewide infrastructure trusted by rural providers through which to successfully implement its Plan. In 2014, the CMS Innovation Center awarded the University of Kansas Health System (TUKHS), the state’s only academic medical center, $12.4 million to build and operate a rural clinically integrated network.[xxiv] Originally comprised of 13 rural hospitals, the network, known as the Care Collaborative, now includes 91 provider organizations across 79 of Kansas’ 105 counties. This includes hospitals in 72 of the 75 rural Kansas counties with hospitals, along with their affiliated clinics.

Through a formal participant agreement, each organization is committed to adopting and adhering to evidence-based protocols and engaging in continuous performance improvement activities. There are no fees to participate; instead, providers invest the time and effort required for

success. The Care Collaborative has been listed continuously as a Patient Safety Organization with the Agency for Healthcare Research and Quality since 2016.[xxv]

The Care Collaborative's "secret sauce" is direct, hands-on engagement with participants. The team works with each organization individually to tailor protocols developed at the academic medical center. All trainings are held locally to ensure all clinical and administrative staff can attend. The Care Collaborative has presented more than 250 of these local "boot camps" on time-critical diagnoses and chronic disease management. Care Collaborative staff collect and analyze data and meet one-on-one with providers to develop performance improvement plans. Just last month, the Care Collaborative launched its newest initiative to bring on-site emergency obstetrics simulation training to 60+ rural communities. The Care Collaborative operates as a department of TUKHS and can access the academic medical center's significant resources to support its work.

Most importantly, the Care Collaborative has established trusted relationships with provider organizations across the state over the last decade. It maintains infrastructure to support implementation across multiple organizations, tailoring interventions to meet each communities' specific needs. With their shared Care Collaborative experience, rural Kansas providers are prepared to do the work required for real transformation of our rural health care delivery system.

Plan Mission, Values, and Objectives. The Plan's mission is tied directly to the RHT Program's strategic goals: improve rural Kansans' health and transform the delivery system by implementing and sustaining initiatives that promote preventive health and address root causes of diseases, enhance rural providers' efficiency and sustainability, attract and retain a high-skilled health care workforce, spark growth of value-based care models, and foster the use of innovative technologies.

Plan Objectives

The Plan's five objectives, again tied directly to the Program's strategic goals, provide the framework for the Plan's five initiatives:

1) Realize meaningful reductions in chronic disease rates and avoidable hospitalizations for complications related to chronic disease in rural Kansas.
2) Substantially reduce the number of rural Kansas hospitals with negative operating margins.
3) Improve provider-to-population ratios for primary care, dental and behavioral health services and ease nursing and allied health shortages in rural Kansas.
4) Have 100% of Medicare and Medicaid beneficiaries in rural Kansas in accountable care relationships by 2031.
5) Enable rural Kansas providers to meaningfully engage in data sharing and analysis, expanded use of telehealth and remote monitoring, appropriate use of artificial intelligence, and utilization of consumer-facing technologies.

Four Core Values Drive All Plan-Related Decision-Making

1) **Improve the Health of All Kansans**. Our current "sick care" system must be transformed into one that enables every rural Kansan to live their healthiest life possible.
2) **Ensure Access to Quality Health Care**. All rural Kansans should have access to a well-coordinated continuum of care, including local primary care and social services and seamless transitions to regional specialty care.
3) **Promote Effective Use of Technology**. Rural Kansas providers should leverage technology, from telehealth and remote monitoring to data analytics and mobile health solutions, to bridge geographic gaps, enhance care delivery, and empower patients.
4) **Make Responsible Investments**. Kansas should invest Program funds wisely by implementing proven solutions in as efficient a manner as possible to maximize the benefit to rural communities across the state.

For each of its five initiatives, the State has identified outcomes to define success in meeting the objective tied to that initiative. The programs the State has developed under each initiative to achieve these outcomes are listed below and detailed in Section III.

Initiative 1: Expand Primary and Secondary Prevention Programs. The following outcomes define success in realizing meaningful reductions in chronic disease rates and avoidable hospitalizations for complications related to chronic disease.

By 2031, all rural Kansas counties will achieve statistically significant:	
1	Reductions in the percentage of adults with fair or poor self-perceived health status
2	Reductions in the percentage of adults reporting poor mental health
3	Improvements in children's performance on the Presidential Fitness Test
4	Reductions in the percentage of residents reporting low health literacy
5	Reductions in the incidence of diabetes, COPD, hypertension, heart failure, and dementia
6	Reductions in the rate of avoidable hospitalizations for diabetes, COPD, and heart failure

The State will implement the following programs to achieve these outcomes:

Initiative 1 Programs	
1	Accountable Food is Medicine + Community Health Worker Deployment Program
2	Consumer-Facing Technologies Program
3	Behavioral Health Services Program
4	Integrated Care for Dual Eligible Beneficiaries Program
5	Mobile Cancer Screenings Program
6	Tribal Health Program

Initiative 2: Secure Local Access to Primary Care. The following outcomes define success in substantially reducing the number of rural Kansas hospitals with negative operating margins.

By 2031, all rural Kansas hospitals will:	
1	Achieve statistically significant improvements on key measures of revenue cycle efficiency
2	Secure commercial payer rates sufficient to cover the costs of providing care in their communities
3	Use data to evaluate and pursue opportunities for regional collaboration in delivery of clinical services and/or business operations
4	Have resources available to support the transition to rural emergency hospital status, if such transition is determined appropriate for the community served
5	Work collaboratively with public health agencies to integrate public health with primary care

The State will implement the following programs to achieve these outcomes:

	Initiative 2 Programs
1	Regional Partnerships Grant Program
2	REH Conversion/Transformative Capital Investment Grant Program
3	Revenue Improvement Program
4	Anchor Hospital Advancement Program
5	Mobile Integrated Health Pilot Program
6	Rural Primary Care – Public Health Integration Program

Initiative 3: Build a Sustainable Rural Health Workforce. The following outcomes define success in improving provider-to-population ratios for primary care, dental, and behavioral health providers and ease nursing and allied health shortages in rural Kansas.

	By 2031, all rural Kansas communities will achieve:
1	Increases in the number of rural middle and high school students participating in health science CTE pathways or other health care career exploration activities
2	Establishment of robust rural physician residency programs in primary care, general surgery, obstetrics, psychiatry, and orthopedics
3	Reductions in vacancy rates and turnover rates for nurses and allied health professionals

The State will implement the following programs to achieve these outcomes:

	Initiative 3 Programs
1	Physician Pipeline Program
2	Education and Training Program
3	Recruitment and Retention Program
4	Career Exploration Program

Initiative 4: Enable Value-Based Care. The following outcomes define success in having 100% of rural Medicare and Medicaid beneficiaries in accountable care relationships by 2031.

By 2031:	
1	All rural providers will achieve statistically significant improvements on specified pay-for-performance measures identified as foundational to clinical integration.
2	All rural providers will actively participate in clinically integrated networks with well-defined regional continuums of care for specified conditions.
3	There will be an adequate regional transportation system to support networks' continuums of care.
4	All rural hospitals and primary care providers will participate in the Medicare Shared Savings Program.
5	The state Medicaid program will include provider incentives for value-based care.
6	Dual eligible beneficiaries will participate in integrated care plans or, if remaining in traditional Medicare, receive tailored care management services.

The State will implement the following programs to achieve these outcomes:

Initiative 4 Programs	
1	Evidence-Based Practice Incentive Program
2	ACO Readiness Program
3	Transportation Program
4	Medicaid Provider Incentive Payment Program

Initiative 5: Harness Data and Technology. The following outcomes define success in enabling rural Kansas providers to meaningfully engage in data sharing and analysis, expanded use of telehealth and remote monitoring, appropriate use of artificial intelligence, and utilization of consumer-facing technologies.

By 2031:	
1	Remote patient monitoring for acute and post-acute care and chronic disease management will be available as needed for rural Kansans.
2	Access to specialist services via telehealth will be available as needed for rural Kansans.
3	All rural providers will demonstrate adherence to TEFCA, and obstacles to rural residents' exercising control over their own data and rural providers' securely accessing patient data will be eliminated.
4	All rural providers will have successfully implemented well-vetted and secure artificial intelligence agents and applications to improve clinical care and enhance operational efficiency.

The State will implement the following programs to achieve these outcomes:

Initiative 5 Programs	
1	Remote Patient Monitoring Program
2	Telehealth Navigator Program
3	Data Infrastructure Program
4	Emerging Technology Program

Other Required Information

Rural Facility and Population Score Factors	
Factor	***State Information***
A.2	The completed CCBHC template is included in the supplemental materials.
A.7	55 Kansas hospitals qualified for Medicaid DSH payments for the FY 2025 rating period.
State Policy Factors	
Factor	***State Information***
B.2	The State does not presently mandate school districts administer the Presidential Fitness Test; it is a matter of local discretion. The State is committed to re-establishing the mandate by the end of 2028. ***(50 points)***
B.3	During the last legislative session, the Governor signed into law a requirement that the State submit a request for a SNAP food restriction waiver. The request was submitted in May 2025 and the State now is in the process of responding to CMS inquiries. ***(75 points)***
B.4	The State does not presently have legislation or regulations requiring nutrition education as part of physician CME. The State is committed to imposing such requirement by legislation or regulation by the end of 2028. ***(50 points)***
C.3	As indicated in the Cicero Institute report, Kansas has no CON requirements. ***(100 points)***
D.2	As indicated in the referenced materials, Kansas is a member state for all referenced compacts. ***(100 Points)***
D.3	PA scope of practice is reduced (0 points); NP scope of practice is full practice ***(100 points)***; pharmacist score is 3 (0 points); dental hygienists can perform 3 allowable tasks. ***(50 points)***
E.3	Kansas does not restrict STLDI beyond the latest federal guidance. ***(100 points)***
F.1	Kansas Medicaid reimburses at least one form of Live Video ***(100 points)***; it does not reimburse Store and Forward or Communication Technology Based Services but intends to establish such reimbursement through legislation by the end of 2027 ***(50 points)***; and it reimburses Remote Patient Monitoring ***(100 points)***. A practitioner may furnish services via telehealth to a person present in the state if the practitioner is licensed or authorized in Kansas, operates under one of the recognized interstate compacts, or obtains a Board of Healing Arts telemedicine waiver. ***(200 points)***

III. Proposed Initiatives and Use of Funds

Initiative 1 – Expand Primary and Secondary Prevention Programs	
Main strategic goal	Make rural America healthy again
Technical score factors	B.2, D.1, E.2, F.3
Use of funds	A, C, F, G, and H
Key stakeholders	Rural primary care providers, CCBHCs, local health departments, regional extension offices, PACE operators, federally recognized tribes
Counties impacted	All rural Kansas counties
Estimated 5-year funding requirement	Approximately $204 million (excluding administrative expenses)

The following summarizes the seven programs under Initiative 1.

1. Accountable Food is Medicine + Community Health Worker Deployment Program. Kansas' rural Food is Medicine (FIM) program will build on several successful rural Kansas pilot programs and a two-state planning process with Fresh Rx in Oklahoma, the results of which were presented to Secretary Kennedy's MAHA team this summer. The program leverages the State's already robust community health worker (CHW) program by deploying CHWs in rural primary care clinics (RHCs, FQHCs, and independent clinics) and CCBHCs at the rate of 20 per year (100 total). Six practice facilitators will provide on-site implementation and ongoing support for clinics. The Care Collaborative will recruit rural clinics, hire and supervise staff, and provide participating clinics with nutrition-related boot-camps and training on deployment and use of consumer-facing technologies discussed below.

An additional 100 CHWs will be hired and deployed at the rate of 20 per year in regional extension offices by Kansas State University (K-State), which has a presence in all rural Kansas counties. K-State will also hire and manage four agricultural specialists to recruit and assist local

farmers with sustainable agriculture practices and to coordinate food distribution to rural communities for FIM participants.

