Project Narrative

Louisiana Department of Health (LDH or "the Department"), as the designated agency for the State of Louisiana, submits this **Louisiana Rural Health Transformation Program (LA RHTP)** application for the Rural Health Transformation Program (CMS-RHT-26-001) to the Centers for Medicare & Medicaid Services (CMS). LA RHTP is grounded in the core principles and strategic goals of the federal Rural Health Transformation Program (RHTP) and will support rural communities in Louisiana, regardless of insurance status, by improving healthcare access, quality, and outcomes through innovative system change.

RURAL HEALTH NEEDS AND TARGET POPULATION

Rural Demographics

Nearly **1.1 million Louisiana residents (23.8% of the population)**[i] live in rural parishes, with 37% covered by Medicaid and 22% covered by Medicare, in a state that covers **52,378 square miles**.[ii] Despite this scale, rural areas are economically underutilized, representing only **11% of the statewide GDP**. Rural parishes face persistent structural disadvantages, including limited industry diversification and economic opportunities, and higher unemployment. As of March 2025, the average **rural unemployment rate is 5.4%**, compared to the urban rate of 4.4%.[iii] Household incomes are significantly lower, with the **rural median household income at $48,582** and some parishes reporting as little as **$28,321**.[iv] With 85% of rural adults aged 25 and older lacking a bachelor's degree and facing unemployment rates above state and national averages, the Landry Administration sees an imperative to link improving health outcomes with efforts to expand our healthcare workforce and rural jobs to achieve economic growth and better rural outcomes.[v]

Health Outcomes

Louisiana ranks 50th in national health rankings, taking the spot as the "least healthy state"

in the U.S. based on 49 measures across five categories of health, including social and economic factors, physical environment, clinical care, behaviors, and health outcomes.[vi] Given this baseline, Louisiana's bold RHTP proposal represents a seminal opportunity for the Trump Administration to catalyze a generational change in health outcomes, truly making Louisiana Healthy Again.

While the whole state faces significant health challenges, health outcomes in Louisiana's rural parishes reflect disproportionate burdens of chronic disease. Older adults, who comprise approximately **20% of Louisiana's total population** (about **one million residents**), with nearly **30% living in rural areas**, bear a disproportionate burden of chronic and comorbid conditions that further contribute to the state's poor health rankings. Compared to their urban counterparts, rural Louisiana residents experience higher rates of: **hypertension** (44%), **obesity** (43%), **heart disease** (9.2%), **diabetes** (17%), **COPD** (11%), and **lung cancer prevalence** (68%).[vii] Rural residents face a maternal mortality rate (37%) that is 14 percentage points (pp) higher than the national average, with 12% lacking a birthing hospital within 30 minutes of their home (compared to about 10% nationally). With **75% of rural hospitals not offering labor and delivery services**, access gaps threaten both maternal and neonatal outcomes.[viii]

Healthcare Access

Only 24% of Louisiana's healthcare facilities are located in rural areas; residents travel an average of 7 miles to hospitals, 20 miles to clinics, and 12 miles to pharmacies, compared to much shorter distances in non-rural areas.[ix] This translates into **13.5 healthcare facilities per 100,000 rural residents**.[x] Access is further strained by a lack of public and private transportation (10% lack access to a

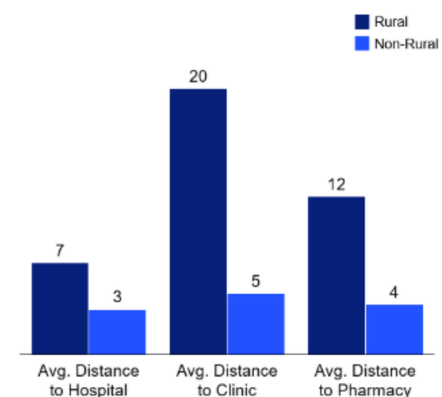

Figure 1. Average distance (miles) to healthcare facility, rural vs urban parishes

vehicle[xi]) and the concentration of services in urban centers.

Rural Facility Financial Health

The financial instability of rural health facilities (RHF) aggravates these challenges, limiting the medical offerings of certain facilities, influencing the range of services, hours, and extent of specialist care. Louisiana hospitals provided uncompensated services (e.g., to the un- or under-insured) to the tune of over **$419 million in 2020**, representing **2.2% of the hospitals' operating expenses**.[xii] Given the extent of uncompensated care and other health ecosystem challenges, **30% of hospitals in Louisiana receive Medicaid Disproportionate Share Payments (DSH)**, with rural hospitals particularly vulnerable to financial pressure.[xiii]

Target Population

The LA RHTP aims to improve access to care and healthcare delivery across rural Louisiana. It targets residents facing the greatest barriers—those with chronic disease, behavioral health needs, perinatal risks, or cancer disparities—while also investing in the providers, workforce, and infrastructure needed for lasting impact. Key groups include:

- Rural residents with chronic or complex conditions—including hypertension, diabetes, cardiovascular disease, and obesity—experiencing higher prevalence rates, greater disease burden, and higher healthcare costs than urban populations.
- Priority populations that require coordinated care, such as individuals with behavioral health needs, perinatal or postpartum risks, and cancer vulnerabilities, facing major gaps in early detection, care management, and treatment access that contribute to preventable mortality.
- Rural healthcare workforce facing persistent recruitment and retention challenges that limit capacity, including clinicians, nurses, community health workers, and emergency personnel.
- Rural healthcare facilities and providers—including rural health clinics (RHCs), Critical

Access Hospitals (CAHs), Federally Qualified Health Centers (FQHCs), and community-based organizations—requiring support to sustain operations, upgrade infrastructure, expand telehealth, adopt electronic health records (EHR), and implement innovative care models such as paramedicine and medically tailored meal programs.

Through these investments, LA RHTP will expand access, strengthen provider capacity, and improve outcomes for Louisiana's 1.1 million rural residents.

RURAL HEALTH TRANSFORMATION PLAN: GOALS AND STRATEGIES

Summary Statement of Intent

The LA RHTP, authorized under 42 U.S.C. § 254c(e), aims to improve healthcare access and outcomes for Louisiana's rural populations by strengthening local healthcare systems and workforce capacity. It targets residents with chronic and behavioral health needs, ensuring access to quality care. RHTP funding will drive adoption and expansion of a health technology ecosystem, workforce development, and economic revitalization, boosting rural health and economy.

Improving Access

The LA RHTP will expand healthcare access for rural residents by **strengthening workforce capacity, modernizing care delivery infrastructure, and creating new service pathways**. Louisiana will develop a sustainable rural healthcare workforce through financial incentives, education partnerships, and recruitment initiatives that address chronic clinician shortages. Strategies range from teaching rural middle school children about healthcare careers to helping clinical students build the future of healthcare access. Technology investments will improve care access and coordination. The program will establish innovative care delivery models, including community paramedicine, certified behavioral health clinics, opioid treatment programs (OTPs), and care navigation systems, that meet the diverse needs of rural residents.

<u>Improving Outcomes</u>

The LA RHTP will target improvements across three dimensions: population health outcomes, access and utilization, and system capacity.

- **Population health outcomes** will improve through reduced rates of uncontrolled chronic disease and earlier detection and management of conditions such as diabetes, hypertension, and cancer. These gains will be driven by coordinated care models, expanded preventive screening, nutrition and wellness interventions, and stronger care navigation to connect residents with continuous, community-based services.
- **Access and utilization outcomes** will include reductions in non-emergent emergency department (ED) visits and preventable hospitalizations, alongside increased preventive care and access to behavioral health services in underserved rural parishes.
- **System capacity outcomes** will strengthen the rural healthcare workforce and modernize care delivery infrastructure through education partnerships, recruitment initiatives, and technology expansion. As part of the development of the Louisiana Health Technology Ecosystem, Louisiana will implement and operate a new CMS-aligned network, including a statewide shared instance of a CMS-certified EHR, providing access to facilities that currently lack electronic health records rather than replacing existing systems.

These outcomes will be achieved through innovative care coordination models linking primary, specialty, behavioral health, and community-based providers, supported by care navigators and convener organizations. Value-based payment arrangements will align financial incentives with quality outcomes and cost containment. Louisiana will hold all partners accountable for tracking and reporting data aligned to RHTP performance measures, which will guide continuous improvement and ensure measurable progress toward population health goals.

Technology Use

LDH will leverage health IT to drive innovation in prevention and disease management. As the first state to pledge to be a CMS-Aligned Network, Louisiana will build a health technology ecosystem that promotes data interoperability and patient access.[xiv] Louisiana's **Rural Tech Catalyst Fund (RTCF-LA)** will invest in scalable digital solutions, such as telehealth and AI-driven diagnostics, to attract innovative technologies and improve access and efficiency. AI-enabled mobile platforms will expand broadband-supported care and engagement for Medicaid members, enhancing rural connectivity and access to digital health resources and preventative care. Additionally, a **statewide shared EHR** will connect rural health units and small provider practices. This connection will lay the groundwork for value-based payments, improve capacity for population-level analytics, and provide targeted tools for managing conditions such as obesity and diabetes, which are our selected focus areas.

Partnerships

The LA RHTP will foster community partnerships linking rural healthcare facilities, regional systems, behavioral health providers, emergency services, the Louisiana Ambulance Alliance, and allied health networks to improve quality, boost economic growth, and ensure financial sustainability. These efforts will involve educational systems, workforce agencies, nonprofits, law enforcement, and elected officials. Strategic alliances will leverage the state's nine-region structure to quickly implement Regional Health Collaboratives—co-chaired by community members and coordinated via Local Governing Entities and Public Health Units—that facilitate information sharing, workforce models, group purchasing agreements, and joint training programs. Community organizations, including healthcare providers, school leaders, and nonprofit health coalitions, will serve as collaborative partners to promote health, behavioral health, and chronic

disease prevention. Governance will ensure community representation and transparency, aligning decisions with local needs. These partnerships aim to improve care, data sharing, and cross-sector innovation, enhancing health outcomes and sustainability in Louisiana's rural parishes.

Workforce

Louisiana faces persistent provider shortages but has identified proven and innovative strategies to address them, such as expanding clinical training pipelines and implementing comprehensive financial incentives for rural services. Through the **Rural Healthcare Employment Reinvestment Opportunity (HERO) Fund** and **Rural Clinician Credit Bank**, the state will provide opportunities to attract and retain healthcare professionals in underserved areas. Clinicians will not be subject to non-compete clauses that limit access to rural communities. Educational partnerships with universities and hospitals will expand **rural rotations, residencies, and faculty positions** across primary care, behavioral health, and allied professions. Career pipeline initiatives will **engage high school and college students** in rural areas through healthcare clubs and mentorships, while "grow-your-own" programs will **upskill community health workers, EMTs, and paramedics** through micro-credentialing and mentorship with regional health systems. Cross-hospital **provider-sharing models** will optimize limited staffing by pooling specialists across rural facilities (enabled also through our technology strategies), ensuring continuity of care and reducing service gaps.

Data-driven Solutions

To improve care quality and access, Louisiana will establish and maintain a new health tech ecosystem, including a statewide, HITECH-certified EHR system. A **statewide shared EHR** that connects RHFs, hospitals, clinics, health units, and community providers will enable interoperability, clinical decision-support, and population health analytics. The initiative includes

a pilot data-sharing infrastructure that links rural providers to major health systems and public health networks, enhancing care coordination, reporting capabilities, and technical assistance to underperforming facilities. These investments complement Louisiana's Broadband, Equity, Access, and Deployment (BEAD) program, which expands broadband connectivity across rural parishes and healthcare facilities, laying the digital foundation for data exchange, real-time decision-making, and sustainable health system modernization statewide.

Financial Solvency Strategies

Louisiana will strengthen the financial stability of our rural providers through **value-based payment reform and capital investment**. The state will pilot **dual-sided risk models, accountable care organizations (ACOs), and clinically integrated networks (CINs)** with shared savings and quality incentives to reward efficiency and outcomes. The **Rural Health Facilities (RHF) Capital Improvement Initiative** will fund infrastructure modernization and service diversification within the required limits of the grant opportunity. Hospitals will be supported in right-sizing their operations and expanding outpatient and mobile care models. Based upon the results of pilot initiatives, Medicaid and state payment policies may be re-evaluated to improve reimbursement and ensure the sustainability of facilities and initiatives.

Cause Identification

Standalone rural hospitals face risks of closure due to low patient volumes, workforce shortages (particularly in specialty services), high rates of uncompensated care, and unfavorable payer mix. The LA RHTP addresses these issues through payment reform, facility reinvestment, workforce incentives, digital health innovation, and service modernization. Louisiana aims to keep these hospitals viable for its 1.1 million rural residents. While needs assessments exist for specific areas (e.g., primary care, hospital service area), LDH will partner with a local university to conduct

a Year 1 needs assessment, identifying priority populations and tailoring interventions to complement data provided to the state from grants and existing health sources.

Program Key Performance Objectives

By FY31, LA RHTP will deliver measurable improvements in access, quality, outcomes, and financial sustainability of rural healthcare, guided by key performance metrics, with baseline and target metrics tracked annually through the **Rural Health Data Dashboard** and partner reporting. The sample performance indicators below are the most appropriate measurable elements; however, baseline data has not yet been collected to inform these specific frames. At program start, LDH will complement existing data through targeted stakeholder surveys and engagement to address gaps and incorporate community feedback. During planning, as outlined in the implementation plan, the LA RHTP team will develop key performance metrics before implementation. LDH will partner with organizations such as the Louisiana Public Health Institute to track program metrics, supplemented by detailed initiative-specific metrics.

