

# NEW YORK STATE RURAL HEALTH TRANSFORMATION PROGRAM APPLICATION

## PROJECT NARRATIVE

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# NEW YORK STATE’S RURAL HEALTH NEEDS AND TARGET POPULATION

## Rural Demographics

New York’s (NY) rural communities are home to about 2.1 million residents, representing 10.6% of the state's total population.<sup>i</sup> With an average population density of 72.87 people per square mile,<sup>ii</sup> a median income of \$67,882,<sup>iii</sup> and an average unemployment rate of 3.8%,<sup>iv</sup> these regions face persistent and well-documented health challenges that threaten both individual well-being and community vitality. Figure 1 below describes employment, education, and health insurance factors impacting NY’s rural population.

Socioeconomic Factor	Rural NY Experience
Employment <sup>v</sup>	The average unemployment rate is 3.8%. The top 5 employment sectors in rural NY are: Educational services, Health care and social assistance (28.9%), Retail trade (11.3%), Manufacturing (9.6%), Professional, Scientific, Management, and Administrative and Waste management services (9.0%), and Arts, Entertainment, Recreation, Accommodation and Food services (8.2%).
Educational Attainment <sup>vi</sup>	Among 18–24-year-olds, 11.3% lack a high school diploma, and only 9% of rural residents 18-24 hold bachelor’s degrees or higher. In the over 25 population, 34.1% have a high school diploma or equivalency, and only 14.1% hold a bachelor’s degree or higher.
Health Insurance <sup>vii</sup>	5% of the rural, noninstitutionalized population aged 19 – 64 is uninsured.

*Figure 1. NY Rural Health Socioeconomic Conditions*

## Health Outcomes

In developing NY’s Rural Health Transformation Program (RHTP) initiatives, a set of comprehensive health outcomes measures was reviewed to assess the unique challenges and needs of rural communities across the state (Figure 2). Per different data sources within the New York State Department of Health (DOH), these measures include rates of chronic conditions, child and maternal health outcomes, and indicators related to care coordination, follow-up after hospitalization, primary care access, and behavioral health. By evaluating these key factors, the initiatives support targeted improvements in health services and outcomes for rural residents.

Indicator <sup>viii</sup> (Sources otherwise noted)	Rural Counties	Non-Rural Counties
<b>Care Coordination</b>		
Potentially Preventable Emergency Department Visits Risk-Adjusted rate (PPV) (2022 Discharge) <sup>ix</sup>	20.90%	14.74%
Patients Receiving Follow-Up After Hospitalization for Mental Illness -7 Days <sup>x</sup> (2024)	52.7%	44.1%
<b>Primary Care %</b>		
Child and Adolescent Well-Care Visits (3-21yr) <sup>xi</sup>	71.3%	72.4%
Rate of Weight Assessment and Counseling for Children/Adolescents: Counseling for Nutrition (3-17 yr) <sup>xii</sup>	77.6%	79.1%
<b>Behavioral Health</b>		
Suicide mortality rate per 100,000 (2022)	12.8	7.8
Suicide mortality among youth, rate per 100,000 population aged 15-19 years (2020-2022)	7.1	4.1
Rate of Depression Screening and Follow-Up for Adolescents and Adults: Depression Screening – Electronic <sup>xiii</sup>	3.9%	7.8%
Overdose rate per 10,000 (2023)	23.5	22.0
Unique individuals enrolled in NY State Office of Addiction Services and Supports-certified substance use disorder treatment programs who reported heroin as a primary substance, crude rate per 100,000 population - Aged 12+ years (2023)	416.1	360.2
<b>Chronic Conditions</b>		
Percentage of individuals aged 45-75 who have had appropriate colorectal cancer screening (2024) <sup>xiv</sup>	60.1%	59.7%
Cardiovascular disease mortality rate per 100,000 (2022)	313.3	264.3
Cardiovascular disease premature death (aged 35-64 years) rate per 100,000 (2022)	133.1	105.1
Potentially preventable diabetes short-term complications hospitalization rate per 10,000 - Aged 18 years and older (2022)	7.3	6.8
Potentially preventable hypertension hospitalization rate per 10,000, aged 18+ (2022)	4.1	7.4
Public-school students with obese weight status	22.8%	18.6%
<b>Maternal &amp; Child Health</b>		
Infant mortality rate per 1,000 live births (2022)	5.4	4.0
Mortality rate per 1,000 live births - Neonatal (<28 days) (2022)	3.0	2.6
Women who report depression during pregnancy (2023)	17.0%	8.2%
Women who experienced depressive symptoms after giving birth (2023)	12.9%	10.4%
Women who report cigarette use in the last 3 months of pregnancy (2023)	10.9%	1.6%
Newborns with neonatal withdrawal symptoms and/or affected by maternal use of opioid or other substance (any diagnosis), crude rate per 1,000 newborn discharges (2022)	13.2	4.4

Figure 2: Comparison of Health Outcomes between Rural and Non-Rural Counties

**Health Care Access**

Transportation poses a significant barrier to health care access for rural residents. With only 0.6% of the rural workforce relying on public transportation between 2019 and 2023, and just 19.5% using alternate commuting methods such as carpooling, biking, walking, or telecommuting,<sup>xv</sup> many individuals face challenges reaching health care facilities. Limited or non-existent public transit options, combined with greater distances to hospitals or clinics, can delay preventive care and treatment, often resulting in poorer health outcomes for rural populations. These transportation

issues are further compounded for individuals with disabilities and those without access to a personal vehicle, making timely and regular health care even less attainable.