All CHWs will be trained by the Care Collaborative to identify FIM-eligible individuals using specific criteria, recruit those individuals as program participants, provide participants with resource navigation (e.g., securing healthy foods, enrolling in nutrition courses), and furnish ongoing support. CHWs will enroll participants in Care Collaborative remote monitoring services to allow providers to track progress and respond to alerts. CHWs also will assist participants in accessing and utilizing consumer-facing technologies to support lifestyle changes.

The CHWs also will play a broader role in supporting population health in rural communities beyond the FIM program including screening individuals for upstream drivers of health, for depression and other behavioral health conditions, and for risk of Alzheimer's Disease and dementia. As indicated by screenings, CHWs will connect individuals to community resources using a customized community resource database for which the State will contract and follow up regarding the same.

As the FIM program matures, CHWs also will engage local families in early childhood healthy eating and physical activities by leading community workshops, presenting cooking demonstrations, and distributing family-focused resources. The Care Collaborative will draw from several successful programs to provide CHWs with training and supportive resources for this work.

The State will contract with researchers to evaluate the FIM program on an ongoing basis, focusing on implementation research. Such continual feedback will allow the State to modify the program to optimize results.

2. Consumer-Facing Technologies Program. Through its procurement process, the State will select multiple vendors to furnish consumer-facing technologies supporting healthy

lifestyles to be available to rural residents through local primary care clinics. The Care Collaborative will educate providers on integrating these technologies into ongoing patient care, and CHWs will facilitate local program operations. Such technologies will include computerized cognitive behavioral therapy and applications that provide on-demand content (e.g., fitness and nutrition, structured disease prevention and disease management programs), or track fitness, nutrition, sleep, mental health, or medication compliance.

Additionally, the Care Collaborative will produce and administer an asynchronous diabetes prevention program tailored for rural populations using CDC-approved curriculum. The program will include engagement with virtual lifestyle coaches and supportive services from local pharmacists.

3. Behavioral Health Services Program. This program comprises several shovel-ready projects to expand access to secondary prevention services for behavioral health conditions. These projects will be managed by qualified organizations under grants awarded by the State.

Program	Description
Behavioral Health Integration in Primary Care	Expand to additional primary care clinics proven BHI training and implementation programs, including limited-time clinic incentive payments offset program start-up expenses.
Behavioral Health Services in Nursing Facilities	Embed behavioral health professionals in nursing facilities to meet clinical needs and reduce inappropriate use of antipsychotic medications. Will serve as a pilot for potential Medicaid behavioral health add-on for nursing facilities.
Emergency Department Behavioral Health Intervention Hubs	Embed behavioral health case managers in 6 rural PPS hospital EDs to assess patients at that hospital and at regional hospitals via telehealth and to connect patients to appropriate resources (e.g., immediate tele-behavioral health services to initiate pharmacological treatment, coordination of transport, arrangements for outpatient services).
Pediatric Psychiatric Access	Develop and distribute screening tools and best practice workflows and provide related educational content for rural PCPs to increase child, adolescent, and postpartum behavioral health screenings.
Statewide SUD Referral & Stabilization Network	Create and operate central referral hub as single point-of-contact for SUD crises to perform rapid SBIRT-aligned screenings, triage callers to the appropriate level of care, and provide active care navigation.

4. Integrated Care for Dual Eligible Beneficiaries Program. At present, 34% of PACE-eligible Kansans (about 4,300 rural residents) do not have access to a PACE program. The State will partner with two successful PACE providers in the state to expand program availability in rural areas, one by expanding an existing program and another by establishing a new one. These providers will focus on two regions with the highest concentration of PACE-eligible beneficiaries without program access based on a market study completed for the State in August 2025. These providers are committed to innovative approaches such as telehealth, alternative care sites, and strategic partnerships with rural hospitals to meet the unique challenges of rural elders. Also, in partnership with the State, these providers will furnish enrollment support for eligible rural residents in existing and expanded rural service areas.

For those dual-eligible beneficiaries for whom PACE is not a feasible option, the Care Collaborative will expand its existing care management program to serve these beneficiaries. Since 2015, the Care Collaborative has operated a centralized team of nurse health coaches providing chronic care management, remote patient monitoring, and behavioral health integration services for Medicare and a limited number of Medicaid beneficiaries referred by participating clinics. The team has delivered well over 150,000 encounters for more than 9,700 unique rural beneficiaries. TUKHS' internal analysis using claims data made available through the Medicare Shared Savings Program shows these services reduced the total cost of care by over 20%.

Working with the State and its participating clinics, the Care Collaborative will identify rural dual-eligible beneficiaries who may require a higher level of care management services. Nurse health coaches will reach out to these beneficiaries to secure consent for services. The health coaches, in partnership with the beneficiary's primary care provider, will develop and execute a comprehensive care plan. As appropriate, these services will include wearable devices and

installation of ambient sensors in the patient's home. Health coaches will also coordinate with the CHWs in beneficiaries' communities to arrange for other supportive services.

5. Mobile Cancer Screening Program. Leveraging a vehicle and equipment previously donated to the Kansas Masonic Cancer Alliance, this project will deliver screenings for skin and urological cancers in ten rural communities each year where these services are not presently available. CHWs will work with local providers to schedule screenings. This program will be operated under a grant from the State to the University of Kansas Cancer Center.

6. Tribal Programs. The federally recognized tribes in Kansas manage three rural Section 638 clinics to serve their members' health care needs. Following consultation with the State Office of Native American Affairs regarding the State's use of RHT Program funds for their benefit, the tribes desire to engage in a planning process through the Kansas Alliance for Tribal and Community Health (KATCH), the intertribal health coalition, to identify and fully develop projects to expand primary and secondary prevention programs through the three rural clinics. The State will dedicate funds in Years 1 and 2 to support projects submitted by KATCH and approved by the State. All projects will comply with all RHT Program requirements and restrictions and will include performance metrics and reporting requirements.

Initiative 2 – Secure Local Access to Primary Care	
Main strategic goal	Sustainable access
Technical score factors	B.1, C.1
Use of funds	B, G, K, J
Key stakeholders	Rural hospitals, rural primary care providers
Counties impacted	All rural Kansas counties
Estimated 5-year funding requirement	Approximately $251 million (excluding administrative expense)

The following summarizes the six programs under Initiative 2.

1. *Regional Partnerships Grant Program.* Through the stakeholder engagement process, the State received dozens of proposals for transformative projects to develop, launch, and/or expand on regional partnerships. For example, three CAHs in adjoining counties proposed a new shared service line to bring needed services to their region, a supporting hospital for several CAHs proposed a regional hospital readmission reduction program focused on coordinated post-discharge services, and three separate groups of providers submitted proposals to form clinically integrated networks in their respective regions.

Having vetted these and similar proposals and considered stakeholder input, the State intends to maximize the impact of funds invested in regional partnerships by creating a statewide competitive grant program. The success of these regional partnerships will then inform broader statewide efforts to build regional strategies.

The State will contract with an organization with significant grant administration experience to operate the program. Partnering with the Kansas Rural Health Innovation Alliance (discussed below in the section addressing stakeholder engagement), the organization will develop for the State's approval specific selection criteria consistent with RHT Program strategic goals and funding requirements and restrictions, promote the grant program to potential applicants, manage the application process and make funding recommendations to the State, provide technical assistance and related support for awardees, and monitor and evaluate awardee performance. The State will retain final decision-making authority and will make all awards. There will be four rounds of funding and awardees will have two years to complete their workplans and expend all awarded funds. Grant funding will be discontinued or recouped if an awardee does not make adequate progress implementing its workplan.

2. *REH Conversion/Transformative Capital Investment Grant Program.* Several Kansas hospitals have formally evaluated rural emergency hospital (REH) conversion to secure health care services in their communities. An analysis performed by the North Carolina Rural Health Research Program found that 16 Kansas hospitals were strong candidates for REH conversion,[xxvi] but only three have done so thus far. KHA, which has assisted hospitals in evaluating REH conversion, has identified necessary facility renovations as an obstacle to conversion for some hospitals. For example, CAHs with swing beds that convert to REH must comply with Medicare Skilled Nursing Facility Conditions of Participation, including specific Life Safety Code requirements. Converting hospitals also need to renovate inpatient rooms to provide expanded outpatient services.

Through the stakeholder engagement process, the State received several proposals from rural providers seeking funding for transformative capital investments for their local communities. For example, one hospital sought funding to convert existing inpatient beds to a distinct part psychiatric unit to address the region's lack of inpatient behavioral health services. Another hospital proposed funding to purchase equipment necessary for a new service line to address unmet community needs and generate new revenue.

To facilitate REH conversions and maximize the impact of funds expended on other transformative capital investments, the State will create a grant program to provide funds for hospitals converting to REH to complete minor facility renovations, repairs, and remodeling, and for hospitals to make transformative capital investments. The grant program will be operated and administered in the same manner as the Regional Transformation Grant Program.

3. *Revenue Improvement Program*. This program includes three projects to assist rural providers in increasing revenue and thus improving their operating margins. First, the State will

contract with a well-qualified consulting firm to perform a statewide rural commercial rate analysis. With an accurate and complete statewide analysis of commercial rates as compared to Medicare reimbursement, as opposed to anecdotal reporting, providers will be well-positioned to negotiate for more favorable reimbursement without driving up employers' health insurance costs. With significant interest throughout the state in pursuing joint contract negotiations through clinically integrated networks, this rate analysis will provide a foundation on which these efforts can move forward.

The second project involves funding the launch of a revenue cycle support and credentialing organization under contract with the State. This new entity will employ or contract with experienced professionals to provide outsourced services for rural providers who lack local resources to effectively manage their revenue cycle (e.g., pursue payment on denied claims, validate data for price transparency reporting requirements). The entity will also credential providers with payers on behalf of hospitals to ensure timely payment for services. RHT Program funds will be used for initial start-up costs, allowing the organization to charge significantly lower fees for its services for rural hospitals.

The third project will fund the development of the infrastructure necessary for provider networks to pursue and successfully perform under direct-to-employer contracts. The State will select a vendor through a competitive bidding process to support the design and implementation of direct-to-employer contracts between rural provider networks and rural employers.

4. *Anchor Hospital Advancement Program.* Prior to Congress creating the RHT Program, Kansas' urban not-for-profit health systems were discussing ways to provide operational support for Kansas' rural anchor hospitals (i.e., larger rural facilities providing specialist services on a regional basis) to strengthen the state's overall rural health delivery system. Specifically, these

systems were exploring how to best share resources and capabilities with anchor hospitals to maintain and expand regional access to specialist services, rather than having rural residents travel to urban areas or forgo needed care. By providing such support, the systems intended to elevate regional anchor hospitals into regional leadership roles as health stewards of a defined geography supporting surrounding CAHs.

Now, with RHT Program funds, the State is well-positioned to support these systems' efforts to engage with anchor hospitals for these purposes. Specifically, the State will use RHT Program funds to contract with the urban not-for-profit health systems to deliver the following services upon request from anchor hospitals in compliance with all funding requirements and restrictions. Under these contracts, the State will retain decision-making authority over all expenditures.