Objective Area	Metric	Sample Baseline	Sample Target / Milestones	Data Source	Data collection responsibility
Workforce	% increase patients receiving primary care service in their parish-of-residence	Estimated calculation 60% (AJPM, 2019; LDH PCNA 2020)	Year 3: 1% increase in coverage from baseline; Year 5: 3%	Hospital and facility-reported data	Partners / grantees
Tech Innovation	% increase of rural providers/facilities leveraging data exchange for care coordination via interoperable platforms	36% of national rural facilities are 'routinely interoperable' (ONC, 2023)	Year 3: +5 pp increase; Year 4: +10 pp; Year 5: +15 pp	EHR usage reports, FHIR API endpoint activations, identity credential issuance	LDH / EHR Vendor / CIN / Cloud Vendor
Innovative Care	% reduction in non-emergent ED visits	Estimated calculation 75,000-85,000 potentially preventable ED visits (Texas Medicaid and Children's Health Insurance Program, 2022)	Year 4: 2pp reduction in visits; Year 5: 5pp reduction in visits	Medicaid/CHIP claims data; encounter data	LDH

Make Rural America Healthy Again (MRAHA)	% improvement in health markers for target conditions (chronic disease, obesity, pregnant / postpartum, cancer)	60.5% of population with high BP control and 63.7% of population with A1c control [less than 8%] (LA Medicaid, 2023)	Year 3: 0.5 pp improvement per marker; Year 4: 1 pp; Year 5: 2pp	Integrated EHR data; partner / grantee reports; MCO data	LDH
Sustainable Access	# new diagnoses overall after screenings among target populations (chronic disease, obesity) (**stratified by parish**)	153,673 women have received screening and diagnostic breast imaging since Medicaid expansion (LDH, 2023) - specific baseline to be outlined once EHR in place to be outlined	Year 3: 500 increase over existing count, by population; Year 4: 2,000 increases; Year 5: 3,000+ To be refined based on eligible pop. size and screening throughput	EHR	LDH

Table 1: Strategic Goal Level: Initial Metrics

Strategic Goals Alignment

Each LA RHTP initiative aligns with RHTP's strategic goals and aims to improve rural healthcare through job creation and retention, reduction of data sharing burdens, enhancement of access via digital strategies such as mobile care and digital monitoring, and promotion of incentivized, coordinated care to prevent fragmentation. A cornerstone of the plan involves preventative care and chronic disease management through integrated services (e.g., nutrition and physical activity programs) that include capital investments for facility improvements.

Partner Selection Approach

To achieve LA RHTP outcomes, LDH will employ three pathways for program delivery and partner selection. 1) **Expedited partnerships** involve quickly identifying strategic partners through stakeholder engagement with rural providers and community organizations—assessing their readiness, performance history, financial stability, and alignment—and ensuring accountability through performance-based agreements. 2) **Specialized expertise partnerships** are accelerator partners that can quickly design, deliver, and measure outcomes. *All partners* must

meet performance-based requirements, which include monthly tracking and quarterly outcome reports. LDH will provide oversight through site visits and technical assistance. If benchmarks are not met, LDH may withhold or claw back funds, ensuring investments produce measurable rural impact. 3) **Competitive subgrants** will begin in Q1 2026, as LDH releases notices of funding opportunities (NOFOs) for initiatives that require sub-awardees. These entities will be dedicated to improving rural health; proposals will reflect plans for design, implementation, outcomes, budget, and capacity. LDH focuses on expanding geographic reach and supporting smaller communities with limited healthcare funding. Additional details on subaward allocation and partner budgets are provided in the budget narrative.

Legislative or Regulatory Action

State Policy Action	Current	Changes/Pursuing	Timeline	Impact
B.2 Presidential Fitness Test (PFT)	Governor Landry signed an executive order reinstating the PFT on 11/4/2025	Reestablish the PFT	EO effective upon signature*	MRAHA alignment, promoting preventative health; shows commitment to RHTP and impacting LA's health
B.3 SNAP Waivers[xv]	Waiver submitted and approved by USDA	Restricts purchase of soft drinks, energy drinks, and candy	Waiver in place - starts 01/15/26	MRAHA alignment with promoting preventive health and addressing root of chronic disease
B.4 Nutrition Continuing Medical Education[xvi]	Act 463 Senate Bill 14 of the Regular 2025 Session	1 hour of nutritional education for certain healthcare providers every 4 years	Signed into law 2025; effective January 2026	Providers with increased nutrition education will better deliver evidence-based interventions to improve chronic disease prevention and root causes
D.2 Licensure Compacts	Act 253 Senate Bill 60 Regular Session 2024[xvii]	Louisiana legislation enabling clinician licensure compacts that allow for providing service across state borders	Signed into law 2024	Align with innovative access; develop a broader set of providers
E.3 Short-Term Limited Duration Insurance	Louisiana mirrors federal practice from the Tri-Agencies and is not enforcing any STLDI rules	In current regulations with Louisiana Department of Insurance.	Current	Aligns with requirements to not limit availability of insurance.
EO urges and requests the Louisiana Department of Education (LDOE) in its process to review physical education content standards, to determine how the PFT may be appropriately integrated into standards. See **Appendix H*				

Table 2: State Policy Actions the State is pursuing or has pursued, and when the policy will be implemented.

Louisiana is pursuing legislative and regulatory actions to improve health outcomes for all, and especially rural citizens. The chart above outlines state actions that are or will be pursued in alignment with RHTP objectives. Other state action policies addressed in the RHTP are listed below. It is anticipated that current practices will allow for partial scoring in these areas.

Other State Policies	
State Policy	***Current Policy***
C.3 Certificate of Need (CON)	Current Legislation mandates use of Facility Need Review rather than CON
D.3 Scope of Practice	PA have a Moderate Scope of Practice; NP have a Reduced Scope
F.1 Remote Care Services	Medicaid payment for at least one form of live video; No Medicaid payment for store and forward

Table 3: State policies with no change

As noted above, the Louisiana Legislature passed Senate Bill 60 in the 2024 regular session, and it was signed into law by Governor Landry (Act 253). This bill provides **universal licensing recognition** for certain occupational licenses. [xviii] Louisiana lawmakers and the Landry Administration realize that allowing universal licensing recognition across states reduces the burden of establishing clinical practices and increases the number of clinicians in the marketplace.

Other Required Information

- *State Policies*: See Legislative or Regulatory Action section above for State policies related to the "State policy actions" technical score factors.
- *Scoring Factor A.2*: The list of Certified Community Behavioral Clinics (CCBHC) in the State of Louisiana is attached in **Appendix F** using the RHTP-provided template.
- *Scoring Factor A.7:* The list below indicates the 14 hospitals in Louisiana that received Medicaid DSH.

Ochsner St. Mary	Christis Ochsner St. Patrick Hospital
Ochsner Medical Center Baton Rouge	Lallie Kemp Regional Medical Center
Ochsner Medical Center Kenner	Ochsner University Hospital
Community Care Hospital	Ochsner Acadia General Hospital
Eastern Louisiana Mental Health System	Christus Shreveport-Bossier Hospital
Central Louisiana State Hospital	Christus Ochsner Lake Area Hospital
Christis St. Francis Cabrini Hospital	Northlake Behavioral Health System

Table 4: Louisiana hospitals that receive Medicaid DSH payments

PROPOSED INITIATIVES AND USE OF FUNDS

As outlined in *Rural Health Needs and Target Populations*, Louisiana's rural parishes experience disproportionate chronic health burdens. LDH will partner with a local academic institution for a rural care gap analysis, guiding grant distribution to areas of greatest need. Grantees must justify their needs with data-driven evidence (see **Appendix E** for chronic health prevalence maps). Resources will be prioritized for regions with severe health disparities while balancing targeted, statewide approaches. Louisiana has established funding mechanisms for expedited distribution of funds to sub-awardees while maintaining fiscal safeguards to ensure the appropriate use of funds, including grants, direct purchasing, Inter-Agency Transfers, and braided funding. Public grant opportunities will follow federal criteria. Stakeholders who have provided input on program development noted that smaller facilities often lack grant writing expertise and face barriers to participation; LDH will conduct outreach and technical assistance to support these facilities. Inter-Agency Transfers will share resources across state agencies.

The **six proposed initiatives** work together to transform Louisiana by expanding the healthcare workforce, promoting the use of technology, AI, digital tools, and data sharing, and deploying financial incentives to change provider behavior and empower communities to address non-clinical factors of chronic disease. Our goal is to Make Rural Louisiana Healthy Again.

Initiative 1: Strengthen Health and Emergency Systems through Workforce Expansion and Integration

Strategic Goal: Workforce Development and Innovative Care | Estimated Required Funding (over 5 years): $245M

Description and Rationale

Rural Louisiana faces critical healthcare workforce shortages and delayed emergency

response times due to geographic isolation and aging infrastructure. In 2023, nearly one in four healthcare workers was over 55, and vacancy rates in critical services exceeded 30%.[xviii] Rural emergency response times are 30% longer than in urban areas, placing additional strain on communities with limited access to care.[xxiii] **This initiative addresses these challenges through a three-part strategy:** (1) expanding the rural healthcare workforce via financial incentives, education partnerships, and tax credits; (2) building a sustainable training pipeline with clinical rotations and mentorship programs; and (3) enhancing emergency response capacity through community paramedicine and tele-EMS pilots. These efforts will improve access, reduce response times, and ensure continuity of care in underserved parishes.

Strategies

Building a Stable Workforce Foundation:

- **Launch Rural HERO grants** targeting rural parishes, collaborating with healthcare training programs to meet workforce needs in nursing, allied health, and other high-need areas. Building on the LA HERO fund's success (established in 2021 and updated 2024 via Act 607), LDH will announce annual funding opportunities to strengthen the rural healthcare pipeline.
- **Establish a rural clinician credit bank** to provide financial resources for sign-on and retention bonuses and allow facilities to apply for state-supported matching incentives. This strategy would tie financial support to 5-year service commitments, promoting recruitment and retention of rural talent to build a sustainable local healthcare workforce. Rural providers can request state funding for relevant activities through an open enrollment process after payment is made to the rural clinician through a Cooperative Agreement with LDH.
- **Implement a state income tax credit program** for clinicians relocating to and serving in rural or Health Professional Shortage Areas. Eligible professionals will receive annual tax credits

tied to a service commitment of at least five years. This program previously existed and saw more than 400 healthcare workers in rural areas receive a tax credit. Funding will be transferred to the State Department of Revenue for implementation after legislative approval, with legislators identified and engagement already underway.

Developing a Continuous Education and Training Pipeline:

- **Develop new education and training pathways** through partnerships with universities, professional schools, and facilities to broaden clinical rotations, residencies, fellowships, and faculty positions. This will prioritize primary care and behavioral health disciplines in rural areas and tie to a five-year service commitment for participants. Funding opportunities for this sub-grant will be announced twice a year; the request must include an established partnership between the teaching institution and the rural facility to be considered.
- **Strengthen local workforce pipelines** through "Grow-Your-Own" Career Pathway and Community Access Network initiatives to build a unified workforce development approach, upskilling community health workers and allied professionals (including EMTs and paramedics) through mentorships, micro-credentialing, and shadowing opportunities with regional health systems. Middle and high school-based healthcare clubs and mentorship programs will also be established to inspire early interest in health careers. The LDOE and Louisiana Community and Technical Colleges will help identify partnerships to apply.

Strengthening System Capacity and Care Integration:

- **Develop collaborative provider models** to foster cross-hospital provider-sharing and rotation programs that extend specialist coverage and enable rural facilities to pool limited staff resources to support patient care, and enhance efficiency, continuity, and quality. Supported by clear guidelines, this approach will leverage telehealth and cross-training and build resilient

regional partnerships that can endure beyond federal funding. This funding opportunity will be announced as an open enrollment, and LDH will facilitate partnerships among providers to build this model and provide technical assistance as needed.

- **Launch regional community paramedicine and tele-EMS pilot programs** to provide urgent "treat-in-place" care in Frontier and Remote (FAR) parishes, the EMS and care deserts with long hospital travel times and limited emergency infrastructure, where treat-in-place protocols could provide significant benefits. The pilot programs will equip paramedics, nurses, and community health workers to deliver care closer to home, ultimately reducing delays in access to urgent care. Louisiana Ambulance Association has served as a key stakeholder and stands ready to assist LDH in identifying partners for the pilot programs.

See Implementation Plan and Timeline for details.

Key Stakeholders

LDH will engage a network of partners to ensure alignment, sustainability, and impact. Academic institutions will expand training pipelines and workforce pathways. Rural providers will co-design collaborative care models and workforce strategies. Community organizations, rural coalitions, and local EMS will tailor implementation to rural needs. State and local agencies, with the State Office of EMS and our newly established health tech ecosystem, will provide coordination, data support, and policy alignment.

Type	Stakeholder(s)
Academic	• Medical schools, nursing schools, and allied health education programs • Middle and high schools, community colleges, and universities serving rural students
Providers	• RHFs: hospitals, health clinics, behavioral health clinics, and CAHs • FQHCs and community health centers
Payers	• Primary care associations and workforce boards • Louisiana Medicaid and its managed care organizations
Community	• Rural health coalitions, local EMS agencies, volunteer corps
Other	• State and local agencies: Louisiana Economic Development, LA Works, LDOE, LDH, LSU Health Sciences Center, Board of Regents, Louisiana Ambulance Association

Table 5: Initiative 1: Key Stakeholders

Impacted Parishes

Implementation will prioritize rural parishes with the most severe workforce shortages, such as East Carroll, Catahoula, Richland, and Webster, which have high provider vacancy rates, a significant number of clinicians over 55 years old, and prolonged EMS response times. These factors indicate an outsized impact on opportunities for paramedicine and tele-EMS pilots serving FAR communities. A statewide needs assessment will finalize parish-level priorities and readiness.

Outcomes

Illustrative outcomes and Year 5 targets
3 pp increase in patients receiving primary care services in their parish of residence instead of having to travel to other parishes for care
5 pp increase in primary care provider coverage across rural parishes
10% increase in coverage in rural areas served by tele-EMS or community paramedicine
10% decrease in EMS response time to high acuity incidents in rural areas (stratified by parish)
15% of low-acuity 911 calls resolved through tele-EMS without hospital transport
% increase in rural-trained health care workers entering Louisiana's workforce within 12 months of graduation

Table 6: Initiative 1: Sample outcomes.

Additional details on baselines, targets, and data sources are in the Metrics and Evaluation Plan.

Projected Impact

By Year 5, Louisiana will have a sustainable rural health and emergency-response pipeline that attracts, trains, and retains clinicians in underserved parishes. Through the Rural HERO Fund, a rural clinician credit bank, and targeted tax-credit incentives, the initiative will strengthen talent development, creating a durable workforce. As these programs mature, Louisiana is projected to achieve at least a five-percentage-point increase in rural primary care coverage, with a 3-point rise in residents receiving primary care in their parish of residence. Tele-EMS and community-paramedicine pilots will expand care reach, reducing response times by approximately 10% and resolving up to 15% of low-acuity 911 calls without requiring hospital transport.