Service	Description
Analytics	Give anchor hospitals access to clinical and operational improvement analytics and assist them in pursuing improvement opportunities based on such data
EHR Optimization	Assist anchor hospitals identify opportunities to optimize EHRs (with a focus on TEFCA adherence) and provide support for implementation of new capabilities (Anchor hospitals will be responsible for any associated licensing fees)
Managed Care Advisory Resources	Leverage internal expertise to assist anchor hospitals in managed care negotiations and tracking payer performance
On-Demand Operational Resources	Make available upon request other internal operational expertise to anchor hospitals (e.g., cybersecurity, revenue cycle operations)

5. *Mobile Integrated Health Pilot Program*. The State will select five rural communities in which to pilot mobile integrated health (MIH) services for Medicaid beneficiaries. Specially trained certified medical assistants (CMAs) (which may include EMTs trained as CMAs) will make home visits for patients not eligible for home health or similar benefits referred to the program by local providers. Such patients may include, but will not be limited to, individuals

recently discharged from the hospital, those identified as fall risks, and dual eligible beneficiaries with significant health needs. (As these services are distinct from the care coordination services the State's MCOs must provide, the pilot will not result in duplication of services.) The CMAs will provide services consistent with protocols developed by the program's Medical Director and their work will be supervised by the Medical Director. The State's Medicaid technology vendor will analyze claims data to determine if MIH services are related to reductions in the total cost of care for Medicaid beneficiaries.

6. *Rural Primary Care - Public Health Integration Pathways Program.* In many rural communities, there is limited communication - much less coordination - between the local health department (LHD) and physician clinics. While LHDs focus on levels and distributions of health outcomes in the community, clinics focus on the needs of individuals while holding responsibility for health outcomes. Both offer primary care services, although LHDs provide a more limited range of services. Both address upstream drivers of health, with LHDs operating at the community level and clinics focused on individual patient needs. The lack of coordination between LHDs and clinics strains already limited resources in rural communities.

Under a State-awarded grant, a qualified team of facilitators will recruit and work with rural communities statewide to identify opportunities for LHDs and clinics to "right-size" primary care services in their communities by coordinating and collaborating to deliver primary care services in a more efficient manner and to address upstream drivers of health in a more holistic manner. One specific focus area will be early childhood nutrition and physical activity programming to complement the State's current public health programming around maternal and child health.

Initiative 3 – Build a Sustainable Rural Workforce	
Main strategic goal	Workforce development
Technical score factors	B.1, D.1
Use of funds	E
Key stakeholders	Rural hospitals, rural primary care providers, Kansas colleges and universities
Counties impacted	All rural Kansas counties
Estimated 5-year funding requirement	Approximately $133 million (excluding administrative expenses)

The following summarizes the four programs under Initiative 3.

1. *Physician Pipeline Program.* The State will contract with a qualified organization to manage three projects to increase the number of physicians practicing in rural Kansans.

Service	Description
Rural Residency Programs	Establish ACGME-accredited rural residencies in five tracks: OB/GYN, psychiatry, family medicine, general surgery, orthopedics. Participation will be tied to a 5-year rural practice commitment.
Expansion of Kansas Bridging Plan (KBP)	Expand successful program (since 1990, 83% of 400+ physicians receiving KBP funds still practice in Kansas) by (1) increasing incentives from $10,000 to $30,000 to remain competitive with other states' programs; (2) adding general surgery and orthopedic resident physicians (2 and 1 annual slots, respectively) to current annual slots for primary care (14), OB/GYN (3), and psychiatry (3); (3) adding 3 annual primary care slots for resident physicians attending non-Kansas residency programs; and (4) adding a two-year $10,000 retention stipend following physician's commencement of practice in rural Kansas after completing residency. Participation will be tied to 5-year rural practice commitment.
Medical Student Rural Rotation Housing	Provide safe and accessible short-term housing (4 to 6 weeks) in rural communities for up to 100 medical students in rural rotations.

2. *Education and Training Program.* The State will contract with a qualified organization to manage this program comprised of several shovel-ready projects to promote the training of healthcare professionals in high-demand healthcare roles and to create incentives to grow the rural healthcare workforce in Kansas.

Service	Description
Health Professions Service Scholarship Program	Establish new scholarship program modeled on successful Kansas Nursing Service Scholarship Program for 200 students in Year 1, 250 students in Years 2 and 3, and 300 students in Years 4 and 5 in high-need allied health training programs (e.g., physical, occupational, and respiratory therapists; EMTs; pharmacy, radiology, and surgical/sterile processing techs; social workers; psychologists; clinical laboratory scientists) in exchange for a 5-year service commitment in rural Kansas.
Health Professions Training Grants	Create grant program to expand existing allied health training programs (e.g., creating distance learning and hybrid programs, establishing rural satellite campuses or training sites) prioritizing high-demand positions and to create new training programs (e.g., community paramedicine, CHWs).
Dental Scholarship Program	Create first State dental scholarship program for up to 10 dentistry students and 15 dental hygiene students who commit to practicing in rural Kansas for at least 5 years.
Mobile Simulation Lab	Care Collaborative will operate and staff high-tech mobile simulation lab to train clinical teams in 90 rural communities over 5 years. Lab capabilities to include high fidelity manikins and SimX, a 15-module virtual reality program (including mass casualty and motor vehicle accidents) with virtual moderator that validates participants' adherence to evidence-based practices.

3. *Recruitment and Retention Program.* According to the 2025 Kansas Health Care Workforce Report, staff vacancy rates remain 60% higher than pre-pandemic levels and turnover rates for some roles remain alarmingly high. The State will contract with a qualified organization to manage five projects that holistically target rural recruitment and retention gaps.

Service	Description
Work in Rural Kansas Health Care Campaign	Multi-channel media campaign to promote career opportunities in rural Kansas health care highlighting breadth and depth of positions available in rural areas
Rural Nurse Residencies	Establish statewide Rural Nurse Residency Program using evidence-based curriculum to provide standardized, accredited training and mentorship for recent nursing school graduates practicing in rural communities (50 rural nurses in Year 1, 100 nurses in Year 2, and 150 nurses in the following years).
Clinical Instructor and Preceptor Incentives	State will incentivize rural healthcare employers to provide qualified rural practice nurses to serve as adjunct clinical instructors for area nursing programs. The State will also support employers providing preceptors to further expand the number of clinical training locations in rural facilities.
Behavioral Health Apprenticeship Program	State will expand its current healthcare apprenticeship to include behavioral health positions. In addition, the State will provide intermediary services to assist facilities in launching programs.

4. *Career Exploration Program*. Students in many rural communities lack robust career exploration and certification opportunities as compared to their urban peers. The State will contract with a qualified organization to manage four projects to build student awareness of health care careers, bridging that awareness into interest in working in health care, and then translating their interest into enrollment in a training program or working in a local facility.

Service	Description
Rural Chapters of HOSA – Future Health Professionals	Create and expand rural chapters of HOSA – Future Health Professionals to increase students' access to mentoring, skills training, and career exploration.
K-12 Health Science Career Technical Education (CTE)	Launch new health care Career and Technical Education (CTE) health science pathways in rural high schools and expand existing pathways to include additional courses and certifications (e.g., patient care technician, phlebotomy, CNA, EMT).
High school certification/pre-apprenticeship programs	Support rural schools and employers in jointly designing and launching health care pre-apprenticeship and micro-credential programs by covering annual participation costs for 50 rural students (e.g., certification exams, background checks, and work-based learning coordination
Regional Career Expo	Expand on successful annual Kansas Virtual Health Care Career Day (with 4,000 attendees from 200 schools in 2025) by sponsoring three regional, hands-on career expos

Workforce Coordination. KDHE has a longstanding partnership with the University of Kansas Medical Center's Rural Health Education and Services: Kansas Recruitment and Retention Center (KRRC-RHES) to help rural providers improve their organizational culture and workforce engagement levels; to collaborate on recruitment and retention efforts; and to promote and disseminate information about the National Health Services Corps loan repayment and scholarship programs and the State's loan repayment program. The State will leverage, but not supplant, its work with KRRC-RHES to maximize the impact of RHT Program funding.

The State also has received funding to support workforce initiatives under the CDC's Public Health Infrastructure Grant Program and the CMS Innovation Center's Transforming Maternal Health Model. Again, the State will leverage, but not supplant, its work under these programs to maximize the impact of RHT Program funding.

Initiative 4 – Enable Value-Based Care	
Main strategic goal	Innovative care
Technical score factors	B.1, C.2, E.1
Use of funds	A, B, I, and K
Key stakeholders	Rural hospitals, rural clinics, CCBHCs, state Medicaid agency, Medicaid MCOs
Counties impacted	All rural Kansas counties
Estimated 5-year funding requirement	Approximately $305 million (excluding administrative costs)

The following summarizes the four programs under Initiative 4.

1. *Evidence-Based Practice Incentive Program.* Rural providers' successful adoption and implementation of evidence-based practices is the single most important step forward on the road to value-based care. Thus, the State's single largest investment of RHT Program funds is

incentive payments for rural hospitals, clinics, and CCBHCs that successfully adopt and implement such practices as evidenced by quarterly reporting on selected performance metrics.

Having worked with Kansas rural hospitals and clinics for over a decade to implement evidence-based practices, the Care Collaborative is familiar with the many challenges these changes bring to providers: training staff, revising workflows, updating EHR systems, and monitoring performance. All too often, change does not stick because new processes are not successfully hard-wired into ongoing operations. Rural providers have numerous competing priorities, and the resources required for such hard-wiring are committed elsewhere, at least in part because there is no perceived financial imperative to maintain evidence-based practices.

By offering rural providers substantial quarterly incentive payments for demonstrating compliance with evidence-based practices (up to $50,000 for rural hospitals and $25,000 for RHCs, independent practices, FQHCs, and CCBHCs), the State will overcome the most significant obstacle to value-based care. It will also create a statewide standard of care that will improve health outcomes and lower costs.

The State has identified specific metrics for different provider types that are tied directly to successful adoption of evidence-based practices. Providers do not currently receive any payments or bear any risk associated with performance on these metrics. All payments will be tied to achieving a specified level of performance to maximize the incentives for change (with the exception of first quarter payments tied to reporting only). The Care Collaborative will make available performance improvement specialists to support providers in program implementation.

Providers will submit data through Quality Health Indicators (QHi,), a web-based program operated by KHA through which hospitals and clinics have reported quality data for several years. The Care Collaborative will follow-up with providers as necessary, validate the data, and make recommendations for payments to the State. Following review, the State will distribute payments to providers. The Care Collaborative will also make recommendations to the State for modifications to the measures based on reported performance and State priorities.

2. *ACO Readiness Program*. In addition to evidence-based practice, participation in value-based care requires providers to manage the total cost of care and understand the level of risk in their patient population. Many rural Kansas providers are now participating in the Medicare Shared Savings Program (MSSP) or ACO REACH through which they are developing these capabilities. Other rural providers, however, have not been invited to participate due to the high total cost of care, while others have remained wary of participation in such programs.

For these providers, the Care Collaborative will operate a "shadow" accountable care organization in partnership with a national ACO management company. Participation in the shadow ACO will be open to all rural providers not presently participating in the MSSP or ACO REACH, making them eligible for incentive payments. Using available claims data, the management company will "attribute" beneficiaries to these providers and support them in developing the capabilities to manage those beneficiaries. As shadow ACO participants develop these capabilities, they will then move into MSSP, ACO REACH, or other alternative payment models, thus sustaining these efforts.

3. *Transportation Program.* Another significant obstacle to rural Kansas providers' successful participation in value-based care is the lack of reliable transportation options when an individual needs to leave the community to receive specialized services. Transport delays mean

delayed care, which translates to poor outcomes and higher costs. And where a patient eventually receives such care is more dependent on available transportation than established provider relationships. In short, it is difficult to maintain a seamless continuum of care if there is no reliable way to move patients to higher levels of care and back home again. In a KHA member survey regarding RHT Program priorities, medical transportation was consistently identified as a top priority.

One particular pain point for rural hospitals is significant delays in transportation of behavioral health patients presenting to their emergency rooms to appropriate care settings. These patients often remain at these hospitals for extended periods waiting for transport, requiring significant resources. At present, there is no regional or statewide system to coordinate care for patients in behavioral health crisis.