Interdependencies, Challenges, and Mitigation Approaches

The success of this initiative depends on coordinated efforts across workforce development,

education, and emergency response modernization. Challenges include delays in cross-agency coordination, slow workforce growth, and administrative complexity tied to new incentive systems. Smaller EMS agencies often face workforce and technology constraints, particularly in rural areas that lack sufficient staff and resources. LDH will partner with Louisiana Works, Office of EMS and Trauma Systems, and education partners to modernize training programs, align credentials, and expand incentives in underserved areas. LDH will deploy a project management team to oversee implementation, coordinate partners, and provide technical assistance for efficient system adoption. Complex funding and reporting barriers to accountability and stability will be addressed by leveraging the HERO Fund and existing infrastructure. A project manager and key metrics will ensure effective implementation and a resilient, data-driven rural emergency workforce.

Initiative 2: Modernize Technology Infrastructure and Capacity for Efficiency and Care Coordination

Strategic Goal: Tech Innovation | Estimated Required Funding (over 5 years): $240M

Description and Rationale

Rural health systems face technological, operational, and financial barriers that limit efficiency, coordination, and equitable access. About 24% of Louisiana's healthcare facilities are in rural areas, and many rely on outdated systems that restrict interoperability and delay care. Fragmented data exchange—caused by inconsistent standards, weak incentives, and data blocking—prevents the seamless flow of information across providers, Medicaid, and public health systems. This fragmentation leads to duplicative testing, delayed diagnoses, and limited insight into population health. Broadband gaps and low digital readiness further limit rural participation in digital care, with more than one in four households lacking reliable high-speed internet.

Louisiana embraces the CMS vision for a unified health technology ecosystem designed to "kill the clipboard" by enabling frictionless, standards-based data exchange. Building on the state's leadership as the first to commit to implementing a CMS Aligned Network, this initiative integrates four strategies to create a secure, interoperable infrastructure that links providers, patients, and payers through modern APIs, FHIR-based standards, and real-time data sharing. The network will eliminate redundant data entry, streamline reporting, and support automated analytics for coordinated care, population health management, and value-based reimbursement.

Community-driven digital literacy programs—anchored by FQHCs, parish health units, libraries, and schools—will expand digital readiness, ensuring all residents can participate in the health technology ecosystem. Data sharing will comply with HIPAA, CMS, and state privacy regulations, reinforced by encryption, role-based access controls, and transparent governance.

Louisiana will collaborate with peer states and national partners, such as the National Academy for State Health Policy and Harvard University, to accelerate cross-state interoperability, expand the use of standardized data frameworks, and catalyze public-private investment in scalable technologies that advance rural health transformation. With Secretary Bruce Greenstein's proven leadership and engagement from tech innovators and investors, Louisiana will help drive the next generation of connected care—where health data moves at the speed of need, not paperwork.

Strategies

- **Implement a single, net new state-managed CMS-certified EHR instance** to connect rural providers, hospitals, and behavioral-health facilities that currently lack electronic systems, enabling secure, FHIR- and USCDI-compliant data exchange, embedding strong identity, security, and trust safeguards, and aligning with the CMS Aligned Network Framework for transparency and interoperability. This will provide access to the EHR instance in areas where

it is currently unavailable, rather than replacing existing systems. Through the EHR and our Developer Portal as part of the Aligned Network, we will ensure providers who currently lack this functionality gain access to a G10 FHIR server.

- **Establish a milestone-based, reimbursable RTCF-LA** to accelerate the modernization of digital infrastructure for rural providers and technology partners. RTCF-LA aims to disrupt normal market economics for rural areas by focusing on start-ups that are developing solutions specifically for rural markets, rather than extending urban solutions into rural areas. The funding aims to develop mature markets over five years by addressing initial start-up costs, design, and customer acquisition, with accountability through milestone-based funding. We will only invest in products that demonstrate a clear path to sustainability and fill critical gaps in the rural health continuum, like mobile specialists who support local hospitals and clinics without losing patients, or mobile labs, imaging, and diagnostic services. We will also focus on those that overcome barriers to MRAHA goals, including nutrition, exercise, and behavior coaching to prevent obesity and chronic diseases. Modeled after ARPA-H, RTCF-LA will emphasize transformative investments, utilize milestone-based payments to ensure measurable outcomes, and adhere to all state and federal program design and compliance requirements.
- **Expand access to and promote the use of remote-monitoring devices**, such as glucometers, blood pressure cuffs, pulse oximeters, and weight scales, for high-risk and chronic disease patients in rural parishes. Data from these consumer-facing tools will securely integrate into the statewide EHR and health tech ecosystem, enabling real-time analytics, proactive clinical alerts, and coordinated interventions that reduce duplicative testing, improve continuity of care, and strengthen rural digital health infrastructure. Funding opportunities will be announced for pilots based on rural community needs, with a focus on managing chronic diseases and cancer.

- **Enhance access to digital literacy** education, training, and technology support, including free or subsidized smartphones with data and health tools for rural residents. Partnering with local clinics, colleges, libraries, and health systems, the program provides hands-on instruction for utilizing digital health platforms. These efforts will increase broadband use, strengthen digital skills among residents and providers, and encourage ongoing engagement in preventive and chronic care. In rural Texas, a smartphone-based diabetes education program improved participants' confidence, weight loss, and glycemic control from baseline to follow-up.[xix]

See Implementation Plan and Timeline for details.

Key Stakeholders

LDH will convene an inter-agency workgroup that includes regional stakeholders to align providers, payers, technology partners, and community stakeholders. Led by LDH IT and Quality leaders, the workgroup will transparently track support implementation (e.g., onboarding, issue mitigation, technical assistance) to maximize value for patients and providers. Broadband providers, health IT vendors, and other technology partners will join in planning to align RHTP deployment with BEAD timelines, prioritize functionality and use cases, and drive interoperability standards. To ensure residents maximize the benefits of the statewide EHR, LDH will collaborate with community-based organizations, parish governments, and higher education institutions to advance digital literacy and resident outreach. Continuous feedback from surveys, regional forums, and provider surveys and consultations will guide updates to system design, implementation strategies, and messaging throughout the program.

Type	**Stakeholder(s)**
Academic	• LSU Health Sciences Center, University of Louisiana System, Tulane Medical Center, community and technical colleges, training health IT specialists
Providers	• RHFs: hospitals, health clinics, behavioral health clinics • FQHCs • Parish Health Units • Medicaid ACOs (once formed)

Payers	• Managed Care Organizations (MCOs)
Community	• Rural health networks / local organizations supporting digital literacy and patient engagement
Other	• Technology partners: EHR vendors, cloud partners, identity management solutions providers, CINs, broadband providers, telehealth and remote-monitoring companies • Government entities: LA Office of Information Technology, Broadband Office, LA Medicaid, LA Office of Public Health, LA Office of Behavioral Health (OBH), Parish Health Units

Table 7: Initiative 2: Key Stakeholders

Impacted Parishes

All rural parishes statewide, beginning with those facing a high burden of chronic disease (e.g., East Carroll, Tensas, Madison, Richland, Bienville, Catahoula, etc.) and having a high percentage of households with broadband access (e.g., Beauregard, LaSalle, Vernon, etc.).

Outcomes

Illustrative outcomes and Year 5 targets
15pp increase in providers leveraging data exchange for care coordination via interoperable platforms
12pp increase in providers exchanging data via a FHIR-compliant network
30pp increase in rural patients with electronic access to their own health data
25pp increase in rural residents using RTCF-supported telehealth or mobile tools from Year 1 baseline
8-10pp increase in preventive-care utilization via digital health tools among patients whose providers use the state-managed EHR
% reduction in duplicate diagnostic orders for patients whose providers use the state-managed EHR
% reduction in paper-based care transitions for patients whose providers use the state-managed EHR

Table 8: Initiative 2: Sample outcomes

Additional details on baselines, targets, and data sources are in the Metrics and Evaluation Plan.

Projected Impact

Modernizing health technology infrastructure will transform a fragmented, manual healthcare system into a connected network, linking patients, providers, and communities through real-time data and digital tools. This initiative will align infrastructure, governance, rural partner engagement, and interoperability metrics, including API usage, query success, rural participation data, and patient access metrics, thereby contributing to CMS's emerging aligned network scorecards. Our technology strategy empowers rural partners to engage in value-based care, quality improvement, analytics, and population health, thereby enhancing care delivery in rural Louisiana. The RTCF-LA will expand this backbone beyond facilities, increasing health literacy and

equipping residents with advanced tools and patient apps that integrate into the shared health tech ecosystem. Within five years, at least 15% more rural providers who currently lack access will use the state-managed, CMS-certified EHR, and 12% more will exchange data via FHIR networks. By Year 5, 30% more rural patients will access their health data electronically, and one in four residents will use RTCF-supported digital health tools. Providers will benefit from streamlined documentation, deeper insights, alignment with value-based models, and rewarding outcomes. By 2031, Louisiana will have fully achieved all the requirements—and fulfilled the promise—of the CMS Aligned Network. Our focus on rural providers acknowledges the unique challenges of rural care (such as lack of scale, fragmentation, and workforce shortages) and addresses them through shared infrastructure, interoperability, governance, and connectivity.

Interdependencies, Challenges, and Mitigation Approaches

The success of this initiative depends on three key factors—provider readiness, broadband coverage, and implementation effectiveness. These reflect the core priorities of the CMS Health Technology Ecosystem—reducing provider burden, promoting interoperability, and digital inclusion. LDH is committed to serving as a national model for CMS Aligned Network adoption.

- Many rural facilities lack IT resources for adopting and supporting EHR systems. To mitigate risks, LDH will provide technical assistance and a Shared IT Help Desk, supporting providers in the health tech ecosystem. Partnerships with community colleges and regional health systems will expand the workforce skilled in health IT, cybersecurity, and EHR maintenance.
- Connectivity gaps persist in rural Louisiana. LDH will coordinate the deployment of digital and telehealth services with broadband-connected communities and will expand as broadband infrastructure improves, leveraging effective and sustainable technology investments.
- LDH will establish a Health Technology Ecosystem Implementation Team to oversee

governance, user experience, vendor coordination, and interoperability. Performance metrics and cross-disciplinary expertise in HIT, clinical data, and provider adoption will ensure accountability and alignment with CMS standards.

These strategies will advance Louisiana's CMS-aligned network, improve data sharing, promote digital inclusion, and accelerate value-based care, positioning the state as a national exemplar for rural health technology implementation.

Initiative 3: Reinforce Innovative, Outcomes-Based Care Delivery in Rural Areas

Strategic Goal: Innovative Care | Estimated Required Funding (over 5 years): $150M

Description and Rationale

Delays in care often result in expensive emergency and inpatient visits, which increase healthcare costs. At the same time, gaps in care delivery exist between proven outcome improvements and current payment incentives. Solutions such as care navigation and transitional services reduce preventable hospitalizations and costs but are often not reimbursed. **This initiative will launch risk-sharing and value-based arrangements** that enable providers to share savings from improved quality. It will also launch high-impact care models that are currently not billable but have reimbursement pathways. These reforms will help ACOs, FQHCs, and rural hospitals deliver coordinated care that rewards outcomes. By integrating payment and delivery innovations into managed-care and Medicaid frameworks, Louisiana will develop a sustainable, performance-driven reimbursement system that supports proven care models, strengthens rural providers, and enhances access and outcomes for high-need communities.

Strategies

- **Facilitate risk-sharing value-based arrangements** between providers serving high-needs rural populations (e.g., RHCs, FQHCs) and plans/providers (e.g., ACOs) with quality-based

incentives to improve care. Support includes provider education, technical assistance, and shared savings. MCO participation may be considered if aligned with quality-based, risk-sharing arrangements. The LA RHTP will fund these arrangements, with stakeholder input on metrics such as selection, calculation, timing, and report design, which are factors that other Medicaid programs have highlighted as crucial for obtaining provider input. Where indicated, Medicaid state plan amendments will be requested to institute pilot programs.

- **Pilot innovative care models** not traditionally billable to improve outcomes for hard-to-reach populations through community partnerships (e.g., care navigation with panel management); post-partum care navigation; mobile units in care deserts; correctional facility care; non-HIS (hospital information system) rural hospitals; and rural pharmacy access and accompanying health literacy. Announced opportunities for funding will include criteria and reporting requirements to demonstrate the long-term viability of these projects.

See Implementation Plan and Timeline for details.

Key Stakeholders

LDH will collaborate with providers and payers to ensure new value-based care arrangements are operationally feasible and financially sustainable. Together, they will co-design performance metrics, quality-based incentives, and shared-savings methodologies, incorporating academic and evidence-based research. Community and advocacy groups will ensure rural social and behavioral health needs are addressed. LDH will host provider-payer workshops, technical assistance sessions, and learning collaboratives to design, test, and refine care models, promote transparency, and align financial incentives with measurable improvements in care.

Type	Stakeholder(s)
Academic	• Academic/research partners: medical schools, health services researchers, and training institutes
Providers	• Rural and urban healthcare delivery organizations: hospitals, outpatient care providers, post-acute/long-term care providers • Healthcare workforce: clinical providers, care coordination staff, behavioral health professionals

Payers	• MCOs/ACOs
Community	• Advocacy and support organizations: professional associations, community health worker coalitions, and patient advocacy groups
Other	• Government and regulatory bodies: LDH, the legislature, and CMS • Infrastructure and technology partners: EHR vendors, actuaries

Table 9: Initiative 3: Key stakeholders

Impacted Parishes

Implementation targets rural populations with high avoidable healthcare costs—those frequently visiting EDs for unmanaged chronic or behavioral conditions and lacking access to coordinated follow-up care. This includes adults with poorly controlled diabetes, hypertension, or kidney disease who would benefit from proactive panel management, home monitoring, and mobile health. Pilots will start in parishes such as Tensas, Claiborne, Madison, East Carroll, and Bienville, which have the highest rates of non-emergent ED use, inpatient admissions for ambulatory-sensitive conditions, and chronic disease mortality.

Outcomes

Illustrative outcomes and Year 5 targets
5 pp reduction in non-emergent ED visits
% increase of Medicaid members in ACOs with controlled diabetes
% increase of Medicaid members with access to a provider participating in accountable care or value-based payment models
30% uptake increase in penetration of piloted care models in rural areas
% reduction in duplicative care among Medicaid members enrolled ACOs
% of Medicaid members in ACOs in risk-stratified panels with improved outcomes

Table 10: Initiative 3: Sample outcomes

Additional details on baselines, targets, and data sources are in the Metrics and Evaluation Plan.