In addition to interfacility transports, the high cost of ambulance transports in rural areas also makes it difficult for rural providers to participate in value-based care. Because of severely limited transportation options in these communities, residents often call 911 for any health-related transportation need. However, most payers only reimburse hospital transports, meaning patients often are transported to the local facility instead of a more appropriate and less costly care setting.

The transportation program includes five projects to address these needs and enable rural provider participation in value-based care arrangements.

Project	Description
Interfacility Transport Teams	State-contracted vendor will place dedicated equipment and teams at 8 locations statewide for interfacility transport and transporting patients back to their communities, with coordination of transportation by centralized dispatch team.
Behavioral Health Crisis Transport	State-contracted vendor will operate behavioral health access network serving 65 rural hospitals across 5 regions to provide 24/7 access to patient assessments, coordination of services, and transportation to appropriate level of care.
Non-Emergency 911 Calls	State-contracted vendor will implement process that permits local 911 dispatcher who identifies caller seeking care for non-life-threatening condition to securely transfer caller to a 24/7 clinician-led access and care coordination program designed for rural communities. Clinicians then assess patient's condition and guide them to safest, patient-centric, and lower-cost care option.
EMS Reimbursement for Treat-In-Place and Transport to Alternative Location	State will administer new reimbursement for (1) services furnished at the scene by EMS for patients who are not transported, and(2) EMS transportation of patients to location other than hospital for treatment (e.g., physician clinic) to the extent such reimbursement not otherwise available. The State will evaluate the impact on total cost of care to determine whether to reimburse these services under Medicaid.
Non-Emergency Transportation Grant Program	Grant program available to rural communities with demonstrated need to implement sustainable plan for transporting individuals to health care-related appointments (with specific focus on chemotherapy, infusion therapy, and dialysis) and/or disabled individuals to other locations. No funds will be used for services presently reimbursable by Medicaid or to supplant other funding sources.

4. *Medicaid Provider Incentive Payment Program*. Kansas' current MCO contracts (2025-2027) encourage but do not require alternative payment models. Kansas is one of 15 states selected for the Transforming Maternal Health (TMaH) Model, which requires the State to implement a value-based payment model for maternal health services by 2029. The state Medicaid agency will coordinate its work under the TMaH Model with the development of new MCO contract requirements for provider incentive payments in addition to the maternal health model, subject to federal approval.

Under their current contracts, the MCOs are required to furnish these services directly, and thus do not reimburse providers for them. The MCOs, however, have reported to the State difficulties engaging rural beneficiaries. To address this immediate need, the Plan includes

development and dissemination of best practices for provider engagement of rural Medicaid beneficiaries coupled with incentive payments through 2027 for providers who identify and engage Medicaid beneficiaries with MCO care coordination services. The State also will evaluate an amendment to current MCO contracts to reimburse providers for these services furnished at the election of a Medicaid beneficiary (as opposed to an MCO providing those services), subject to federal approval. This work will lay the foundation for incentive payments under future MCO contracts for rural providers who furnish care coordination and care management services directly to eligible beneficiaries.

Additionally, the State will develop new provider incentive payments to be incorporated into future MCO contracts relating to Plan programs that demonstrate Medicaid cost savings, subject to federal approval. This may include, for example, Accountable Food is Medicine, consumer-facing technologies, and expanded EMS services.

Initiative 5 – Harness Data and Technology	
Main strategic goal	Tech Innovation
Technical score factors	F.1, F.2, F.3
Use of funds	C, D, F
Key stakeholders	Rural hospitals, rural primary care providers, CCBHCs
Counties impacted	All rural Kansas counties
Estimated 5-year funding requirement	Approximately $110 million (excluding administrative expense)

The following summarizes the five programs under Initiative 5.

1. *Remote Patient Monitoring Program.* Through its procurement process, the State will select a vendor to implement a remote patient monitoring system for rural hospital inpatients, rural residents recently discharged from a hospital, and other rural residents for whom monitoring is medically indicated. System specifications will include FDA-cleared medical grade wearable

sensors that continuously measure and transmit a patient's vital signs (e.g., respiratory rate, heart rate, temperature) and other advanced biometrics to a cloud-based monitoring system. The State will require the system provide AI-powered clinical intelligence that alerts a centralized command center clinician to adverse trends in vital sign measurements which may indicate emerging complications. When appropriate, that clinician will then escalate to local nursing staff and/or the responsible provider teams. Such early detection of clinical deterioration and proactive intervention will result in reduced nursing staff workload, lower complication and mortality rates, fewer transfers to higher levels of care, shorter lengths of stay, and greater patient satisfaction.

Specifications also will include delivery of devices and related hardware, network set-up, command center build-out and staffing, workflow design, policies and procedures, staff training on device management, patient education materials, and ongoing technical assistance. The vendor will continuously support program evaluation and refinement and will track data to demonstrate return on investment for program sustainability.

2. *Telehealth Navigator Program.* No one doubts telehealth holds enormous promise for expanding access to specialty services in rural communities. The delivery of specialty services via telehealth, however, requires a different infrastructure than the delivery of primary or urgent care services. With the latter, a patient can join an online queue for the next available provider. A successful specialist telehealth program, however, requires a significant level of coordination between the primary care provider referring the patient and the specialist who will furnish those services.

For this reason, the tele-behavioral health network now operated by the Care Collaborative employs local care coordinators responsible for scheduling appointments, compiling and transmitting relevant records to the specialist, checking in patients for their appointments, and

following up with the specialist and the patient following the appointment. Such follow-up includes scheduling any diagnostic or therapeutic services ordered for the patient, ensuring the results are available to the specialist at the time of the appointment, and scheduling follow-up appointments. The coordinators also ensure the referring physician receives a complete report regarding the specialist consultation. The tele-behavioral health network's use of coordinators makes efficient use of specialists' time to maximize the number of appointments, reduces administrative burden on the primary care practice at which the patient presents, and significantly improves patient compliance and outcomes. For this reason, primary care providers and patients give high markets to the tele-behavioral health network.

The State will build on this model by contracting with the Care Collaborative to deploy nurses trained as telehealth navigators to support primary care practices through which specialist telehealth services are offered. These navigators will work closely with specialists to operate telehealth clinics at primary care practices, thus eliminating administrative barriers to specialists furnishing telehealth services. The Care Collaborative recently received a substantial award from a local private foundation to recruit and hire at least three dedicated specialists (endocrinology, neurology, and rheumatology) to provide telehealth services for rural Kansans, and these new services will be deployed using the telehealth navigator model.

3. *Data Infrastructure Program.* This program consists of five projects designed to improve the availability of and enhance rural providers' ability to use data effectively in patient care and population health management.

Service	Description
All Payer Claims Database	State to lease of a state-of-the-art All Payer Claims Database infrastructure and contract with qualified organization for data management to facilitate providers' use of the database
HIE Connectivity for Rural Providers	State funding to connect remaining rural providers to Kansas-certified health information exchange and optimize utilization of HIE for care coordination
Diabetes Data Dock	State grant to build out platform to synthesize EHR and CGM device data to enable rural providers to detect and facilitate response to patient deterioration, with expanded use of platform to monitor other conditions
CCBHC Data Center	State grant to operate central data warehouse for CCBHC reporting in consistent manner for program evaluation and expansion of services.
Kansas Data Trust	State grant to develop and deploy legal and governance framework to enable multiple organizations to share and manage data securely and ethically for public health monitoring, clinical research, and cost and quality transparency

4. *Emerging Technology Program*. One theme that emerged through the stakeholder engagement process was the need to support rural providers' adoption of new technologies, as they lack resources to identify and vet appropriate technology solutions and the expertise to develop and execute on technology implementation plans. To support rural providers' adoption of patient-facing technologies, the State will identify and convene an expert panel to evaluate and recommend such technology solutions for specific patient populations and to develop guidance for rural providers on implementation of recommended solutions. The State will promote the expert panel's recommendations and guidance to rural providers, provide technical assistance as requested by providers relating to implementation and ongoing use of recommended solutions, and make available funding based on applications from providers to offset implementation-related expenses.

To support rural providers' adoption of artificial intelligence solutions, the State will identify and convene an expert panel to evaluate and recommend AI solutions for rural providers relating to clinical documentation, predictive analytics, and operational automation. Again, the State will promote expert panel's recommendations and guidance to rural providers; provide

technical assistance as requested by providers relating to implementation and ongoing use of recommended solutions; and make available funding based on applications from providers to offset some or all implementation-related expenses (depending on the size of the organization). The Care Collaborative, as part of its overall project management duties, will coordinate both efforts.

IV. Implementation Plan and Timeline

The KDHE Secretary will be the Plan Director. Subject to approval by the Governor, the Plan Director will retain final authority and responsibility for all decisions regarding Plan implementation and will authorize all expenditures of RHT Program funds.

KDHE will be the lead agency for Plan implementation. The Interagency Task Force, which participated in the Plan development and is comprised of representatives from KDHE, the Kansas Department for Aging and Disability Services (KDADS), and the Governor's Office, will continue to coordinate State resources. KDHE will create four new RHT Program-funded positions to perform Plan-related administrative functions, including a section director, a program manager, a contract specialist, and a fiscal analyst. These positions will be filled with qualified individuals as soon as possible following receipt of RHT Program funds. The State will pursue funding through its normal budgeting process for four additional program managers to perform Plan-related functions. Other State resources will be utilized as necessary and appropriate.

The Kansas Rural Health Innovation Alliance, created by the Governor to facilitate stakeholder engagement during the Plan's development, will advise the Interagency Task Force . The Alliance's membership is detailed in the Stakeholder Engagement section. The Alliance will meet on at least a quarterly basis to serve as the primary vehicle for ongoing stakeholder engagement.

The State intends to enter into a subrecipient agreement with the Care Collaborative to provide project management and program coordination services, as specified in the parties' Memorandum of Understanding. The definitive agreement between the State and the Care Collaborative will be executed before December 31, 2025. The Care Collaborative's responsibilities will include:

Engage with and provide support for rural providers relating to Plan implementation	Support collection and reporting of data for each of the Plan's performance metrics;
Assist in vendor selection and contracting and grant awards; monitor and report to State on vendor/grantee performance	Coordinate requests to State for payment from RHT Program funds in support of Plan initiatives
Recruit, employ, train, and supervise program staff, subject to State approval	Track RHT Program fund expenditures as compared to budget
Identify and assist with mitigating risks to successful Plan implementation	Make recommendations regarding resolution of issues or challenges with Plan implementation
Submit reports and meet regularly with State on status of implementation plan	Develop and execute on communication plan (including Plan website) subject to State approval
Support State in completing all CMS submissions	Assist State in addressing stakeholder concerns

The State has designed a detailed implementation plan and timeline for each of the Plan's five initiatives, detailing the dates and milestones that align with the stages specified in the NOFO. The timeline reflects calendar quarters beginning with Q1 (January 1 to March 31, 2026) and continuing through Q20 (October 1 to December 31, 2030). Regarding general program set-up, the State is committed to the following:

Timeline	Plan Operations
Q1	Place individuals in 4 newly created State positions
Q1	Establish State accounts and related processes
Q1	Finalize implementation plan/timeline with detailed task list, assigned responsibilities
Q1	Prioritize grant funding distribution to key programs and commence procurement process for all vendor contracts
Q1	Finalize communication plan; launch website and establish process for regular updates
Q1-Q20	Bi-weekly internal status reports/meetings, quarterly Alliance meetings
Q1-Q20	Engage with CMS Project Officer; participate in CMS learning collaboratives; submit all required reports; satisfy all other Cooperative Agreement obligations; evaluate Plan operations and make necessary modifications
Annually	Make Plan modifications based on actual funding received

The following tables summarize the implementation plan and timeline for each initiative. The State has included in its Supplemental Materials the detailed quarter-by-quarter workplan for Initiative 3 as an example to illustrate the level to which the State is prepared to move forward with its Plan.