Projected Impact

By Year 5, Louisiana will demonstrate that value-based, innovative care models can transform rural healthcare from reactive to outcomes-driven care. The state will launch pilots in one to three rural health facilities to test and refine value-based payment arrangements that align financial incentives with improved quality and efficiency. These pilots will set the stage for wider risk-sharing contracts, aiming for a 5-point reduction in non-emergent ED visits and specific

improvements in chronic disease management. In parallel, LDH will manage a portfolio of innovative care models—like mobile health and care navigation—implemented by subgrantees and then evaluated and scaled statewide. Adoption of proven care models in rural areas is expected to increase by 30%, resulting in reduced duplicative care and improved patient outcomes. By 2031, Louisiana will institutionalize value-based reimbursement for Medicaid and scale successful care models in rural regions, enhancing coordination, sustaining provider viability, and delivering measurable, population-level gains in access and outcomes.

Interdependencies, Challenges, and Mitigation Approaches

Louisiana's transition to value-based care depends on coordinating providers, payers, and state agencies to align reimbursement, data sharing, and quality metrics. Success depends on integrating health information exchanges, the statewide EHR, and Medicaid systems for transparency and accountability. Challenges include variable provider readiness, limited infrastructure, and workforce constraints in rural areas, which may slow the adoption of innovative payment and care models. Providers may be hesitant about entering into these arrangements if they distrust the accuracy of the data or lack a voice in the model design. Provider capacity for risk-sharing models also varies widely across regions. LDH will conduct readiness assessments to identify gaps in staffing, technology, and financial management. LDH will convene providers, health systems, FQHCs, and managed care organizations to define overall design, payment structures, data-sharing agreements, and common quality measures that support value-based care. Targeted technical assistance and pilot programs will demonstrate feasibility and build provider confidence in new payment models. Transitioning to value-based reimbursement requires clear incentives and shared learning; LDH will co-design reimbursement approaches with providers, share initial outcomes, and integrate lessons learned into Medicaid contracts to achieve sustainable,

scalable value-based care across the state.

Initiative 4: Expand Physical Activity and Nutrition Interventions Through Community-Based Partnerships

Strategic Goal: MRAHA | Estimated Required Funding (over 5 years): $45M

Description and Rationale

Louisianians face access issues due to economic instability and environmental barriers. These challenges underscore the need for multimodal care models that prioritize preventive care and address non-clinical barriers, such as transportation and financial constraints. Additionally, food insecurity is a critical issue, with up to 33% of residents relying on the Supplemental Nutrition Assistance Program (SNAP), compared to the national average of 12%.[xx] This initiative expands interventions for chronic disease and maternal health. It employs a **two-pronged approach**: **direct nutrition interventions** through "food FARMacies" and **broader nutritional and fitness programs** for rural health. The goal is to integrate prevention and community-based care into rural healthcare to sustainably improve access, coordination, and population health.

Strategies

- Partner with rural healthcare facilities to launch "food FARMacy" programs that integrate nutrition into healthcare, combining access to healthy foods with education on diet, disease prevention, and meal planning. Collaborating with local farmers and community groups, these initiatives will expand access to fresh, healthy foods as part of evidence-based treatment and prevention. Through food prescriptions and nutrition-focused care plans, participants can better prevent and manage chronic diseases sensitive to improvement through diet, such as diabetes. Funding opportunities will include an open enrollment process requiring collaboration between rural facilities and local community partners.

- Support and expand community-based nutrition and fitness through partnerships with Louisiana agriculture, fitness programs, nutrition for youth, and established institutions such as Pennington Biomedical Research Center and WellAhead. These collaborations will promote healthy eating, increase access to nutritious foods, and provide fitness opportunities to foster lifelong healthy habits and prevent chronic disease. Funding will support new evidence-based programs in rural areas, with LDH facilitating partnerships.

See Implementation Plan and Timeline for details.

Key Stakeholders

Efforts will center on building sustainable, trust-based partnerships among healthcare providers, community organizations, academic institutions, and agricultural partners. Regular stakeholder forums and working groups will ensure that community perspectives guide program design, implementation, and evaluation. Leveraging established relationships with institutions such as Pennington Biomedical Research Center will promote coordinated action, shared learning, and alignment of goals to achieve lasting impact in rural communities.

Type	Stakeholder(s)
Academic	• Local Education Agencies & State Agricultural Schools
Providers	• Rural health facilities
Payers	• MCOs & Private Health Insurers
Community	• Community centers
Other	• Pennington Biomedical Center • Local groceries/farmers • LDH, Office of Public Health, Office of Surgeon General

Table 11: Initiative 6: Key Stakeholders

Impacted Parishes

Parishes with disproportionate rates of chronic disease (e.g., diabetes, hypertension, and coronary heart disease) and limited access to preventive care (e.g., Tensas, Claiborne, Madison, East Carroll, Bienville, Sabine, and Webster).

Outcomes

Illustrative outcomes and Year 5 targets
1-2 pp improvement in clinical health markers (e.g., BP, glucose levels, weight) among individuals with chronic disease risk factors from baseline
10% annual participation increase of schools participating in the Presidential Fitness Test in rural areas
5 pp self-reported improved well-being following community-based nutrition and physical health events
17.5% participation in food pharmacies following provider referral, monitored quarterly through referral and participation tracking systems

Table 12: Initiative 4: Sample outcomes

Additional details on baselines, targets, and data sources are in the Metrics and Evaluation Plan.

Projected Impact

By Year 5, Louisiana's rural nutrition and physical activity initiatives will measurably improve community health through coordinated efforts that address non-clinical drivers and expand care access via workforce and technology initiatives. Participating parishes are projected to see a 1-2 percentage-point increase in clinical health markers, such as blood pressure, glucose, and weight, and a 5% rise in self-reported well-being. Successful models will scale statewide across schools, health facilities, and community partners. Rural schools' participation in the Presidential Fitness Test is expected to grow 10% annually, and Food FARMacy engagement is expected to reach 17.5% of referred participants. Evidence suggests that incentive programs can motivate short-term improvements in exercise and nutrition; however, sustaining behavior change and achieving long-term health benefits and cost savings are challenging. Louisiana believes that combining initiatives affecting behavior, access, and care quality will lead to lasting improvements.

Interdependencies, Challenges, and Mitigation Approaches

Sustaining nutrition and food-access initiatives requires coordinating healthcare providers, community organizations, and agricultural partners to align resources and expand reach. Challenges that hinder long-term impact include limited infrastructure, workforce shortages, and inconsistent access to funding and transportation. LDH will strengthen collaboration among providers, farmers, and community organizations through shared planning, joint implementation, and standardized reporting with WellAhead and Pennington Biomedical Research Center to

improve efficiency, scale, accountability, and data sharing. Rural programs also face unstable funding streams and limited reimbursement for nutrition-based interventions. LDH is engaging MCOs to create reimbursement pathways for Food FARMacy and piloting value-based payment mechanisms that demonstrate cost savings through reduced hospitalizations and improved chronic disease management. Additional partnerships with health systems, philanthropic funders, and agricultural stakeholders will build a diversified, braided funding model to ensure sustainability. LDH will regularly engage stakeholders through working groups and performance reviews, addressing barriers and adjusting strategies to sustain programs.

Initiative 5: Strengthen Care Integration for High-Needs Populations Through Coordinated, Multi-Modal Models

Strategic Goal: MRAHA | Estimated Required Funding (over 5 years): $130M

Description and Rationale

Rural Louisiana faces multiple health challenges, exposing high-need populations to care gaps. One in nine Louisiana adults (~400,000 people) live with severe depression or anxiety, and only 1 in 20 with substance use disorders receive treatment, compared with 1 in 9 nationally.[xxi] [xxii] Diabetes prevalence is 20% higher than the U.S. average, with Black adults 45% more likely to have it. The state has only 171 mental health professionals and 184 primary care shortage areas, leaving many rural parishes without integrated services.[xxiii] [xxiv] Older adults in these areas experience high rates of chronic disease, functional limitations, and institutional care.[xxv] **This initiative will develop a coordinated, multi-modal care infrastructure** that unites fragmented services into an integrated framework. While each component serves a distinct function within the health system, together they will strengthen the full continuum of care, creating a cohesive ecosystem. Rural residents will benefit from accessible, person-centered services that meet their

physical, behavioral, and social needs closer to home.

Strategies

- Develop regional care conveners and navigation networks to coordinate physical, behavioral, and social-service providers through hub organizations (e.g., FQHCs, CCBHCs, hospitals) and deploy community and school-based navigators connecting residents to care.
- Increase telehealth infrastructure access across rural facilities to support behavioral health, prenatal, and chronic-care services in underserved parishes. Funding through open enrollment will enable facilities to apply for telehealth improvements and enhance patient access.
- Expand partnerships among CCBHCs, OTPs, and rural health facilities to provide co-located care like medication-assisted treatment (MAT) and crisis response. Behavioral health providers express concern about adding OTP as a billable service due to licensure risks. Funding will offset startup costs and incentivize clinics to incorporate this module, providing rural residents with integrated services in one location.
- Establish alternative Program of All-Inclusive Care for the Elderly (PACE) sites by retrofitting rural hospital spaces for wraparound, community-based services for elderly residents, like day health centers and at-home support. Louisiana values PACE programs, but there has been limited expansion of these services into rural areas. Providers cite high startup costs as a barrier, which aren't billable. Funding would help cover startup costs.

See Implementation Plan and Timeline for details.

Key Stakeholders

LDH will engage telehealth companies, convener organizations, care navigation networks, Medicaid MCOs, rural providers, and others to co-design implementation and sustainability models. The Department will hold regional sessions to define referral pathways, data-sharing

standards, and joint quality metrics. MCOs will participate in funding and evaluating convener pilots, integrating telehealth and MAT reimbursement into capitation contracts, and aligning incentive structures around improved access, reduced preventable hospitalizations, and better health outcomes. LDH will ensure ongoing feedback through quarterly advisory meetings, public data dashboards, and parish stakeholder sessions, incorporating community input into each stage.

Type	Stakeholder(s)
Academic	• K-12 school districts, school-based health centers, and student support services
Providers	• Behavioral health providers and facilities: mental health clinics, substance use disorder treatment programs, integrated care providers • Healthcare delivery organizations: hospitals, primary care practices, FQHCs, community-based organizations • Care coordination workforce: care navigators, community health workers, peer support specialists, social workers
Payers	• Louisiana Medicaid, MCOs, and commercial insurers
Community	• Advocacy and professional organizations: mental health advocacy groups, substance use disorder coalitions, and provider associations
Other	• Government and regulatory: LDH OBH, LDOE, Department of Children and Family Services, other federal agencies

Table 13. Initiative 7: Key Stakeholders

Impacted Parishes

Implementation will prioritize rural parishes with overlapping behavioral health and chronic disease burdens, many residents over 65, and limited provider access. Parishes such as Madison, Tensas, Claiborne, Bienville, East Carroll, and Richland have high rates of diabetes, depression, and primary care vacancies. Poor broadband coverage and long travel times to health facilities make them ideal for early telehealth and convener deployment. LDH, with OBH and LA Works, will refine priorities through a statewide needs assessment.

Outcomes

Illustrative outcomes and Year 5 targets
15 pp increase in adults referred for behavioral-health or SUD consultation within 30 days of screening in participating rural parishes
4-10 pp reduction in inpatient admissions among adults enrolled in new PACE geographies
4 pp improvement in clinical outcomes for target conditions (chronic disease, obesity, maternal health, cancer)
4% increase in rural residents accessing care through telehealth or virtual behavioral-health services
% increase in postpartum follow-up within 30 days among rural women receiving integrated maternal-health care
# additional rural residents receiving MAT services

Table 14. Initiative 5: Sample outcomes

Additional details on baselines, targets, and data sources are in the Metrics and Evaluation Plan.

Projected Impact

By Year 5, Louisiana will set a new standard for rural care by integrating physical, behavioral, and social support for high-risk populations, ensuring access through community-based providers, virtual platforms, and coordinated care. This system-level integration aims to achieve a 15-percentage-point increase in adults receiving behavioral health or substance use care within 30 days of screening, a 4- to 10-percentage-point reduction in inpatient admissions, a 4-point improvement in chronic disease and maternal health outcomes, and a 4% increase in telehealth access. As integration matures, Louisiana's rural care system will shift from isolated services to a cohesive, person-centered model with shared data, multi-payer financing, and community workforces. By 2031, this sustainable model will reduce avoidable hospitalizations and close access gaps for vulnerable populations.

Interdependencies, Challenges, and Mitigation Approaches

Expanding telehealth and care navigation statewide depends on LDH's coordination with partners and subgrantees. Success depends on centralized oversight with rigorous local execution. Progress in workforce development, broadband expansion, and data exchange will impact the reach and effectiveness of these models. LDH will set statewide standards for quality, interoperability, and performance, while partners and subgrantees enact local delivery models, leveraging operational expertise and infrastructure. Workforce shortages—particularly in behavioral health and geriatrics—and uneven broadband pose challenges. LDH will coordinate with LA Works, the OBH, and the Office of Aging and Adult Services to strengthen clinician pipelines and expand digital access by providing technical assistance and milestone-based funding. Complex cross-agency data governance can impede integration and tracking. LDH will align

financing, reporting, and oversight with MCOs and other state offices through standardized data agreements, secure protocols, and shared dashboards.

Initiative 6: Strengthen Access to Essential Health Services Through Capital Investments

Strategic Goal: Sustainable Access | Estimated Required Funding (over 5 years): $175M

Description and Rationale

Rural hospitals struggle with aging infrastructure, outdated equipment, and limited capital, hindering modern care and value-based payment adoption. Higher uninsured rates and workforce shortages restrict access, and hospitals often lack the resources for diagnostics or expansion without external support. This initiative will modernize rural healthcare through 30 targeted capital investments, upgrading equipment and enabling at least one facility per rural parish to shift from basic to advanced, tech-enabled care.

Strategies

- Establish RHF Capital Improvement Initiative as a competitive grant for rural facilities (validated by needs assessment) to request funds for capital improvements like facility renovations, high-cost medical equipment, and IT upgrades.

See Implementation Plan and Timeline for details.

Key Stakeholders

Collaboration with rural healthcare facilities and community organizations ensures local needs are addressed. Regular communication, inclusive planning, and feedback will align priorities, build trust, and promote shared ownership. Engaging infrastructure and technology partners ensure sustainable, scalable investments tailored to the challenges of rural healthcare.

Type	*Stakeholder(s)*
Academic	• Health services researchers, needs assessment consultants, and evaluation specialists
Providers	• Rural healthcare delivery organizations: rural hospitals, CAHs, and regional health systems • Healthcare workforce: clinical providers, hospital administrators, and facility operations staff
Community	• Advocacy and support organizations: rural health networks and community advocates

Other	• Government and regulatory: LDH, HRSA Office of Rural Health Policy, federal agencies • Infrastructure and technology partners: HIEs, EHR vendors, medical equipment suppliers, and construction/engineering firms

Table 15. Initiative 8: Key Stakeholders

Impacted Parishes

Rural parishes, with the goal of a fit-for-purpose care and infrastructure landscape.

Outcomes

Illustrative outcomes and Year 5 targets
10-15% reduction in distance to specialized care in rural parishes (e.g., OB, Oncology)
3000+ new diagnosis after screenings among target populations (chronic disease, obesity)
10-15% increase in rural asset utilization by service line (e.g., laboratory, diagnostics, rapid testing)
30 total RHF capital projects funded with at least one per rural parish

Table 16. Initiative 6: Sample outcomes

Additional details on baselines, targets, and data sources are in the Metrics and Evaluation Plan.

Projected Impact

By Year 5, capital investments will improve rural health infrastructure, making it more connected and equitable. Upgraded facilities and technology will provide more local service options, reducing the need for travel. These upgrades are projected to enable more than 3,000 new diagnoses following screenings and a 15% increase in rural asset utilization by service line. These investments lay the groundwork for rural system resilience by establishing regional care hubs, expanding diagnostic and specialty services, and enhancing readiness for value-based models.

Interdependencies, Challenges, and Mitigation Approaches

Achieving lasting impact requires strategic alignment among healthcare providers, government agencies, technology partners, and community organizations to coordinate investments and sustain outcomes across rural communities. Implementation requires coordinated planning and resource management for complex infrastructure and community health projects. Many rural communities lack the capacity and technical expertise to manage large-scale initiatives. LDH will provide technical assistance to strengthen capacity and ensure timely execution.

Coordination across diverse partners can slow decision-making and create bottlenecks. LDH will establish cross-sector governance structures to guide planning, monitor milestones, and facilitate transparent communication among all stakeholders. Maintaining momentum beyond initial funding requires shared accountability and ongoing collaboration. LDH will use joint planning, shared data dashboards, and stakeholder forums to track progress, address challenges, and sustain community health and infrastructure outcomes.

Summary of Initiatives, Strategic Goals, Uses of Funds, and Technical Score Factors

Initiative	Strategic Goal	Use of Funds	Technical Score Factors
Initiative 1: Strengthen Health and Emergency Systems through Workforce Expansion and Integration	Workforce Development and Innovative Care	E. Workforce Development: Funding and training programs to expand the rural clinical workforce, supporting healthcare provider recruitment, retention, and education in underserved areas D. Training and Technical Assistance: Supporting education, mentorship, and skill-building programs that strengthen local health workforce capacity and rural training pipelines G. Appropriate Care Availability: Assisting rural communities to right-size health care delivery systems by identifying preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines. I. Innovative Care: Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models K. Fostering Collaboration: Initiating/fostering local and regional strategic partnerships between rural facilities and other health care providers to promote quality improvement, improve financial stability, and expand access	B.1. Population health clinical infrastructure C.1. Rural provider strategic partnerships C.2. EMS D.1. Talent recruitment D.2. Licensure compacts D.3. Scope of practice F.1. Remote care services, initiative-based evaluation, and state policy actions (Medicaid payment, for example)
Initiative 2: Modernize Technology Infrastructure and Capacity for Efficiency and Care Coordination	Tech Innovation	A. Prevention and Chronic disease: Promoting evidence-based interventions to improve prevention and chronic disease management. C. Consumer Tech Solutions: Promoting consumer-facing, technology-driven solutions for prevention and management of chronic diseases. F. IT Advances: Fund software, hardware, and cybersecurity upgrades to strengthen Louisiana's rural health tech ecosystem, enabling interoperability and digital innovation. D. Training & Technical Assistance: Providing education, vendor coordination, and implementation support to help rural hospitals and clinics adopt and optimize shared EHR systems	B.1. Population health clinical infrastructure C.1. Rural provider strategic partnerships F.1. Remote care services F.2. Data infrastructure F.3. Consumer-facing technology

Initiative 3: Reinforce Innovative, Outcomes-Based Care Delivery in Rural Areas	Innovative Care	B. Provider Payments: Providing payments to health care providers for the provision of health care items or services, subject to RHT Program restrictions I. Innovative Care: Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models G. Appropriate care availability: Assisting communities to right-size health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient, outpatient, and post-acute care services K. Fostering Collaboration: Initiating and fostering local and regional strategic partnerships between rural facilities and other health care providers to promote quality improvement, improve financial stability, and expand access to care	B.1. Population Health and Clinical Infrastructure E.1. Medicaid provider payment incentives
Initiative 4: Expand Physical Activity and Nutrition Interventions Through Community-Based Partnerships	Make Rural America Healthy Again	A. Prevention and Chronic Disease: Promoting evidence-based, measurable interventions to improve prevention and chronic disease management	B.1. Population Health and Clinical Infrastructure B.2. Health and Lifestyle B.3. SNAP Waivers B.4. Nutrition Continuing Medical Education
Initiative 5: Strengthen Care Integration for High-Needs Populations Through Coordinated, Multi-Modal Models	Make Rural America Healthy Again	A. Prevention and Chronic Disease: Promoting evidence-based interventions to improve prevention and chronic disease management G. Appropriate Care Availability: Assisting communities to right-size health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient, outpatient, and post-acute care services K. Fostering Collaboration: Initiating and fostering local and regional strategic partnerships between rural facilities and other health care providers to promote quality improvement, improve financial stability, and expand access to care	B.1. Population health clinical infrastructure F.1. Remote care services F.3. Consumer-facing technology
Initiative 6: Strengthen Access to Essential Health Services Through Capital Investments	Sustainable Access	J. Capital Expenditures and Infrastructure: Investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions in the funding policies and limitations	B.1. Population health clinical infrastructure

Table 17. Summary of Initiatives, Strategic Goals, Uses of Funds, and Technical Score Factors

LA RHTP will not allocate grant funds for unauthorized spending categories, as described in funding policies and limitations in the RHTP NOFO. The application for funding includes required

safeguards with project managers monitoring compliance.

IMPLEMENTATION PLAN AND TIMELINE

LDH has developed a detailed, phased plan for FY26-FY31 that includes initial setup and planning activities and key milestones for implementing the LA RHTP. The process is designed to begin with early planning and capacity-building in Stages 0-1, then proceed with gradual rollout, assessment, and adjustments in Stages 2-5. When applicable, the plan also incorporates legislative or regulatory actions aimed for completion by December 31, 2026, or December 31, 2027, aligning with technical scoring factors B.2 and B.4. Timelines for implementation are deliberately overlapping. LDH aims to act swiftly and decisively when an initiative shows an obvious win. Each initiative will include a comprehensive implementation plan with monitored metrics, timelines, roles, and responsibilities, and will progress through a consistent set of implementation stages to ensure structured development, accountability, and measurable progress:

Stage	Description
0	Planning is underway, but no execution against project plan or implementation
1	Project plan developed, staff assigned, and initial implementation underway
2	Plan refined, implementation, and goal achievement are underway
3	Plan and goal achievement are halfway complete, continuously being worked on
4	Deliverables being finalized, proposed goals nearly achieved
5	Initiative fully implemented, goals completely achieved, and producing measurable results outcomes

Table 18. Implementation planning stages

Initiative 1: Strengthen Health and Emergency Systems through Workforce Expansion and Integration

Workforce development and emergency response modernization will progress in parallel, under shared governance, to maximize synergy and resource efficiency. Early efforts will build foundational governance and coordination frameworks across the LDH, LA Works, Louisiana Economic Development (LED), State Office of EMS and Trauma Systems, and local partners. The unified plan prioritizes strong stakeholder engagement, data-driven oversight, and mitigation strategies to ensure scalability and sustainability across rural parishes.

Phase	Timeline	Activities
0	Jan 2026 - Sep 2026	• Define shared objectives, success metrics, and data-reporting standards across LDH, LA Works, and LED • Establish governance, roles, and protocols for aligned funding, incentive tracking, and policy coordination • Engage universities and technical colleges to align curricula and rotations with Rural HERO-funded disciplines and paramedicine workforce needs • Update baseline data on workforce supply, training gaps, and EMS coverage to identify high-need and FAR parishes for early rollout • Develop readiness plans for early-moving strategies with unified data-reporting and evaluation standards
1	Mar 2026 - Apr 2027	• Launch Rural HERO Fund and Tax Credit programs; initiate five-year commitment tracking, via contractual agreement with recipient across Rural HERO, Tax Credit, and Credit Bank incentives • Begin design of community-paramedicine and tele-EMS pilots in broadband-ready FAR parishes integrated with local hospitals and clinics • Expand university and technical college partnerships to increase rural rotations, mentorships, and Grow-Your-Own pathways • Set up shared data and performance-tracking systems covering workforce incentives and EMS pilots
2	Sept 2026 - Dec 2027	• Finalize pilot frameworks for community-paramedicine and tele-EMS, including budgets, governance, and evaluation plans • Deploy initial pilots in two to three regions; launch tele-EMS connectivity for real-time consultations • Collect early workforce and operational data: response times, vacancy rates, provider retention, to inform expansion • Refine Rural HERO, Tax Credit, and Credit Bank models based on performance. • Continue university engagement to align training with emerging workforce needs
3	Jan 2027 - Jun 2028	• Expand pilots to more parishes and introduce 24/7 tele-consultation for EMS crews • Integrate protocol refinements from pilot feedback; strengthen regional training and credentialing to ensure quality and sustainability • Analyze mid-cycle outcomes: EMS diversion rates, response-time improvements, recruitment, retention, and use findings to adjust incentive and training programs • Launch statewide Grow-Your-Own pathways in coordination with universities and technical colleges
4	Jul 2028 - Oct 2030	• Complete pilot evaluations and publish findings with policy recommendations for statewide expansion • Develop quality and credentialing standards for EMS and rural-clinical partners • Scale Rural HERO Fund, Tax Credit, Credit Bank, and Grow-Your-Own models statewide; align with state budget cycles for long-term support • Establish a scale-up roadmap with priority regions and implementation sequences • Deepen local ownership through agency and regional leadership coordination
5	Nov 2030 - Sep 2031	• Institutionalize a permanent statewide framework linking funding, education, telehealth, and clinical placement systems. • Embed Rural HERO Fund and tax incentives into recurring state budgets and reporting • Maintain cross-agency governance and continuous quality improvement processes for all workforce programs • Sustain university partnerships and Grow-Your-Own initiatives as integral components of rural workforce development • Monitor long-term workforce outcomes, EMS performance metrics, and population-health indicators to ensure lasting impact and system resilience • Continue tracking 5-year required commitments and put in place methodology to continue tracking post-RHTP funding period

Table 19. Initiative 1: Implementation plan. See Initiative 1 Description and Metrics and Evaluation Plan

Initiative 2: Modernize Technology Infrastructure and Capacity for Efficiency and Care Coordination

The initiative establishes Louisiana as the **first state to implement a CMS Aligned Network and health technology ecosystem**, combining a state-managed, CMS-aligned EHR with the RTCF-LA to fund innovative digital tools and mobile care platforms. These technologies are designed to expand access, enhance efficiency, and advance interoperability in rural communities. Early efforts will finalize the EHR vendor contract, establish interoperability and security standards, and launch RTCF-LA's first funding round in broadband-ready parishes. Over time, these efforts will evolve into a sustainable, data-driven platform that enables real-time coordination, supports value-based care, and positions Louisiana as the first fully CMS-aligned network state.

Phase	Timeline	Activities
0	Jan 2026 - Oct 2026	• Convene inter-agency working group (Medicaid, Office of IT, Broadband Office, associations) to design and sequence EHR, RTCF-LA, and mobile-health initiatives • Build the Health Technology Ecosystem Implementation Team • Finalize statewide EHR vendor procurement, governance framework, and data security standards aligned with the CMS Aligned Network • Apply HIPAA, CMS, and state data-privacy standards across activities, establishing protocols for secure data exchange, encryption, and access control • Design RTCF-LA structure, eligibility, and milestone-based funding model using ARPA-H methodologies • Coordinate with BEAD and FCC to map broadband coverage and readiness by parish • Define evaluation metrics for remote-monitoring pilots and mobile-access distribution, ensuring integration with LDH's analytics platform
1	Jul 2026 - Jun 2027	• Execute the EHR vendor contract and launch phased deployment for pilot facilities in broadband-ready parishes • Establish RTCF-LA operations, issue Round 1 funding opportunities, and select initial provider and technology grantees • Begin procurement and setup for remote-monitoring and connected-care device pilots targeting chronic disease populations • Launch smartphone distribution program with preloaded health and telemedicine tools through FQHCs and parish health units
2	Jul 2027 - Dec 2028	• Expand EHR deployment to additional rural facilities and conduct interoperability testing with Medicaid and public health systems • Distribute RTCF-LA Round 2 funding in additional parishes • Integrate remote-monitoring data into the statewide EHR and provider dashboards; begin real-time reporting pilots • Continue smartphone and digital literacy programming through local schools, libraries, and community partners • Refine implementation models based on early data on provider adoption, patient engagement, and technology utilization

3	Jan 2029 - Dec 2029	• Complete EHR rollout to majority of rural hospitals and clinics; expand interoperability across behavioral health facilities • Evaluate RTCF-LA-funded projects; identify high-performing models for replication • Scale connected-care infrastructure statewide, integrating telehealth platforms, mobile apps, and monitoring devices for chronic disease management • Conduct mid-cycle evaluation on patient digital engagement and provider satisfaction; adjust training and support programs
4	Jan 2030 - Dec 2030	• Finalize statewide EHR adoption and ensure integration with the CMS Aligned Network for value-based payment readiness • Institutionalize RTCF-LA governance; transition to performance-based funding • Consolidate remote-monitoring and telehealth data streams into LDH's analytics platform for population-health reporting • Expand smartphone and mobile-access programs to cover all rural parishes and establish ongoing digital-literacy partnerships • Publish evaluation findings demonstrating improved operational efficiency, chronic disease management, and access
5	Jan 2031 - Sep 2031	• Complete statewide integration of all digital-health systems—EHR, connected-care, and mobile platforms—into a single, interoperable ecosystem • Transition RTCF-LA to long-term funding mechanism. Sustain smartphone and digital literacy programs through public–private partnerships with broadband and health-system partners • Institutionalize quality assurance, cybersecurity, and data-governance standards • Publish final evaluation showing improved provider efficiency, digital engagement, and health outcomes for rural residents statewide

Table 20. Initiative 2: Implementation plan. See Initiative 2 Description and Metrics and Evaluation Plan

Initiative 3: Reinforce Innovative, Outcomes-Based Care Delivery in Rural Areas

Securing buy-in for risk-sharing, value-based arrangements involves demonstrating long-term value for payers and providers. Innovative care models—such as care navigation, panel management, mobile units, and rural pharmacy access—need further development for delivery design, partnership building, and evidence creation for sustainable reimbursement. The implementation plan launches value-based payment pilots early to demonstrate the potential for shared savings, test innovative care models for service effectiveness, and develop business cases to transition successful models from grant funds to permanent reimbursement structures.