In keeping with the transformation imperative, the State has committed to an aggressive timeline for Plan implementation but acknowledges some dates may have to be adjusted due to the requirements of state procurement laws. The State will keep CMS advised of any anticipated delays and will work with CMS to adjust the timeline accordingly.

Initiative 1: Expand Primary and Secondary Prevention Programs
1. Accountable Food is Medicine + Community Health Worker Deployment Program
S1: Q1-4 Contract for and implement community resource database; finalize job descriptions and training materials; finalize practice and patient educational materials; purchase remote monitoring equipment and integrate into existing Care Collaborative program; hire and deploy 6 practice facilitators; hire and deploy 4 agricultural specialist; recruit and train 1st cohort of up to 20 clinics; hire and train first cohort of clinic-based and extension office-based CHWs; hire and train first cohort of 6 extension office-based nutritionists; develop food distribution plan; purchase 2 refrigerator trucks; develop program evaluation plan
S2: Q5-8 Deploy 1st cohort of CHWs and nutritionists; recruit and train 2nd cohort of 20 practices; hire, train, and deploy 2nd cohort of CHWs and nutritionists; purchase 2 refrigerator trucks; collect and evaluate program data; make program refinements
S3: Q9-12 Recruit 3rd cohort of 20 practices; hire, train, and deploy 3rd cohort of CHWs and nutritionists; complete preliminary analysis of impact on Medicaid total cost of care; collect and evaluate program data and publish mid-point evaluation report; make program refinements
S4: Q13-Q16 Recruit 4th cohort of 20 practices; hire, train, and deploy 4th cohort of CHWs and nutritionists; collect and evaluate program data; make program refinements
S5: Q17-20 Recruit 5th cohort of 20 practices; hire, train, and deploy 5th cohort of CHWs and nutritionists; complete final analysis of impact on Medicaid total cost care; collect and evaluate program data and publish final evaluation report
2. Consumer-Facing Technologies Program
S0: Q1-6 States seeks to finalize technology RFP specifications and vendor selection and contracting; finalize DPP workflow, including virtual health coaching sessions, pharmacist consultations, and remote monitoring; complete asynchronous DPP content; finalize vendor app deployment plan and DPP enrollment processes; finalize provider and consumer engagement/marketing plan; finalize CHW workflow and training program
S1: Q7-8 Complete training for initial CHW cohort; execute on provider and consumer engagement/marketing plan; commence app deployment and DPP enrollment
S2-4: Q9-16 Perform following tasks on annual basis: training for subsequent CHW cohorts; work with vendors to implement platform enhancements; evaluate consumer app utilization and experience and make appropriate program modifications; evaluate DPP patient experience and outcomes and make program modifications; pursue CDC certification for DPP
S5: Q17-20 Complete same annual tasks; secure CDC certification for DPP; finalize and execute on sustainability plan
3A. Behavioral Health Service Program: Behavioral Health Integration In Primary Care
S1: Q1-4 State awards grant for project implementation including tasks listed herein; develop clinic participation agreement; recruit 40 rural clinics to participate in facilitated BHI planning and implementation
S2: Q5-8 Onboard recruited clinics (training, logistics/workflow development); pay clinic stipends; provide ongoing implementation support
S3: Q9-12 Recruit and onboard 40 clinics; pay clinic stipends; provide ongoing support; data collection and evaluation for Year 1 cohort
S4-5: Q13-20 Provide ongoing implementation and operational support; data collection and evaluation for Year 1 and 2 cohorts

3B. Behavioral Health Service Program: Behavioral Health Services in Nursing Facilities
S1: Q1-6 State awards grant for project implementation including tasks listed herein; complete model design (job descriptions, staffing levels, policies and procedures); secure nursing facility participation and CCHBC staffing commitments
S2: Q7-8 Launch, evaluate, and refine pilot program
S3: Q9-12 Scale program on statewide basis; evaluate and refine model
S4: Q13-16 Maintain operations; develop plan to incorporate integrated model into State funding streams, subject to federal approval
S5: Q17-20 Transition program to permanent funding mechanism
3C. Behavioral Health Service Program: ED Behavioral Health Intervention Hubs
S1: Q1-6 State awards grant for project implementation including tasks listed herein; complete model design (job descriptions, staffing levels, communication protocols, policies and procedures); secure commitment from six hub hospitals; secure CCBHC staffing commitments; execute hospital space leases; secure equipment and supplies
S2: Q7-8 Establish first 3 hubs and engage with regional hospitals; evaluate and refine model
S3: Q9-12 Establish second 3 hubs and engage with regional hospitals; evaluate and refine model
S4-5: Q13-20 Evaluate and refine hub operations; develop and execute on sustainability model
3D. Behavioral Health Service Program: Pediatric Psychiatric Access
S0: Q1-6 State awards grant for project implementation including tasks listed herein; hire staff; engage with rural practices to survey existing capabilities and needs and to gain commitments to participate; develop curriculum and training materials
S1: Q7-10 Conduct initial in-person trainings with rural PCPs; evaluate curriculum and training materials and modify as necessary
S2 -3: Q11-15 Conduct second round of in-person trainings; develop Project ECHO curriculum; develop sustainability plan
S4-5: Q16-20 Conduct Project ECHO sessions; develop and record on-demand content; execute on sustainability plan
3E. Behavioral Health Service Program: Statewide SUD Referral and Stabilization Network
S0: Q1-6 State awards grant for project implementation including tasks listed herein; hire program director; finalize model design; develop operating procedures, job descriptions and staffing plan, and statewide communication plan; secure supplies and equipment
S1: Q7-8 Recruit, hire, and train supervisory staff, screeners/patient navigators, peer support specialists; establish operations
S2: Q9-12 Launch services; evaluate and refine operations, including staffing levels based on utilization
S3-4: Q13-16 Continue services; expand rural provider outreach; evaluate and refine operations, including staffing levels based on utilization; develop sustainability plan
S5: Q17-20 Same as Q9-16 plus execute on sustainability plan

4A. Integrated Care for Dual Eligible Beneficiaries Program – PACE Expansion
Rural PACE Pilot Program
S0: Q1-Q6 State awards grant for program implementation including tasks listed herein; collaborate with State and Federal agencies to develop full scope of rural PACE pilot program ; develop detailed workplans with assigned responsibilities; launch stakeholder workgroups; secure provider and partner commitments
S1: Q7-Q10 Obtain all necessary government approvals; renovate facilities to serve as PACE service centers; contract network providers/partners
S2-3: Q11-16 Hire and train interdisciplinary team; begin recruitment and enrollment; commence service delivery
S4-5: Q17-20 Expand recruitment and enrollment; conduct annual evaluations; transition to financial sustainability
Additional Satellite Locations of Existing PACE Program
S1: Q1-8 State awards grant for program implementation including tasks listed herein; alternate care sites opened in up to 4 communities; purchase and deploy Care Coach technology for PACE beneficiaries (24/7 interactive avatar); engage in outreach activities; obtain any necessary federal approval
S2-3: Q9-16 1st primary site opened; continue technology deployment and outreach activities; evaluate and refine operations
S4-5: Q17-20 2nd primary site opened; continue technology deployment and outreach activities; transition to financial sustainability
4B. Integrated Care for Dual Eligible Beneficiaries Program – Care Management
S1: Q1-4 Care Collaborative identifies rural dual eligibles not eligible for PACE; develop and launch outreach program; hire dedicated health coach; purchase ambient monitoring devices and integrate into Care Collaborative monitoring program
S2-5: Q5-20 Commence and continue services for dual eligibles; continue outreach program; transition to financial sustainability
5. Mobile Cancer Screening Program
S1: Q1-4 State awards grant for program implementation including tasks listed herein; hire staff; develop operating procedures; schedule first 10 communities; engage with local CHWs to promote screenings
S2: Q5-8 Conduct screenings in first 10 communities; patient and provider follow-up; schedule screenings for next 10 communities
S3-4: Q9-16 Schedule and conduct screenings and follow-up at a rate of 10 communities per year; develop sustainability plan
S5: Q17-20 Conduct screenings and follow-up in final 10 communities; execute on sustainability plan
6. Tribal Programs
S1: Q1-6 State contracts with KATCH for program implementation including tasks listed herein; select facilitator and complete strategic planning process to identify priority projects; complete project development; secure State approval on project implementation and evaluation plans
S2-5: Q7-20 Execute on project implementation plans; perform evaluation; develop and execute on sustainability plans

Initiative 2: Secure Local Access to Primary Care
1. Regional Partnerships Grant Program
S0: Q1-4 State awards grant to organization with grant administration experience to operate regional partnership grant program including, but not limited to, tasks listed herein; develop grant program parameters and requirements, application and scoring criteria, and marketing plan; obtain State approval for same
S1: Q5-8 Solicit Round I applications; assist potential applicants; score submitted applications; make award recommendations to State; State makes award decisions and distribute funds
S2: Q9-12 Monitor and assist Round I recipients; modify program parameters and requirements as necessary; conduct Round II in same manner as Round I, with modifications
S3: Q13-16 Monitor and assist Round I and II recipients; modify program parameters and requirements as necessary; conduct Round III in same manner as Round II, with modifications
S4-5: Q17-20 Conduct Round IV in same manner as Round III; monitor and assist all recipients; receive final reports from each recipient 2 years following award; prepare evaluation report
2. REH Conversion/Transformation Capital Investment Grant Program
S0 – 5: Q1-20 Same timeline/milestones as Regional Partnerships Grant Program
3. Revenue Improvement Program
S0: Q1-4 State seeks to finalize commercial rate analysis consultant and direct-to-employer contracting consultant RFP specifications and complete vendor selection and contracting; State awards grant for revenue cycle support and credentialing organization including tasks listed herein
S1-3: Q5-10 Vendor receives and analyzes data and completes commercial rate analysis and report; vendor furnishes technical assistance for rural providers on direct-to-employer strategies and implementation; organization hires staff, secures supplies and equipment, develops operating procedures, and markets services to rural providers
S4: Q11-18 Organization commences service delivery; continued marketing of services; ongoing program evaluation and refinement; develop sustainability plan (transition to user fees)
S5: Q19-20 Continue service delivery; execute on sustainability plan

4. Anchor Hospital Advancement Program
S1: Q1-6 State awards grant for anchor hospital advancement program implementation including tasks listed herein; complete anchor hospital needs survey; develop and secure State approval for detailed scope of anchor hospital services (eligibility criteria, method of delivery, staffing, resources, costs, workplan, timeline); secure necessary staff and resources
S2: Q7-8 Outreach to anchor hospitals re: available services; commence initial service delivery; evaluate and make modifications
S3: Q9-12 Continue Stage 2 activities; commence delivery of additional services; survey anchor hospitals on program impact
S4: Q13-16 Continue Stage 3 activities; commence final expansion of services; develop sustainability plan
S5: Q17-20 Continue Stage 4 activities; collect data and evaluate program impact; execute sustainability plan
5. Mobile Integrated Health Pilot Program
S0: Q1-8 Identify State program director responsible for tasks listed herein; define scope of and eligibility and reimbursement for MIH services; establish process for submission and payment of claims; recruit 5 participating communities; recruit, train, and place CMAs to provide MIH services in participating communities; define data collection requirements
S1: Q9-12 Commence delivery and payment for services and data collection; evaluate operations and made modifications, as necessary
S2-3 Q13-16 Continue Stage 1 activities; with State Medicaid technology vendor, analyze impact of MIH services on total cost of care and outcomes for Medicaid beneficiaries
S4-5: Q17-20 Continue Stage 1 activities; develop expansion plan including establishing Medicaid reimbursement for MIH services, if indicated, subject to federal approval
6. Rural Primary Care – Public Health Integration Pathways Program
S1: Q1-6 State awards grant for rural primary care/public health integration pathways program implementation including tasks listed herein; grantee develops communication/recruitment plan and implementation plan with up to six regional hubs to facilitate integration and provide resources; State and grantee promote participation to rural providers and LHDs and secures participation commitments
S2: Q7-12 Participating communities' providers and LHDs engage in hub-facilitated assessment to identify and scope integration opportunities and planning to select population health measures and identify partners' respective commitments and roles
S3-4: Q13-16 Hubs assist participants engaging in implementation and right-sizing by ensuring continuity of dedicated staff, integration of data systems, alignment to payment models, and co-location of services
S4-5: Q17-20 Hubs assist participants in collecting data to evaluate impacts of integration and in developing and executing on sustainability plans