Phase	Timeline	Activities
0	Jan 2026 - Jun 2026	• Partner with local university to design and launch needs assessment with community stakeholders to identify priority interventions for innovative care model pilots • Assess possible patient populations and identify concentrated geographies for targeted pilot deployment • Develop criteria and selection processes for risk-sharing value-based payment pilots partnering with rural providers and payers • Develop seed funding criteria and selection process, determining partnership readiness and innovation potential

		• Begin designing provider education and technical assistance frameworks for organizations transitioning to new care and payment models.
1	Jul 2026 - Feb 2027	• Execute partnership agreements with clear service delivery and cost targets with value-based payment partners, and award results-based financing contracts to innovative care model pilot organizations • Launch provider education programs on value-based care models and evidence-based model implementation for pilot partners • Complete state plan amendments for value-based models, if indicated • Establish performance tracking systems and provide technical assistance to partners on data collection and quality reporting
2	Sept 2026 - Dec 2027	• Launch initial value-based payment and innovative care model pilots • Provide technical assistance on care navigation, mobile health service delivery, panel management protocols, and rural pharmacy access model implementation • Establish baseline tracking of partner reach, service utilization patterns, and initial outcomes for both payment and care delivery innovations • Refine quality metrics and shared savings methodologies based on partner feedback and initial performance data • Conduct evaluation of partner impact on care coordination effectiveness, preventable hospitalizations, and ED utilization patterns
3	Sept 2027 - Jan 2029	• Evaluate outcomes, including provider education satisfaction and uptake with innovative care models, as well as non-emergent ED visits from innovative models. When fully ready (expected Q1 CY 2028), evaluate full outcomes measurement for avoidable ED visits • Launch additional ACOs and eligible populations based on pilot results and expand innovative care model partnerships to additional sites demonstrating readiness. • Document partner outcomes and develop business cases for permanent reimbursement mechanisms supporting value-based arrangements and innovative care models • Evaluate which care models demonstrate cost-effectiveness for different populations and service contexts • Create implementation toolkit and standards for statewide model replication based on successful pilot approaches
4	Jan 2029 - Dec 2029	• Scale results-based partnership models statewide with standardized quality contracts supporting both payment transformation and innovative care delivery • Establish permanent reimbursement structures for proven innovative care models integrating into Medicaid managed care contracts and multi-payer arrangements • Establish continuous quality improvement mechanisms across payer and provider partners, ensuring ongoing performance accountability • Develop sustainability plan for scaling results-based arrangements statewide with MCO integration and long-term oversight structures
5	Jan 2030 - Sep 2031	• Transition from pilot to permanent statewide operations, embedding successful value-based and innovative care models across rural providers • Establish enduring governance and financial oversight structures to ensure long-term sustainability and adaptability • Maintain ongoing performance monitoring, stakeholder engagement, and reinvestment of savings into community health improvement • Demonstrate measurable reductions in non-emergent ED visits, improved chronic disease outcomes, and enhanced provider capacity under sustainable, value-based, and innovative care models

Table 21. Initiative 3: Implementation plan. *See Initiative 3 Description and Metrics and Evaluation Plan*

Initiative 4: Expand Physical Activity and Nutrition Interventions Through Community-Based Partnerships

Expanding physical activity and nutrition programs requires early partnership mobilization and ongoing community engagement to achieve impact. Strategies such as community wellness campaigns can be quickly implemented due to existing relationships. More complex initiatives, such as food pharmacy programs, require rural healthcare partnerships, referral systems, and reimbursement development, which take longer to plan, pilot, and implement. The plan emphasizes launching wellness pilots early, building food pharmacy infrastructure gradually with rural partners, and creating sustainable funding that shifts from grants to permanent reimbursement.

Phase	Timeline	Activities
0	Jan 2026 - Jul 2026	• Partner with rural facilities to assist with startup costs associated with "food FARMacy" programs to roll out to medically necessitated treatment plans • Develop statewide campaign strategy and identify community partner organizations for wellness programming (e.g., nutrition, exercise, and preventive screenings) • Develop operational frameworks, including food distribution logistics, prescribing protocols, eligibility criteria, and blended financing models exploring rural healthcare facility investment, Department of Health and Human Services (DHHS), and food donation partnerships • Create framework to fund local wellness campaigns and programs, and develop evaluation and behavior-change measurement plans
1	Aug 2026 - Dec 2026	• Launch community wellness pilot campaigns in 3-5 rural regions through community organizations, schools, and faith organizations • Co-design outreach materials on nutrition, exercise, and preventive screenings, and provide mini-grants to support community-delivered guidance or nutrition programs • Begin baseline data collection tracking participation, awareness, and behavior indicators for community wellness initiatives • Monthly track outputs, including facilities funded and patients enrolled for food pharmacy programs, beginning within six months of first implementation
2	Jan 2027 - Jun 2027	• Launch 1-2 pilot "food FARMacy" programs co-located in rural healthcare facilities serving high food insecurity communities • Establish local partnerships with farmers' markets, food co-ops, and food banks for food sourcing and distribution infrastructure • Begin tracking patient participation, nutritional prescriptions, and health outcomes for food pharmacy programs • Implement referral systems from facilities and providers to food pharmacies • Expand community wellness pilots based on initial engagement data and establish partnerships with WellAhead and Parish Health Units for preventive screening days • Evaluate early outcomes, including participation rates and screening uptake for community wellness programming
3	Jul 2027 - Dec 2027	• Conduct evaluation of pilot data, including enrollment, utilization, and early health outcomes for both food pharmacy and community wellness strategies. • Gather patient and provider feedback to refine prescribing guidelines, investment models, and campaign delivery approaches • Expand successful pilots and establish additional partnerships to integrate preventive services into existing community infrastructure • Develop framework for statewide policy adoption and align data collection with broader disease prevention metrics

4	Jan 2028 - Dec 2029	• Expand food FARMacy and community wellness programs to facilities statewide • Expand programs to additional partner healthcare facilities and secure standardized reimbursement mechanisms through MCOs for facilities • Secure long-term sustainable funding through diverse mechanisms, including public health investments, higher education partnerships, municipal budgets for community programming, and foundation partnerships • Integrate into LDH's population health initiatives and publish outcomes (reductions in food insecurity, improved patient outcomes, and increased preventive services)
5	Jan 2030 - Sep 2031	• Maintain statewide implementation with continuous reporting of outcomes • Institutionalize data-driven feedback loops for program and policy refinement • Disseminate best practices to other rural regions nationally under framework • Continue scaling through new partnerships and innovative funding mechanisms to ensure program longevity and adaptability

Table 22. Initiative 4: Implementation plan. See Initiative 4 Description and Metrics and Evaluation Plan

Initiative 5: Strengthen Care Integration for High-Needs Populations Through Coordinated, Multi-Modal Models

Strengthening population health management through multi-modal service integration requires coordinated partnerships across various organizations and platforms. Some strategies can be implemented quickly because of existing foundations, whereas others need time-consuming activities (e.g., setting up facilities, recruiting staff, and building systems). The plan emphasizes rapid deployment of telehealth and PACE, with a phased partnership approach.

Phase	Timeline	Activities
0	Jan 2026 - Jun 2026	• Conduct statewide needs assessment to identify priority parishes and populations for integrated care expansion (telehealth, PACE, behavioral health, and convener models) • Define the subgrantee framework and funding criteria for partner organizations capable of implementing multi-modal care models • Align early planning with workforce and broadband initiatives to ensure readiness for telehealth and co-located service delivery
1	Jul 2026 - Dec 2026	• Release competitive funding opportunities and execute award agreements with qualified subgrantees (e.g., FQHCs, RHCs, CCBHCs, rural hospitals, community organizations) • Award funds and initiate early pilots in high-priority parishes to test regional convener networks, telehealth access, and behavioral-health integration • Begin preliminary planning for the first PACE site retrofits in partnership with licensed rural hospitals and the Office of Aging and Adult Services • Onboard awardees through technical assistance sessions covering reporting, metrics, and implementation of milestones • Finalize MCO data-sharing agreements and establish baseline performance dashboards for care access and service coordination
2	Jan 2027 - Dec 2027	• Scale up telehealth infrastructure and broadband connectivity for rural facilities participating in pilot regions • Expand behavioral-health and primary-care integration through CCBHC and OTP partnerships, prioritizing parishes with the greatest service gaps • Launch initial PACE site retrofits and begin patient enrollment to provide integrated, community-based care for aging populations

		• Strengthen convener-led coordination networks, embedding community navigators and MCO collaboration in care delivery processes • Continue rapid-cycle feedback and refine funding and performance frameworks based on partner evaluations
3	Jan 2028 - Dec 2028	• Extend successful telehealth and convener models statewide, increasing the number of operational integrated-care hubs and connected rural facilities • Evaluate early performance outcomes, including access gains, utilization rates, and care-navigation efficiency • Expand behavioral-health integration pilots into additional rural communities and complete the second wave of PACE site retrofits • Facilitate peer-learning collaboratives to share best practices among partners and strengthen alignment across MCOs, providers, and conveners • Advance integration of value-based payment structures with MCOs to sustain successful models
4	Jan 2029 - Dec 2029	• Institutionalize proven delivery models across all participating regions, ensuring full functionality of convener networks, telehealth systems, and PACE operations • Transition oversight from grant-based to performance-based accountability structures, emphasizing patient access, quality, and outcomes • Document measurable improvements in chronic disease management, behavioral health outcomes, and care access for aging populations • Finalize sustainability planning, including braided funding models across LDH, MCOs, and federal reimbursement mechanisms
5	Jan 2030 - Sep 2031	• Operate statewide integrated care network with local conveners, telehealth, behavioral health and primary care integration, and expanded PACE services • Shift LDH's role from implementation to oversight, focusing on data-driven quality measurement, evaluation, and continuous improvement • Maintain service delivery through embedded MCO reimbursement and Medicare capitation mechanisms for PACE and integrated-care services • Demonstrate sustainable care-integration model that measurably improves outcomes, reduces avoidable hospitalizations, and strengthens rural health system resilience

Table 23. Initiative 5: Implementation plan. *See Initiative 5 Description and Metrics and Evaluation Plan*

Initiative 6: Strengthen Access to Essential Health Services Through Capital Investments

The RHF Capital Improvement Fund enables swift deployment of resources through a competitive grant process, prioritizing facilities with documented readiness and needs. While capital improvements can be implemented quickly, translating these investments into sustained operational improvements requires longer timelines. The implementation plan launches the grant program rapidly for visible facility upgrades, providing technical assistance and evaluation.

Phase	Timeline	Activities
0	Jan 2026 - Jun 2026	• Conduct statewide infrastructure assessment to understand critical infrastructure deficits impacting access and quality of care across rural health facilities • Design competitive application process with evaluation criteria and scoring methodology for capital improvement projects • Identify funding sources, including federal grants, state appropriations, and public-private partnerships, and secure initial appropriations for program launch

1	Jul 2026 - Dec 2026	• Launch application for the RHF Capital Improvement Fund and provide technical assistance for rural facilities navigating submission requirements • Award seed funding to initial cohort of rural facilities demonstrating greatest need and implementation readiness • Provide project management and compliance support to grantee facilities beginning procurement and renovation planning • Track outputs, including facilities funded and capital projects initiated, monthly, and report quarterly beginning within six months of first awards.
2	Jan 2027 - Dec 2027	• Award second round of grants to additional rural facilities based on refined evaluation criteria, expanding program reach across additional parishes • Monitor grant recipient progress against contractual deliverables and provide technical assistance addressing implementation challenges • Begin tracking early utilization metrics as upgraded facilities deploy enhanced capabilities for patient care
3	Jan 2028 - Jun 2028	• Conduct comprehensive evaluation measuring asset utilization growth, community access improvements, and financial sustainability indicators • Award final round of grants to remaining priority facilities
4	Jul 2028 - Dec 2029	• Launch formal outcomes measurement (Q1 2028 onward) to assess whether capital investments translate into measurable improvements in access to specialized care • Collaborate with RHFs to develop and institutionalize maintenance and sustainability protocols beyond the program's lifetime • Begin drafting the final comprehensive evaluation, synthesizing results from facility upgrades, access gains, and workforce retention • Design transition mechanisms for continued state or regional support post-program (e.g., revolving maintenance grants or technical support hubs)
5	Jan 2030 - Sep 2031	• Publish and disseminate the final comprehensive evaluation report, highlighting measurable improvements in service capacity, patient access, and financial health • Establish an RHF Sustainability and Innovation Network to support ongoing collaboration, data sharing, and continuous improvement • Conduct post-program monitoring (every 6-12 months) for at least two years to ensure facilities maintain operational and financial stability • Transfer remaining technical tools, templates, and datasets to a state health authority or regional coordinating body for long-term use • Close out the Capital Fund, ensuring compliance with all financial and audit requirements and documenting lessons learned

Table 24. Initiative 6: Implementation plan. See Initiative 6 Description and Metrics and Evaluation Plan

Governance and Project Management

The project management structure will include 12 full-time employees from LDH, such as the RHTP Lead, 4 Initiative Managers, 4 Strategy Managers, a Sustainability Director, a Budget Manager, and a Data Analyst. Part-time roles will include a Rural Health Director, an Executive Management Officer, and a Procurement/Contract Analyst. Following ARPA-H's model, Initiative Managers will act as "program managers," overseeing milestones and resource allocation to ensure accountability and innovation. Staffing will begin in January 2026, with all roles filled

within three months. Detailed responsibilities are provided in **Appendix B**.