Initiative 3: Build a Sustainable Rural Health Workforce
Physician Pipeline Program
S0: Q1-4 State awards grant for program implementation including tasks listed herein. Develop implementation plan, milestones, and evaluation framework for Rural Residency Program, Expansion of Kansas Bridging Plan (KBP) and Medical Student Rural Rotation Housing Assistance. Begin outreach to hospitals and medical schools for rural residency partnerships. Contract/hire one FTE to manage KBP expansion and 0.5 FTE to manage Medical Student Rural Rotation Housing Assistance.
S1-2: Q5-8 Q5: convene roundtable meetings with both allopathic and osteopathic Kansas residency programs and other key stakeholders; increase KBP incentive amounts to up to $30,000 and add new residency slots (General Surgery, Orthopedics, 3 additional out-of-state primary care slots). **Q6**: identify and prioritize 3–5 rural sites for new ACGME-accredited residency programs; identify rural track assistant program director; prepare and begin faculty development **Q7-8**: begin ACGME accreditation application as applicable; launch Medical Student Rural Rotation Housing Assistance stipends. **Q7-8**: initiate data system enhancements for participant tracking; issue retention stipends to Year 1 and Year 2 residents; continue issuing housing stipends. **Q8**: marketing/recruitment for first cohort of 2–3 rural residencies
S3-5: Q9- 20 Launch first cohort of residents in Q11 (subject to ACGME accreditation), add final cohorts in Q14. Continue KBP expansion and retention payments, monitor physician service commitments. Continue issuing Medical Student Rural Rotation Housing Assistance. Perform evaluation and develop and execute on sustainability plans during Q18-Q20.
Education and Training Program
S0: Q1-4 State awards grant for program implementation including tasks listed herein. Develop implementation plan, milestones, and evaluation framework. Establish application/tracking portal, develop 5-year rural service agreements and reporting frameworks for Health Professions Service Scholarship Program and Rural Dentistry Scholarship. Contract/hire one FTE nurse trainer, one physician trainer, and one program manager for Mobile Simulation Lab.
S1-2: Q5-8 Promote Health Professions Service Scholarship Program to colleges, students, and stakeholders. Launch scholarships in Q5 with second round in Q7. Develop sustainability metrics and workforce data collection system. Launch Rural Dentistry Scholarship Program in Q4 with second round in Q6. Purchase equipment, software, and training modules for Mobile Simulation Lab. Deploy Mobile Simulation Lab to first rural communities in Q5 with second round of trainings in Q7. Open Health Care Training Grant applications in Q5 with awards in Q7.
S3-5: Q9-20 Health Professions Service Scholarship Program continues with new rounds launching in Q9, Q13 and Q17. Rural Dentist Scholarship Program continues with new rounds launching in Q9, Q13 and Q17. Mobile Simulation Lab visits continue. Perform evaluation; develop and execute on sustainability plans during Q18-Q20.
Recruitment and Retention Program
S0: Q1-4 State awards grant for program implementation including tasks listed herein. Develop implementation plan, milestones, and evaluation framework. Secure marketing firm, develop campaign messages, finalize plan for Work in Rural Kanas Health Care Campaign. Acquire curriculum for Rural Nurse Residencies, develop program guidelines for participating nurses/hospitals, begin marketing to hospitals/nursing schools, hire 1 FTE program manager. Adapt existing clinical faculty academy curriculum for rural use for Clinical Instructor and Preceptor Incentives, contact with instructor for Clinical Faculty Academy, develop program guidelines for participating hospitals, market opportunity to hospitals/nursing schools. Collaborate with behavioral health organizations and educational institutions to identify potential roles for Behavioral Health Apprenticeship Program.

S1-2: Q5-8 Launch Work in Rural Kanas Health Care Campaign in Q5. Launch cohort 1 of Rural Nurse Residencies in Q5 with additional cohort launch in Q4. Initial hospital/school pilot partnerships form for Clinical Instructor and Preceptor Incentives and Clinical Faculty Academy in Q5. Pilot test launch in Q6 and an additional cohort launch in Q8. Contract with intermediary to assist with Behavioral Health Apprenticeship program, apply for registered apprenticeship status, start promotion of program to employers in Q5. Launch first apprenticeships in Q7.
S3-5: Q9-20 Rural Nurse Residencies continue with new cohorts launching every other quarter, Clinical Instructor and Preceptor Incentives continue with Clinical Faculty Academies in every other quarter. Behavioral Health Apprenticeship Program continues with quarterly networking sessions of employers taking place through Q18. Perform evaluation; develop and execute on sustainability plans during Q18-Q20.
Career Exploration Program
S0: Q1-4 State awards grant for program implementation including tasks listed herein. Establish financial support for Rural Chapters of HOSA program, planning for workforce development day/regional conferences and hire staff. Meet with Kansas Department of Education (KSDE)to develop program guidelines for K-12 Health Science Career Technical Education (CTE) and begin marketing opportunity. Collaborate with KSDE and educational institutions to identify potential roles for high school certification/pre-apprenticeship programs. Establish guidelines for Regional Career Expo support.
S1-2: Q5-8 HOSA Chapter support program and HOSA Workforce Development Days launch in Q5. HOSA State Leadership Conference in Q8. HOSA Fall Leadership Conference in Q8. Identify curriculum needs and equipment needs for K-12 CTE. Build pilot program with schools with launch in Q8. Identify curriculum needs and equipment needs for High School Certification/Pre-Apprenticeship Program. Build pilot program with employers with launch in Q8. Launch Career Expo support program, coordinate with HOSA and other applicable projects.
S3-5: Q9-20 – HOSA work continues with HOSA State Leadership Conference in Q9, Q13 and Q17. HOSA Workforce Development Days in Q10 ,Q11, Q14, Q15, Q18 and Q19. HOSA Fall Leadership Conferences in Q12 and Q16. HOSA simulation training expansion in Q9 and membership database launch in Q13. Chapter sustainability training in Q20. CTE work continues with additional chapters added in Q11,Q15, Q19. High School Certification/Pre-Apprenticeship work continues with additional employer sites added in Q11,Q15, Q19. Regional Career Expo support continues. Perform evaluation; develop and execute on sustainability plans during Q18-Q20.

Initiative 4: Enable Value-Based Care
1. Evidence-Based Practice Incentive Program
S0: Q1-2 State contracts with QHi for data submission; State finalizes metrics and performance targets for each provider type, timelines and process for data submission through QHi, and initial criteria for scoring provider data submissions; Care Collaborative hires performance improvement (PI) specialists, develops provider education/assistance plan, and develops and executes on provider communication plan.
S1: Q3-6 Provider submission of Q2 data by end of Q3; PI specialist review and scoring of provider submission and payment recommendations to State (pay-for-reporting) within 30 days of data submission deadline (October 31); State distribution of funds to providers within 30 days of receipt of payment recommendations (November 30); PI specialist outreach and assistance to providers with opportunities for improvement; provider submission of Q3 data by end of Q4, followed by aforementioned process for scoring and payments (pay-for-performance); continue submission, review, and payment process for Q4 and Q5 data; PI specialist outreach and assistance to providers with opportunities for improvement; PI specialist outreach to encourage non-participating providers to submit data.
S2-3: Q7-10 Continue submission, review, and payment process for Q6 to Q9 data; continue PI specialist outreach; conduct provider survey on program experience and internal operational review and modify program processes and infrastructure, as appropriate
S4: Q11-14 Continue submission, review, and payment process for Q10 to Q13 data; continue PI specialist outreach; conduct provider survey on program experience and internal operational review and modify program processes and infrastructure, as appropriate.
S5: Q15-20 Continue submission, review, and payment process for Q14 to Q19 data; continue PI specialist outreach through end of Q18; complete final program report
2. ACO Readiness Program
S0: Q1-6 State seeks to finalize ACO management company RFP specifications and complete vendor selection and contracting; vendor and Care Collaborative finalize program activities, technical assistance, and payments, subject to State approval; Care Collaborative identifies and recruits potential participants
S1: Q6 Providers execute participant agreements; complete participant orientation; vendor secures claims data
S2: Q7-8 Program activities commence; vendor produces performance reports; additional providers recruited to program
S3-4: Q9-16 Continue Stage 2 activities; transition successful participants to formal shared savings programs; terminate participation of providers not actively engaging in program activities
S5: Q17-20 Continue Stage 2 activities; evaluate program results

3A. Transportation Program – Interfacility Transport Teams
S0: Q1-6 With stakeholder input, State identifies up to 8 locations for rural interfacility transport hubs; State seeks to finalize RFP specifications and complete vendor selection and contracting; vendor engages with local EMS to develop detailed implementation plan and timeline to place equipment and teams at selected locations and to establish communication and operational protocols for interfacility transports.
S1: Q7-8 Secure equipment and hire and train personnel to be place with local EMS at first 4 location; outreach to surrounding communities; develop and implement regional communication and operational protocols; commence interfacility and return-to-home transports; evaluate performance and make program modifications
S2: Q9-12 Implement program at second 4 locations following same processes; evaluate performance and make program modifications
S3-5: Q13-20 Maintain operations and ongoing evaluation; analyze impact on transport costs; develop and execute on sustainability plan
3B. Transportation Program – Behavioral Health Crisis Transport
S0: Q1-4 With stakeholder input, State identifies up to 5 network regions; State seeks to finalize RFP specifications for regionalized behavioral health access network and complete vendor selection and contracting; vendor develops detailed implementation plan and timeline to staff 5 regions; vendor develops hospital engagement strategy and network communication and operational protocols
S1: Q5-6 Vendor launches Region 1, including placement of statewide dispatchers and telehealth assessors and local certified peer mentors to coordinate assessment, placement, and transport of persons presenting in EDs requiring behavioral health or addiction treatment and to provide routine weekday transportation for behavioral health appointments and recovery support as available; vendor provides SUD treatment for uninsured individuals unable to be placed elsewhere
S2-4: Q7-16 Vendor launches remaining regions in same manner; evaluate network performance and make program modifications, as appropriate; develop sustainability plan
S5: Q17-20 Execute on sustainability plan; evaluate network's impact on patient access to behavioral health services, hospital operating costs
3C. Transportation Program – Non-Emergency EMS Calls
S0: Q1-4 State seeks to finalize RFP specifications for non-emergency EMS call dispatch and complete vendor selection and contracting; vendor develops detailed implementation plan and timeline, including operating procedures and training program for rural 911 dispatchers
S1: Q5-8 Vendor staffs and launches program and delivers training for rural 911 dispatches; track utilization and referrals
S2-4: Q9-16 Maintain services; evaluate program and make modifications, as appropriate; track utilization and referrals; develop sustainability plan
S5: Q17-20 Maintain services; complete program evaluation, including impact on total cost of care; execute on sustainability plan