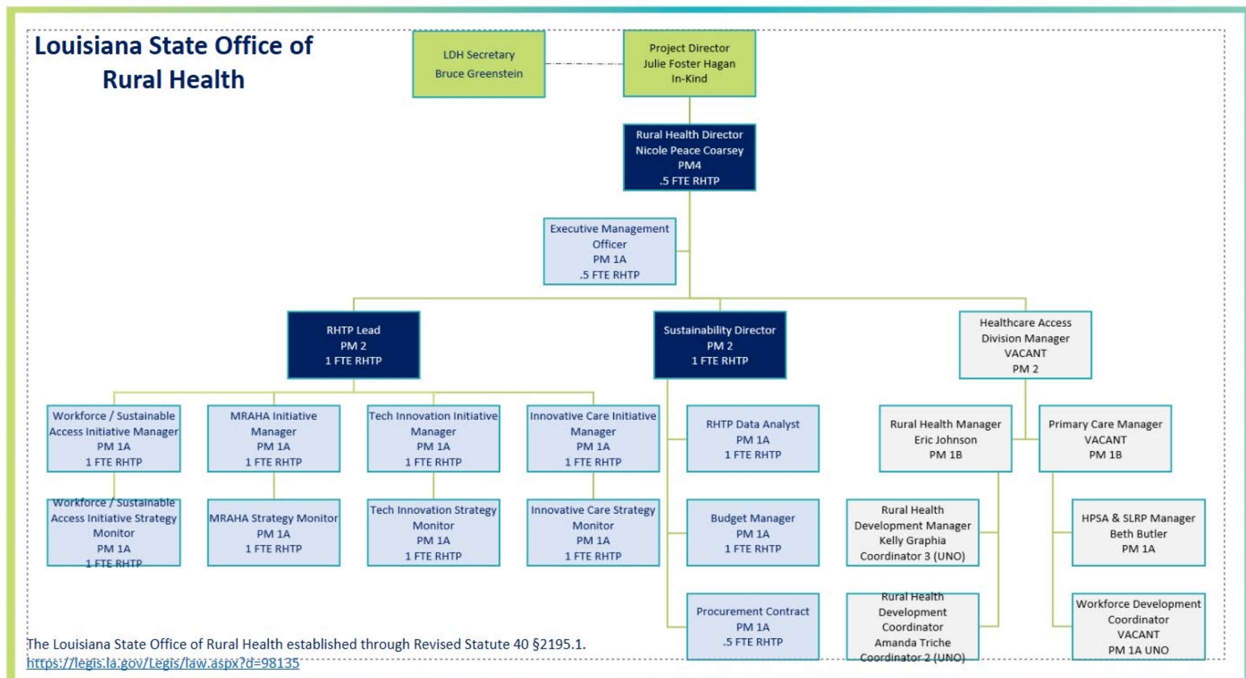

Figure 2. Louisiana RHT Program Governance

Governance will ensure accountability, remove barriers, and support efficient program delivery. LDH will serve as the lead agency, with the Secretary as the program sponsor. Roles and responsibilities for each governance level are outlined in the exhibit below.

Governance Structure	Role	Responsibilities
Secretary of the Department of Health	Secretary of the Department of Health	• Ensures all strategic decisions align with department's mission to protect and promote health across Louisiana • Sponsor of Rural Health Transformation Program
Executive Management Council	Executive Management Council	• Provide strategic direction for the RHTP, focusing on long-term goals and ensuring that the program's initiatives are effectively integrated into the broader health objectives of the state
Advisory Council	Advisory Council	• Provides an external perspective to guide the RHTP strategy
Rural Health Office	Rural Health Office	• Responsible for developing and overseeing the strategic framework of the RHTP, ensuring the program's objectives are met • Coordinates the implementation of various program components across working teams, ensuring resources are allocated appropriately and initiatives are executed effectively • Submits the annual application for continued funding and support
Working Team	Working Team	• Manages the day-to-day operations of the RHTP • Manges program operations • Evaluates the performance of subgrantees throughout the program's duration

Figure 3. Louisiana RHT Program governance structure with roles and responsibilities

STAKEHOLDER ENGAGEMENT

Proposal Planning

Stakeholder engagement has been central to the LA RHTP's development, emphasizing transparency and ongoing dialogue to inform design and evaluation. LDH has involved a wide range of stakeholders, including rural healthcare providers, patients, hospital and medical systems, local governing entities, community leaders, tribal representatives, employers, healthcare advocates, and insurance providers. Evidence of support and engagement is included in **Appendix A and G,** respectively**.** Engagement activities included: **1) LA RHTP Task Force**: LDH assembled more than 60 health professionals and stakeholders to fundamentally rethink how rural healthcare is delivered to improve outcomes for all Louisiana residents living in rural areas. **2) Request for Information (RFI)**[xxvi]: LDH issued an open RFI process to gather feedback from hospitals, healthcare providers, academic institutions, rural residents, community-based organizations, and technology suppliers on suggested strategies. **3) Working Group Meetings:** LDH hosted five working group sessions focused on a different strategic goal, where Task Force members provided input on issues, potential strategies, outcome measurement, expected costs, and sustainability. **4) Community "Idea Raiser" Meetings:** LDH hosted community meetings across the state to receive public input from hospitals, healthcare providers, academic institutions, technology suppliers, and rural residents on strategies to address challenges in delivering rural healthcare. **5) Dedicated communication channels**: LDH launched a program webpage[xxvii] and email address to provide updates, share meeting materials, and collect feedback from stakeholders throughout the proposal development process.

Ongoing Stakeholder Engagement, Governance, and Representation

To ensure sustained engagement throughout project implementation, LDH will establish a

formal engagement and transparency plan, including: **1) Advisory Group**: The existing Task Force will transition into a standing Rural Transformation Healthcare Advisory Group that will provide ongoing guidance, including reviewing performance dashboards, funding and budget reports, milestone progress, and program outcomes. **2) Regional Rural Community Networks**: LDH will facilitate regional meetings in rural communities that are open to the public. These sessions will continue to share information about program initiatives and outcomes. **3) Public Presentations and Outreach:** To maintain transparency and encourage stakeholder participation, RHT updates, initiatives, and strategies will be communicated widely through public presentations, press releases, and community briefings. **4) Facility Visits:** LDH will visit rural healthcare facilities to engage providers, staff, and patients. LDH will serve as the primary facilitator for ongoing partnerships and continually identify new partners focused on rural healthcare. LDH will also promote direct participation from rural residents to ensure that initiatives and strategies are fully implemented and transparent.

METRICS AND EVALUATION PLAN

LDH uses SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) metrics to track RHTP performance. The listed metrics illustrate the measurement framework LDH plans to develop. Due to baseline data gaps, LDH aims to collect additional data through the CMS Aligned Network, taking into account the data burden on rural providers. The 2028 statewide EHR rollout will enhance data collection, enabling detailed rural outcomes tracking. The metrics were developed using a laddering approach to align program goals with outcomes. This helps Louisiana track progress and determine required revisions. LDH will use leading and lagging metrics to identify early signs of success or challenges, enabling data-driven, agile decisions and timely adjustments. We will fully cooperate with CMS-led evaluation or monitoring efforts, including

providing data, participating in site visits, and supporting third-party evaluators.

Metrics	**Baseline**	**Targets / Milestones**	**Data source**	**Data collection responsibility**
Initiative 1: Workforce Integration and Expansion (see Description and Implementation Plan)				
% increase patients receiving primary care service in their parish-of-residence **(stratified by parish)**	Estimated calculation 60% (AJPM, 2019; LDH PCNA 2020)	Year 3: 1% increase in coverage from baseline; Year 5: 3%	Hospital and facility-reported data	Partners / grantees
% increase in rural-trained HCWs entering Louisiana's workforce within 12 months of graduation	Estimated 55.5% of state trainees who completed residency from 2012-21 practice in state of residency (AAMC, 2022)	TBD based on data received from grantees in phase 0/1	University and training program graduate placement reports, HRSA Area Health Resource File	LDH / University partners
% increase of specialty care provider coverage across rural parishes	Estimated 23 specialty providers per 100k (vs 78 for urban parishes) (e.g., Oncologists 0.7 per 100k vs 4.6 in urban areas, Psychiatrics 3.2 vs 17.4 in urban areas) (Definitive Healthcare)	Year 3: 3% increase in coverage from baseline; Year 5: 5%	Rural health facility staffing data (HR records), HRSA Area Health Resource File	LDH / Rural Health Facilities
% penetration increase in viable rural areas (i.e. broadband available), served by tele-EMS or community paramedicine	Estimated calculation 10–12% (Commonwealth Fund, 2023)	Year 3: 5 pp coverage increase over baseline; Year 5: 10 pp	EMS encounter data; platform analytics	LDH
% decrease in EMS response time to high acuity incidents in rural areas **(stratified by parish)**	Estimated 18 min response time (NEMSIS State Performance Dashboard 2024)	Year 3: 5% decrease in response time; Year 4: 7.5% decrease; Year 5: 10% decrease	EMS encounter data; platform analytics	LDH
% reduction in low-acuity 911 calls resolved through tele-EMS without hospital transport	Estimated 60% (American College of Surgeons Clinical Congress 2025)	Year 3: 5% reduction in low acuity transports; Year 4: 10 % reduction; Year 5: 15% reduction	EMS encounter data; platform analytics	LDH
Initiative 2: Modernize Tech Infrastructure (see Description and Implementation Plan)				
% increase of rural providers/facilities leveraging data exchange for care coordination via interoperable platforms	36% of national rural facilities are 'routinely interoperable' (ONC, 2023)	Year 3: +5 pp increase; Year 4: +10 pp; Year 5: +15 pp	EHR usage reports, FHIR API endpoint activations, identity credential issuance	LDH / EHR Vendor / CIN / Cloud Vendor

% of rural providers exchanging data via FHIR-compliant network	40% of rural facilities use EPIC (FHIR-compliant) in Louisiana	Year 3: +5 pp increase; Year 4: +10 pp; Year 5: +12 pp	Platform analytics	LDH
% of rural patients with electronic access to their own health data through state-managed EHR	0% (Not established yet)	Year 3: +20 pp increase; Year 4: +25 pp; Year 5: +30 pp	EHR portals / patient access logs	LDH / Providers
% of rural residents using RTCF-supported digital-health tools (telehealth apps, mobile platforms)	TBD based on grantee baselines once RTCF grantees are determined	Year 2: +10 pp increase; Year 3: +15 pp; Year 4: +20 pp; Year 5: +25 pp	Platform analytics / RTCF grantee reports	LDH / RTCF Grantees
% increase in preventive-care utilization among digitally connected patients (e.g., annual checkups, screenings)	TBD (Year 1 claims review based on participants)	Year 3: +4 pp increase; Year 4: +6 pp; Year 5: +8–10 pp	Claims and encounter data	LDH / MCOs
Initiative 3: Outcomes-based Care Delivery (see Description and Implementation Plan)				
% reduction in non-emergent ED visits **(stratified by parish)**	Estimated calculation 75,000-85,000 potentially preventable ED visits (Texas Medicaid and Children's Health Insurance Program, 2022)	Year 4: 2pp reduction in visits; Year 5: 5pp reduction in visits	Medicaid / CHIP claims data; encounter data	LDH
% of patients in ACOs with controlled diabetes and other chronic conditions	Baseline to be established following program launch from ACOs	Target to be determined in phase 0/1	MCO / ACO reports	LDH
% of rural patients with access to a provider participating in accountable care or value-based payment models	Baseline to be established in phase 0/1 based on 1,578,450 statewide Medicaid managed care enrollment (Healthy Louisiana, 2025)	Target to be determined in phase 0/1	Platform analytics; subgrantee reports	LDH, partners / grantees
% penetration of piloted care models in rural areas **(stratified by parish)**	Baseline to be established following program launch from subgrantee platform analytics	Year 2: 10 % uptake increase; Year 4: 20 % increase; Year 5: 30% uptake increase	Partner / grantee reports; platform analytics	Partners / grantees
Initiative 4: Physical and Nutrition Interventions (see Description and Implementation Plan)				
%. improvement in health markers (e.g., BP, glucose levels, weight) among target patient populations (chronic diseases)	60.5% of population with high BP control and 63.7% of population with A1c control [less than 8%] (LA Medicaid, 2023)	Year 3: 0.5 pp improvement per marker; Year 4: 1 pp; Year 5: 2pp	Integrated EHR data; partner / grantee reports; MCO data	LDH
% participation in school-aged physical fitness programming in rural parishes	31/64 parishes in the state currently participate in PFT; rural baseline to be established in stage 0/1	Year 2: 10% increase over baseline; Year 3-5: 10% increase over prior year	Governor's Council on Physical Fitness & Sports	LDH