3D. Transportation Program – EMS Reimbursement for Treatment-In-Place and Transport to Alternative Location
S0: Q1-6 Identify State program director responsible for tasks listed herein; define scope of and eligibility and reimbursement for specified EMS services; establish process for submission and payment of claims; s; define data collection requirements
S1: Q7-12 Commence delivery and payment for services (to extent reimbursement not otherwise available) and data collection; evaluate operations and made modifications, as necessary
S2-3 Q13-16 Continue Stage 1 activities; with State Medicaid technology vendor, analyze impact of services on total cost of care and outcomes for Medicaid beneficiaries
S4-5: Q17-20 Continue State 1 activities; develop expansion plan including establishing Medicaid reimbursement for services, if indicated, subject to federal approval
3E. Transportation Program – Non-Emergency Transportation Grant Program
S0: Q1-Q6 State awards grant for program implementation including tasks listed herein; develop grant program parameters and requirements; develop application and scoring criteria; develop and execute on marketing plan
S1: Q7-8 Solicit Round I applications; assist potential applicants; score submitted applications; make award recommendations to State; State makes award decisions and distributes funds
S2: Q9-12 Monitor and assist Round I recipients; modify program parameters and requirements as necessary; conduct Round II in same manner as Round I, with modifications
S3: Q13-16 Monitor and assist Round I and II recipients; modify program parameters and requirements as necessary
S4-5: Q17-20 Monitor and assist all recipients; receive final reports from each recipient 2 years following award; prepare evaluation report
4. Medicaid Provider Incentive Payment Program
S1: Q1-4 State defines specifications and process for rural provider incentive payments for Medicaid beneficiary engagement; State evaluates whether to amend MCO contracts to permit provider payments for care coordination at beneficiary election and initiates amendment, if appropriate, subject to federal approval
S2: Q5-6 Circulate best practices for beneficiary engagement; commence incentive payments; engage stakeholders regarding potential MCO contract provision on provider payments for care coordination and care management (including outreach, education, and evaluation requirements)
S3: Q7-8 Finalize and secure any necessary federal approvals for MCO contract provision; include explanation of provision in solicitation for 2028-30 MCO contract period; continue incentive payments
S4: Q9-16 Monitor MCO performance and take corrective action, if necessary; work with Medicaid technology vendor to evaluate impact of provider-furnished services; evaluate other initiatives' impact on Medicaid total cost of care for purposes of including requirements for 2031-33 MCO contract period and engage stakeholders
Stage 5: Q17-20 Finalize and secure any necessary federal approvals for MCO contract provisions

Initiative 5: Harness Data and Technology
1. Remote Patient Monitoring Program
S0: Q1-4 – State seeks to finalize remote monitoring RFP specifications and complete vendor selection and contracting; vendor provides detailed plans for implementation, operations, reporting, evaluation, and program sustainability through 2030
S1: Q5-6 – Vendor completes implementation at pilot hospitals; State evaluates vendor performance and addresses outstanding issues
S2-4: Q7-12 – Vendor completes implementation at anchor hospitals; State evaluates performance and addresses issues; vendor collects data and reports monitoring impact on hospital operations and outcomes
S5: Q13-20 – Monitoring services and evaluation continue; vendor executes on sustainability plan
2. Telehealth Navigator Program
S1: Q1 to Q4 – Care Collaborative hires and trains nurse navigators and secures necessary supplies and resources, prioritizes clinics for implementation; navigators work with participating specialists and individual clinics to establish processes
S2-5: Q5-20 – Implement and maintain telehealth navigator program at clinics as specialists available to provide services; evaluate program operations and refine processes, as appropriate; collect data and evaluate provider and patient satisfaction and impact on patient outcomes
3. Data Infrastructure Program
S1: Q1-6 – State executes lease agreement for All-Payer Claims Database infrastructure; State awards grant for data management to facilitate rural providers' use of APCD; State contracts with state-certified HIEs for rural provider connectivity and HIE feature enhancements; State awards grants for implementation of Diabetes Data Dock, CCBHC Data Center, and Kansas Data Trust
S2: Q7-10 – Complete transition to updated APCD, finalize operating procedures, pursue regulatory changes as needed to facilitate its use, and promote and educate providers on APCD usage; monitor HIE participation and performance and make program modifications, as necessary; monitor awardees' compliance with submitted workplans; evaluate and pursue options for expanding Data Infrastructure Program to support interoperability
S3-4: Q11-16 – Monitor APCD participation and utilization and make program modifications, as necessary; continue other S2 activities; collect and analyze data for program evaluation; develop sustainability plans
S5: Q17-20 – Implement sustainability plans
4. Emerging Technology Program
S1: Q1-6 – Identify, convene, and facilitate the work of AI and consumer-facing technology expert panels; establish expert panels' respective work plans/priority lists; develop processes to promote panel recommendations and provide related technical assistance; establish requirements and process for rural providers to secure funding to implement recommended technologies
S2: Q7-8 – Panels make initial recommendations and publish related guidance; State promotes recommendations, provides technical assistance, and funds start-up costs consistent with established processes.
S3-4: Q9-20– Continue Stage 2 activities; evaluate program operations and results and make modifications, develop and execute on sustainability plan

V. Stakeholder Engagement

Prior to the release of the Notice of Funding Opportunity (NOFO), representatives from the Governor's Office, KDHE, and KDADS met with representatives from multiple organizations to discuss potential uses of RHT Program funds in rural Kansas. Unlike other states, Kansas did not issue a public solicitation of comments, electing to wait until the publication of the NOFO to have a clear understanding of RHT Program requirements and restrictions.

Soon after the NOFO's release, the Governor appointed the following organizations to the Kansas Rural Health Innovation Alliance to fully engage stakeholders in Plan development:

Kansas Hospital Association	Community Care Network of Kansas (State primary care association)
Association of Community Mental Health Centers of Kansas	Kansas Association of Local Health Departments
Kansas Rural Health Association	Kansas Medical Society
Kansas Academy of Family Physicians	Kansas Chapter, American Academy of Pediatricians
Kansas Health Institute	LeadingAge Kansas
Kansas Health Care Association	Kansas Grantmakers in Health

The team appointed by the Governor to draft the State's application, including the Interagency Task Force and the Care Collaborative, presented a webinar for Alliance members and other stakeholders in late September to discuss application requirements and answer attendees' questions. During the webinar, the team requested submission of proposals for Plan initiatives consistent with RHT Program requirements and restrictions. The request, along with a recording of the webinar, was posted on State websites. In response, the State received more than 225 formal proposals from a wide range of stakeholders.

Following the webinar, the team held one-on-one meetings with Alliance members as well as other stakeholders to solicit input on Plan initiatives. These other stakeholders included, but

were not limited to, leaders of the state's existing rural health networks, professional associations, community-based organizations, consumer groups, philanthropies, researchers, technology vendors, colleges and universities, and Medicaid managed care organizations. In total, the team participated in 55 one-on-one stakeholder meetings. The team also met with multiple organizations that submitted proposals to address specific questions and concerns.

Alliance members then participated in two two-hour virtual meetings in October to review, refine, and approve the Plan's vision, mission, values, and objectives and to scope potential initiatives. Attendance at these virtual meetings was not limited to Alliance members; the meetings were announced publicly, and recordings have been posted to the State website.

A four-hour in-person Alliance meeting was held in Topeka on October 20 to review and provide feedback regarding Plan initiatives and the specific programs and projects under each initiative, as well as the proposed governance and management structure. Approximately 50 people attended in person with others participating via livestream. There was robust discussion during the meeting, resulting in several important refinements to the draft Plan to address opportunities and concerns raised by Alliance members. Included in the supplemental materials is a letter of support for the Plan signed by Alliance member representatives who participated in the process.

As discussed above, the Alliance will continue to serve as the primary vehicle for stakeholder engagement in the Plan's implementation, meeting at least quarterly to advise and assist the State on specific implementation-related matters. Additionally, the State's communication plan will include regular public reporting and outreach activities, including a robust website through which stakeholders can raise concerns and make recommendations.

As detailed under the Accountable Food Is Medicine + CHW Deployment Program, the Plan will place CHWs at K-State local extension offices in every rural county. Among other

responsibilities, these CHWs will be the local eyes and ears for the Plan, communicating any concerns to the Care Collaborative, which in turn will address those matters with KDHE.

For purposes of coordination, the lead agency, KDHE, includes the Division of Health Care Finance (the state Medicaid Agency) and the Division of Public Health under which the State Office of Rural Health operates. KDADS, under which behavioral health (single state agency) and long-term care services operate, is also a part of the Interagency Task Force. The Kansas Office of Native American Affairs is under the Governor's Office and was directly engaged in Plan development. As discussed above, the Plan includes funds for rural primary and secondary prevention programs to be developed and implemented by the federally recognized tribes.

V. Metrics and Evaluation Plan

With the Plan's vision of rural Kansans leading healthier lives and having access to high quality, well-coordinated, and comprehensive health care services, the critical metric for evaluating the Plan's impact will be changes in rural residents' perception of access to and experience of care. The State, therefore, will contract with a research organization to survey adult rural Kansans on health care access and experience, with questions tailored to Plan initiatives to evaluate specific impacts. Such survey will target at least 2,400 completions statewide with 400 representative responses from each region, yielding statistically valid sample at a +/-5% margin of error for each region's rural population. Both region- and state-level results will be reported in the form of a technical report and a public-facing interactive data visualization with mapping. The baseline survey will be fielded April-May 2026 with follow-up surveys fielded every two years (2028 and 2030) at the same time of year to help control for any seasonal effects on response. Results will be released by September 15 following each survey administration.

Other performance metrics to be tracked for the duration of the Cooperative Agreement include the following:

Initiative 1 Metrics and Evaluation Plan		**Expand Primary and Secondary Prevention Programs**
Metrics	**Description**	**Parameters**
1 Accountable Food Is Medicine (FIM) Outcomes	Participation, health outcomes, impact on total cost of care	- Report quarterly at county and state levels on (1) number of placed community health workers, (2) number of individuals newly enrolled in FIM, (3) number of enrollees completing FIM curriculum *Target:* meet projected number of CHWs each year, 2,000 enrollees by 2030, 100% completion rate for FIM curriculum - Report at regional and state level for enrollees who complete curriculum pre- and post-intervention comparison for weight, blood pressure, and blood glucose levels (data collected from monitoring device data, EHRs) *Target:* All enrollees completing curriculum within normal range for weight, blood pressure, and blood glucose levels - Report at state level for Medicaid enrollees who complete curriculum year-over-year comparison of total cost of care *Target:* 10% year-over-year reduction in total cost of care for Medicaid enrollees who complete curriculum
2. Consumer-Facing Tech Adoption	Utilization and outcomes	Report semi-annually at state level vendor-reported utilization in rural Kansas counties and vendor-reported outcomes for rural Kansas users *Baseline:* pre-implementation data from vendors, if any; *Target:* 20% of rural adults using one or more technologies by 2031
3. Dual Eligible Participation in Integrated Care	Engagement	Report semi-annually at state level (1) number of PACE-eligible individuals in rural Kansas counties enrolled in PACE, and (2) number of non-PACE enrolled dual eligibles in rural Kansas counties receiving intensive care management services *Baseline:* 2025 dual eligible and PACE enrollment data. *Target:* 20% increase in PACE enrollments; 20% of rural non-PACE-enrolled dual eligibles receiving care management services through Care Collaborative

4. Access to Behavioral Health Services	Rural PCPs' and rural hospital CEOs' perception of access to behavioral health services (in addition to aforementioned patient access and experience survey)	Report annually at state level results of survey of rural PCPs and rural hospital CEOs regarding access to behavioral health services for their patients *Baseline*: 2026 survey. *Target*: 50% reduction in reported restrictions or limits on access by 2031.
5. Cancer Screenings	Number of screenings and follow-up	Report annually on (1) number of rural communities in which screenings were held, (2) number of skin and urological cancer screenings performed in rural communities, and (3) follow-up rate for positive screens Baseline: 0. Target: Screenings in 10 communities per year, all appointments filled at each site, 100% follow-up rate on positive screens.