% self-reported improved well-being (e.g., NQF) following community-based nutrition and physical health events	40.1% adults in LA report they are obese (BFRSS, 2023); 14.7% of adults in LA report they've been told they have diabetes (BFRSS, 2023); 11.5% of adults in LA report they've been told they have CVD (BFRSS, 2023); baseline on self-reported well-being to be collected	Year 2: 1 pp improvement in reported wellbeing; Year 4: 3 pp improvement; Year 5: 5 pp improvement	Partner / grantee reports	Partners / grantees
% participation in food pharmacies following provider referral **(stratified by parish)**	0% no record of programs operating in the state	Year 2: 10% in targeted rural areas among eligible groups; Year 3: 12%; Year 5: 17.5%+	Partner / grantee reports	Partners / grantees
Initiative 5: Strengthen Care Integration (see Description and Implementation Plan)				
% of adult population referred for Mental Health/SUD consult within 30 days of screening	57.9% initiation and engagement for new SUD (LA Medicaid, 2023); mental health figures TBD in staged 0/1	Year 3: 5pp increase; Year 4: 15 pp; Year 5: sustain 15 pp increase	Partner / grantee reports; EHR data	LDH; grantees
% increase in rural resident access to telehealth or virtual BH services	3.2 million live in officially designated mental-health shortage areas (HRSA, 2025); to be stratified by rurality in Stage 0/1	Year 3: 1 pp increase; Year 4: 3 pp increase; Year 5: 4 pp increase	Partner / grantee reports; EHR data	LDH; grantees
% decrease in inpatient admission among adults participating in new PACE geographies **(stratified by parish)**	78 per 100 participants in existing sites in urban parishes (ranges from 35% to 99% readmission at existing sites); to be determined for rural parishes in stages 0/1	Year 3: 1-3pp reduction over established rural baseline; Year 5: 4-10 pp	Encounter data; integrated EHR data;	LDH
% clinical outcomes for target conditions (chronic disease, obesity, pregnant/postpartum women, cancer)	60.5% of population with high BP control (LA Medicaid, 2023) and 63.7% of population with A1c control [less than 8%] (LA Medicaid, 2023); additional baselines to be established in stage 0/1	Year 3: 1pp improvement per marker; Year 4: 2pp; Year 5: 4pp	EHR; platform analytics	LDH; grantees
Initiative 6: Capital Investments (see Description and Implementation Plan)				
% reduction in time to specialized care in rural parishes (chronic disease, obesity) **(stratified by parish)**	> 30 minutes (WWAMI Rural Health Research Center, 2021)	Year 3: 5% decrease in time to specialized care Year 5: 10-15% decrease	EHR; Claims data	LDH
# new diagnoses overall after screenings among target populations (chronic disease, obesity) (**stratified by parish**)	153,673 women have received screening and diagnostic breast imaging since Medicaid expansion (LDH, 2023) - specific baseline to be outlined once EHR in place to be outlined	Year 3: 500 increase over existing count, by population; Year 4: 2,000 increases; Year 5: 3,000+ To be refined based on eligible pop. size and screening	EHR	LDH

% increase in rural asset utilization by service line (e.g., laboratory, diagnostics, rapid testing)	Baseline to be established following program launch with information from RHFs	Year 1 post-investment: 5%+ avg utilization by service line; Year 3 post-investment: 10%+; Year 4 post-investment: 10-15%+	RHF reports	LDH
# RHF capital projects funded	0%	Year 2: 10+ requests fulfilled; Year 3: 20+ funding; Year 5: 30+	Office of Rural Health reports	LDH

Table 25: Program metrics

SUSTAINABILITY PLAN

Louisiana's approach to post-grant sustainability recognizes that different health system interventions require different long-term mechanisms to ensure sustained financing and impact. We have evaluated each initiative across the five strategic goals to identify the most appropriate and durable sustainability pathway using four complementary archetypes.

Medicaid funding supports initiatives eligible for reimbursement through State Plan Amendments (SPAs), waiver authorities, or managed care contracts, financed through the federal and state match under CMS oversight. For example, Louisiana plans to sustain the Food FARMacy program through managed care integration, enabling MCOs to offer medically tailored meals as an "in lieu of" benefit that reduces emergency department use. While Louisiana primarily operates under managed care, some services may require coordination with fee-for-service billing as benefits expand. For initiatives serving dually eligible beneficiaries, such as PACE and integrated behavioral health models, the state will align Medicaid financing with Medicare capitation to ensure seamless, sustainable coverage across both programs.

Braided funding supports system-strengthening initiatives where multiple stakeholders maintain separate funding commitments with distinct accountability for their contributions. Our workforce development programs, including collaborative provider models and rural clinician credit banks, benefit hospitals, MCOs, local governments, and communities simultaneously.

Sustainability depends on demonstrating measurable returns on investment to each funding partner through metrics such as workforce retention, enrollment increases, and cost savings that align with their objectives. This is then followed by securing formal, multi-year commitments with tracking mechanisms that ensure accountability for each funder's contribution.

State and local appropriation provides dedicated funding through state or local government budgets via ongoing legislative appropriation for direct financial incentives that support the rural healthcare workforce. For instance, we plan to fund the state income tax credits for rural service through annual state budget line items, established through statutory authorization that requires legislative appropriation for each fiscal year.

Planned sunset describes time-limited interventions that create lasting infrastructure, workforce capability, or policy change without requiring ongoing dedicated funding after implementation. The RHF Capital Improvement Fund will be capitalized through grant funds as a revolving loan fund that sustains itself through loan repayments, enabling continuous support for RHC infrastructure improvements beyond the grant period.

Initiative 1: Strengthen Health and Emergency Systems through Workforce Expansion and Integration

Braided funding: By **2029**, workforce development and innovative care initiatives, including training models, rural clinician credit banks, workforce pipelines, and university partnerships, will transition to a **braided funding structure**. From **2026-2028**, grant funds will build program infrastructure, pilot rotations, and demonstrate results such as stronger recruitment and retention in high-need areas. By **2029**, outcome data on clinician engagement and retention will support **cost-sharing agreements** among LDH, hospitals, universities, and workforce boards. Each partner will contribute resources (hospital budgets, tuition, workforce grants, and

philanthropy) to maintain mentorship networks, clinical rotations, and shared staffing models to create a **sustainable, performance-based workforce pipeline**.

Launching regional community paramedicine and tele-EMS pilots will transition to sustained multi-payer support. Engagement with regional EMS providers and MCOs showed strong early buy-in for value-based emergency care innovations. MCOs are interested in aligning reimbursements with reductions in ED visits and avoidable transports, with the Louisiana Ambulance Alliance collaborating on pilot design and evaluation. These partnerships are paving the way for multi-payer involvement once outcomes prove effectiveness. Grant funding in Years 1-3 will develop pilot programs and demonstrate ROI. By Year 4, the goal is to secure commitments from the State Office of EMS and Trauma Systems, MCOs (via shared savings arrangements), rural hospitals/CAHs (via community benefit programs), local EMS agencies, and the Louisiana Ambulance Alliance, ensuring long-term support and statewide expansion.

State and local appropriation: If the interventions show measurable success, Louisiana can utilize its experience with the HERO Fund and state income tax credits to secure ongoing funding, ensuring long-term sustainability. Grant resources from 2026 to 2028 will focus on fiscal modeling, legislative drafting, and system setup. Prioritizing rural service tax credits in legislation will aid in passage. Once established, recurring state and local contributions will support rural scholarships and service incentives, strengthening Louisiana’s workforce and EMS sustainability. These combined funding streams will create a robust system that maintains healthcare and emergency response capacity across rural Louisiana, ensuring continued recruitment and rapid response capability in every parish.

Initiative 2: Modernize Technology Infrastructure and Capacity for Efficiency and Care Coordination

Braided funding: In 2029, the statewide interoperable EHR and supporting digital infrastructure will shift from grant funding to a braided cost-sharing structure among LDH, Medicaid MCOs, rural hospitals, and FQHCs. Grant funds in the early years will cover planning, implementation, and support; thereafter, partners will contribute proportionally—LDH and Medicaid through administrative and technology budgets, MCOs through shared-savings reinvestments, and providers through operating funds—to sustain EHR operations and interoperability. This model also maintains funding for ongoing provider technical assistance and patient digital-readiness support as part of standard operations, ensuring sustained use.

Medicaid funding (SPA): By Year 5, LDH will secure a State Plan Amendment (SPA), enabling Medicaid reimbursement for remote monitoring, telehealth, and digital engagement services that are not already covered, launched through the RTCF-LA. These services will transition from grant support to billable benefits within managed-care contracts, tied to quality and outcome metrics reported through the statewide EHR. This SPA ensures that digital care and connected care models remain financially sustainable and fully integrated into Louisiana's Medicaid modernization framework beyond the cooperative agreement period. This model can serve as a blueprint for other states or regions seeking to become CMS-aligned networks, thereby extending its impact beyond our state's rural communities.

Initiative 3: Reinforce Innovative, Outcomes-Based Care Delivery in Rural Areas

Medicaid funding (managed care integration): Risk-sharing value-based agreements and innovative care models will be transitioned into MCO contracts through performance-based payments and shared savings structures. Rural facilities have historically lacked participation in such models, but these pilots will help providers and MCOs demonstrate their value. Grant funds will cover Years 1-3 for implementation and actuarial analysis to quantify cost savings and quality

improvements, leading to contract negotiations with MCOs for ongoing reimbursement. By the end of the grant, these care models will be sustained through MCO capitation adjustments or risk-sharing arrangements that link payment to performance.

Braided funding: The broader effort to expand mobile monitoring and digital care access will evolve toward a blended funding model supported jointly by hospitals, managed care organizations, and public health partners. Initial grant investments will be used to purchase mobile health units, integrate connected care platforms, and demonstrate measurable outcomes. As these outcomes substantiate value across sectors, partners will enter cost-sharing arrangements to sustain operations, including platform licensing, maintenance, and workforce training. Louisiana's Medicaid Managed Care Organizations' contracts are through the end of 2026 and are competitively awarded. LDH expects that the timing of that forthcoming procurement and market dynamics will create a favorable climate for MCO participation in on-going efforts. By Year 4, the program will operate under a braided financing structure, combining MCO shared savings, hospital community benefit funds, and local government health grants, to ensure continuous digital access for rural communities beyond the grant period.

Initiative 4: Expand Physical Activity and Nutrition Interventions Through Community-Based Partnerships

Medicaid funding (managed care integration): Food FARMacy programs in rural areas will utilize Louisiana Medicaid reimbursement for medically tailored meals to ensure sustainability after the grant period. While MCO reimbursement is limited, discussions are ongoing to include Food FARMacy in value-based models. Grant funds will support startup costs for the first two years, enabling the creation of necessary infrastructure and workflows and to demonstrate ROI. We expect that negotiations with MCOs about the ROI of these strategies will

be reflective of the combined impact of multiple efforts, e.g. incentives for better nutrition and physical activity, combined with improved access to primary care and with digital tools to monitor health status. Once reimbursement pathways are established, these programs will directly bill MCOs for eligible services, promoting long-term sustainability within managed care systems.

Braided funding: Community-based nutrition and fitness solutions will transition to support from MCOs, local health departments, RHFs, and organizations. In the first two years, grant funds will be used for implementation and data collection while developing partnerships for long-term funding. Outcome data showing health improvements and cost reductions will support ongoing investment. By program end, partner sites will secure sustainable funding through formal agreements, ensuring service continuation after the grant.

Initiative 5: Strengthen Care Integration for High-Needs Populations Through Coordinated, Multi-Modal Models

Medicaid/Medicare funding (managed care integration): CCBHC, OTP, telehealth, and coordination services will move from grant-supported pilots to Medicaid managed care reimbursement through directed payments and capitation adjustments. Starting in Year 3, LDH will collaborate with MCOs to integrate these models into benefit packages and quality-based payment structures. Subgrantees will sustain operations with combined MCO reimbursement, provider cost-sharing, and local contributions tied to improvements in access and outcomes.

Alternative PACE sites established in licensed rural hospitals will be sustained through direct Medicare capitation payments. Grant funds will support facility retrofits, accreditation, and initial operations in Years 1-3. Once certified, PACE sites will generate recurring Medicare revenue, providing a durable reimbursement pathway for comprehensive, community-based elder care in rural regions.

Planned sunset: One-time investments in telehealth, data integration, and facility upgrades will enhance service capacity for rural providers. These assets will be sustained through operational budgets, cost-sharing, and workforce integration, as detailed in Initiative 1. By 2030, the funding model will shift from grants to a self-sustaining, performance-driven integrated-care approach supported by ongoing Medicaid and Medicare funding.

Initiative 6: Strengthen Access to Essential Health Services Through Capital Investments

Planned sunset: The RHF Capital Improvement Initiative will offer one-time grants for RHC infrastructure. Funding in the first three years will be allocated towards facility upgrades and equipment, enabling RHCs to sustain improvements through operational revenue as they grow, thereby eliminating the need for continued grant funding. LDH is committed to implementing data-driven programs and will evaluate each initiative annually to identify the most impactful efforts. Over the five-year program period, the Office of Rural Health will refine activities and integrate lessons learned into broader state health policy by:

- Incorporating Rural Transformation Goals and Initiatives into the State Health Improvement Plan (SHIP): Building on existing chronic disease metrics, leverage SHIP's infrastructure and real-time data capabilities to deepen analysis and accelerate measurable health outcomes
- Aligning results in the Medicaid Managed Care Contract/Manual and Managed Care Incentive Plans: Incorporating rural-focused metrics and real-time data to improve program impact
- Applying workforce insights: Using lessons from this program to inform certification, training, and career pathway initiatives that strengthen the rural healthcare workforce

[i] Census tract population and land area from 2020 Census of Population and Housing; rural area based on HRSA census tract level designation
[ii] Census's Master Address File/Topologically Integrated Geographic Encoding and Referencing (MAF/TIGER®) database as of January 1, 2010; US Census Bureau 2022
[iii] U.S. Bureau of Labor Statistics March 2025
[iv] OpenStreetMap 2025; LightCast
[v] CareCOMPASS Louisiana
[vi] America's Health Rankings 2023 Annual Report. https://assets.americashealthrankings.org/allstatesummaries-ahr23.pdf
[vii] 2022 PLACES. Centers for Disease Control and Prevention., National Program of Cancer Registries and Surveillance, Epidemiology, and End Results SEER*Stat Database - United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. Based on the 2023 submission.", Rural parish definition as defined by HRSA
[viii] America's Health Rankings 2023 Annual Report
[ix] Q2 2025 CMS Provider of Services file (Critical Access Hospitals, Rural Emergency Hospitals, Rural Health Clinics, CMHCs, other rural hospitals), HCRIS 2023 CMS Hospital Cost Reports (SCHs, MDHs, LDVs), HRSA zip code-level rural designation (CCBHCs, OTPs, other rural hospitals), HRSA Health Centers and Look-Alikes (FQHCs & Sec 330 Grantees), SAMHSA (CCBHCs, OTPs), IPPS FY2026 Final Rule (other rural hospitals)
[x] OpenStreetMap 2025; LightCast
[xi] Lightcast, HRSA, U.S. Census
[xii] MACPAC March 2024 Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States, Table 3a-4
[xiii] CMS Provider of Services (POS) file, hospital & non-hospital facilities, Q2 2025; Hospital Cost Report Information System (HCRIS) – Including all hospitals in dataset inclusive of all program termination types: active provider, Other - provider status change, etc. as of Q2 2025
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[xv] Louisiana SNAP Food Restriction Waiver, USDA, https://www.fns.usda.gov/snap/waivers/foodrestriction/louisiana
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