Initiative 2 Metrics and Evaluation Plan		**Secure Local Access to Primary Care**
Metrics	**Description**	**Parameters**
1. Rural Hospital Sustainability	Hospital operating margins	Report at individual rural hospital level year-over year changes in operating margins reported on Medicare cost reports *Baseline*: 2024 cost report data. *Target*: Fewer than 20% of rural hospitals with negative operating margins by 2031.
2. Access to Care	Rural residents' perception of access to care and quality of care	Report bi-annually at regional and state level on rural resident survey results *Baseline*: 2026 survey. *Target*: Year-over-year statistically significant improvements
3. Grant Program Participation	Number of awardees and awardee performance for Regional Partnerships and REH Conversion/Transformational Capital Investments Grant Programs	- Report at state level for each application cycle number of applicants and funded projects - Report annually on individual grantee's adherence to implementation timeline and reported outcomes *Target*: Award full amount budgeted for each application cycle to meritorious applications, 100% awardee compliance with implementation and reported outcomes

4. Anchor Hospital Advancement Program	Anchor hospital engagement	- Report quarterly at individual hospital level utilization of Anchor Hospital Advancement Program services by type of service - Report annually on results of survey of rural anchor hospital CEOs' perceptions of program participation and effectiveness *Target*: All rural anchor hospitals reporting positive operating margins by 2031; 100% hospital CEO satisfaction with program

Initiative 3 Metrics and Evaluation Plan		**Build a Sustainable Rural Workforce**
Metrics	**Description**	**Parameters**
1. Physician Pipeline	Expanded physician training opportunities in rural communities Impact on rural provider-to-patient ratios	- Report annually at state level (1) increase in rural physician residency programs/tracks by specialty; and (2) number of medical students assisted with housing during rural rotations. *Baseline:* 2026 survey. *Target*: New programs in 5 specialties by 2031, 200 medical students per year by 2028 - Report County Health Rankings & Roadmaps Project year-over-year changes in provider-to-patient ratios in rural Kansas counties. *Baseline:* 2026 report. *Target*: year-over- year statistically significant reductions
2. Education and Training	Impact of training and education projects on allied health workforce shortages	- Report semi-annually at state level number and types of allied health scholarships awarded with RHT Program funds - Report quarterly at state and regional level (1) number of training sites and number of participants in mobile simulation labs; (2) participant-reported skill improvement on post-training survey. - Report year-to-year changes in allied health staff shortages reported in Kansas Hospital Association's Kansas Health Work Force Report (reported at state level). *Baseline*: 2025 Work Force Report. *Target*: year-over-year statistically significant reductions in reported allied health staff shortages

3. Recruitment and Retention	Impact of recruitment and retention projects on workforce shortages	- Report annually marketing campaign's social media reach and impressions - Report at state level year-to-year changes in nursing and allied health staff turnover rates reported in KHA Kansas Health Work Force Report - Report annually at state and county level number of students trained at new clinical sites by job category and number of behavioral health apprenticeships created with RHT Program funds. *Baseline*: 2025 Work Force Report. *Target*: year-over-year statistically significant reductions in nursing and allied health staff turnover rates
4. Career Exploration	K-12 student engagement	Report annually at state level number of rural HOSA chapters created and number of rural schools offering the health science CTE pathway using RHT Program funds

Initiative 4 Metrics and Evaluation Plan		**Enable Value-Based Care**
Metrics	**Description**	**Parameters**
1. Value-Based Care Models	Provider participation	Report year-over-year changes in number (at county and state levels) and percentage (at state level only) of rural providers (by provider type) participating in Medicare or Medicaid value-based care arrangements *Baseline*: 2026 data. *Target:* 100% participation by rural providers enrolled in Medicare or Medicaid for at least 1 year by 2031
2. Evidence-Based Practice	Adoption of and adherence to evidence-based protocols	Report quarterly at county and state level number and percentage of eligible rural providers receiving full or partial incentive payments *Baseline*: 0. *Target:* 100% of all eligible providers receiving incentives by 2031

3. Medicaid Provider Incentive Payments	Provider engagement in care management/care coordination services	- Report quarterly on county and state level number of incentive payments made to PCPs for engaging eligible Medicaid beneficiaries in care management/care coordination services - Report quarterly on progress towards inclusion of rural provider incentive payments for care management services for defined populations in MCO contracts for 2028-2030 period *Target:* All MCOs providing rural provider incentive payments beginning in 2028 with year-over-year growth in provider participation in 2029 and 2030
4. Transportation – Resolution of Challenges	Reported status of transportation-related challenges	Report annually at regional and state level results of surveys of rural hospital CEOs regarding status of transportation challenges (facility-to-facility and behavioral health-related transports) *Baseline*: 2026 survey. *Target:* Zero reported challenges by 2031
5, Transportation – Total Cost of Care	Estimated savings	Report annually on state level Medicaid savings generated by EMS payments for treat-in-place and transport to alternate location *Baseline*: 2026 spending. *Target*: 10% reduction in Medicaid EMS transport costs by 2031

Initiative 5 Metrics and Evaluation Plan		Harness Data and Technology
Metrics	**Description**	**Parameters**
1. Remote Monitoring Outcomes	Clinical performance measures for hospitals performing monitoring	Report year-over-year at individual hospital level changes in Medicare Inpatient Quality Reporting Program safety of care measure scores, complication rates, mortality rates, lengths of stay, and readmission rates at hospitals implementing remote monitoring *Baseline*: 2025 reported data. *Target*: statistically significant improvements on year-over-year basis
2. Telehealth Coordinators	Access to specialist services (pulmonology, rheumatology, neurology, psychiatry)	Report annually at regional and state level results of survey of rural PCPs regarding access to specialist services for their patients *Baseline*: 2026 survey results. *Target*: statistically significant improvements on year-over-year basis
3. Emerging Technologies	Technology utilization	Report annually at regional and statewide level results of survey of rural PCPs, rural hospital CEOs, and rural nursing facility CEOs regarding use of consumer-facing technology and AI solutions for patient care delivery, *Baseline*: 2026 survey results. *Target*: Year-over-year 10% increase
4. Health Information Exchange	Utilization and utility	- Report at state level year-over-year changes in rural provider HIE utilization (reported by state-certified HIEs) - Report annually at regional and statewide level results of survey of rural PCPs and rural hospital and CCBHC CEOs regarding utility of HIE connectivity for clinical care and/or revenue cycle *Baseline*: 2026 survey results. *Target:* all rural providers connected to HIE by 2031, year-over-year improvements in reported utility of HIE connectivity
5. Data Infrastructure	Rural providers' perception of data infrastructure	Report annually at regional and statewide level results of survey of rural PCPs and rural hospital and rural CCBHC CEOs regarding perception of secure access to relevant data for patient care purposes *Baseline:* 2026 survey results. *Target:* year-over-year improvements in PCP and CEO perception of data accessibility

VII. Sustainability Plan

The State's Rural Health Transformation Plan is the equivalent of a business plan for a new start-up aiming to transform rural health and health care delivery. The venture requires capital for start-up costs for which other funding is not available. The State views RHT Program funds as an investment in its venture for which the State must demonstrate significant, long-term returns. The State, therefore, will not spend funds to maintain the status quo because it is unsustainable over the long term. The budget for each program and project under the five initiatives has been vetted against the Plan values to test whether the investment will produce sustainable results. In short, the State has no interest in throwing good money after bad, consistent with its history of maintaining a fiscally responsible budgeting structure.

The Plan places a heavy emphasis on developing the infrastructure rural providers need to transition from fee-for-service reimbursement to value-based care. This infrastructure includes robust wellness and prevention programs, hard-wired evidence-based practices, total cost of care management, regional partnerships, reliable transportation, access to specialty services, and technology solutions. With purposeful investments and disciplined adherence to the Plan's implementation plan and timeline, the State is confident in leading rural providers through this critical transition period.

With these critical start-up investments in infrastructure, rural providers can break the vicious cycle of fee-for-service reimbursement and participate in value-based arrangements. While the State presently encourages its contracted Medicaid managed care organizations to pursue value-based arrangements with providers, the MCOs report that providers are unprepared to participate in such arrangements. With the next round of MCO contracting in 2028, the State will further incorporate value-based arrangements based on the strength of the infrastructure for rural

providers to participate in and benefit from these arrangements. As necessary, the State will leverage Medicaid waivers and state plan amendments to include rural provider payments for maintenance of critical infrastructure (e.g., telehealth, virtual services, technology solutions, enhanced care management). The infrastructure also will enable providers to successfully participate in traditional Medicare value-based arrangements, generating funds to maintain infrastructure.

Beyond these federal health care programs, the Plan includes investments that will enable rural providers to better serve the commercial market. These include a statewide commercial rate analysis to understand how current rates impact rural providers' bottom lines, investments in rural clinically integrated networks to negotiate with commercial payers, and assistance with implementing direct-to-employer contracting and other alternatives to traditional commercial insurance products that rely on fee-for-service reimbursement. With legislative leadership, the State will pursue policy changes to support adoption of these alternatives, as necessary.

The State's robust metrics and evaluation plan will produce reliable results on the impact of specific programs on outcomes, access to care, and the cost of care. These results will make the case for future investments needed to maintain or expand the value-based care infrastructure. Such future investors include payers that have calculated the value of such infrastructure to their own financial performance, providers managing risk for a defined patient population, and local communities and philanthropies wanting to maintain and improve health and health outcomes.

By way of example, the Plan includes substantial funding to bring CHWs to at least 100 rural communities. At present, there is limited fee-for-service reimbursement for CHW services which, in nearly all cases, is insufficient to cover the employer's expenses, especially while CHWs are establishing themselves in the community and thus have a limited caseload. By evaluating the

impact of a mature CHW program established with Program funds, the State will produce the evidence to support funding these programs at a sustainable level, whether through enhanced fee-for-service reimbursement or as part of value-based care arrangements.

In addition to this overarching approach to sustainability, the State will employ strategies tied to specific programs:

Program	Sustainability Strategy
Regional Partnership Grant Program and REH Conversion/Transformative Capital Investment Grant Program	Each grantee receiving RHT Program funds will be required to develop and implement submit a sustainability plan.
Contracted vendors	Each vendor selected by the State to provide Plan-related services will be required to provide a sustainability plan to continue services after the award period.
Revenue Cycle Support and Credentialing Organization and Anchor Hospital Advancement Program	Both will transition to cost-based user fees in place of RHT Program funds as they demonstrate their value to rural providers. Because they will not have incurred start-up costs, the fees will be affordable for rural providers.
Workforce programs	The demonstrated success of individual workforce programs will make the case for state appropriations, local government funding, and/or philanthropic support to continue incentives, scholarships, and/or training programs.

Additionally, the State will systematically review all existing State programs and initiatives supporting rural health care delivery to identify how such programs may be modified to align with and sustain specific Plan initiatives and will pursue such modifications, as appropriate. As part of this review, the State will account for reductions in federal Medicaid funding due to eligibility restrictions and reductions in state-directed payments beginning in 2028.

Critically important to sustainability is developing and maintaining public trust in the Plan's implementation and ongoing operations. Members of the Kansas Rural Health Innovation Alliance, the representative stakeholder group advising the State Plan implementation, will be responsible for communicating with and sharing feedback from their constituencies regarding the Plan and its impact on rural health care delivery. The Plan website will serve as a one-stop shop for Plan-related information and public comments. The State is committed to transparency throughout the process and will communicate regularly to the public, the State Legislature, and the federal Congressional delegation regarding Plan progress.

End Notes

These pages do not count toward 60-page limit

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[xv] County Health Rankings, available at https://www.countyhealthrankings.org/health-data/kansas?year=2025

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[xx] Available at https://cdn.ymaws.com/communitycareks.site-ym.com/resource/resmgr/documents/2025-membermap-ccnk-4-15-25.pdf

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