There are also significant gaps in access to the maternal health system of care in NY. In rural areas across the state, 47.6% of women live more than 30 minutes from a birthing hospital compared to 3.8% of women living in urban areas of NY.<sup>xvi</sup> Rural and underserved areas in NY continue to experience suboptimal outcomes in maternal and child health. Many communities face elevated risks of infant mortality and neonatal complications, such as neonatal withdrawal symptoms, affected by maternal use of opioids or other substances (13.2 per 1,000 newborn discharges).<sup>xvii</sup> Most striking, the rate of women who report depression during pregnancy is 17% in NY's rural counties, which is more than double the rate in the state's non-rural counties.<sup>xviii</sup> Contributing factors include disparities in access to prenatal care, socioeconomic inequities, and persistent gaps in mental health support for mothers and families.

Behavioral health risks in rural NY are higher compared to other areas of the state, with gaps observed in access to care and support services. The suicide rate in rural NY has increased by 83% since 2004, now double that of urban areas, with pronounced social isolation as a contributing factor.<sup>xix</sup> The 16 most rural counties in NY have 6.9 mental health practitioners per 10,000 people, which is less than half the statewide ratio of 16.1.<sup>xx</sup> Herkimer County, one of those 16 counties, has the lowest ratio at 2.5 mental health practitioners per 10,000 people.<sup>xxi</sup> Improving health in rural areas requires approaches that consider the distinct characteristics of these communities. Factors like low population density, extended travel times to population centers, limited public transportation, fewer health care providers, and lower broadband availability contribute to restricted access. Workforce shortages of health care professionals affect multiple fields and specialties, indicating a need for comprehensive solutions.

## **Rural Facility Financial Health**

Hospitals in rural communities often operate at lower occupancy rates and experience financial instability due to declining patient volumes, aging infrastructure, and reimbursement challenges. Per NY cost report data, rural hospitals in NY have an average government payer mix of 65.3%, and 9 rural hospitals have experienced negative operating margins for the past three consecutive years. These financial pressures can limit a hospital's ability to maintain critical services, invest in and maintain infrastructure, and recruit and retain qualified staff. As more rural facilities face mounting challenges, the risk of closure or service limitations increases, further jeopardizing access for rural residents and compounding disparities in health outcomes. Health Resources and Services Administration (HRSA) Data Explorer and Healthcare Cost Report Information System (HCRIS) and a current analysis by Stroudwater shows the current patient volumes for rural critical access hospitals (CAH), prospective payment system (PPS) hospitals, psychiatric hospitals, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Skilled Nursing Facilities (Figure 3).

In NY, there have been four rural hospital closures since 2005. While a relatively low number, rural hospitals have felt increasingly threatened with their financial viability given their aging infrastructure, workforce challenges exacerbated by the COVID-19 pandemic, and difficulty recruiting in specialty areas such as obstetrics and behavioral health.

Hospitals				
Volume Type	CAH	PPS	Psych	Total
Beds	416	2,868	108	3,392
Discharges	7,495	91,784	226	99,505
Labor & Delivery Days	N/A	4,112	N/A	4,112
Nursery Total Days	134	18,515	N/A	18,649
Swing Bed Days	45,456	7,178	N/A	52,634
Clinic Federally Qualified Health Centers (FQHC) and Rural Health Clinic (RHC)				
Volume Type	FQHC	Free Standing RHC	Provider-Based RHC	Total Visits
Visits	1,230,094	33,682	261,455	1,525,231
Skilled Nursing Facilities				
Volume Type	Free-Standing	Provider-Based	Total Days	
Days	3,602,719	577,327	4,180,046	

Figure 3: Utilization Levels and Patient Volumes at Rural Facilities<sup>xvii</sup>

### Target Populations and Geographic Areas

According to HRSA’s Federal Office of Rural Health Policy definition and including counties with 10% or more of the population in rural census tracts or with fewer than 200,000 residents, NY has identified 47 out of 62 counties that have been classified as rural for the purposes of this application. All of NY’s RHTP initiatives have been carefully designed to address the needs of the rural populations within the counties listed below.

**List of Counties with FIPS codes:** Allegany (36003), Broome (36007), Cattaraugus (36009), Cayuga (36011), Chautauqua (36013), Chemung (36015), Chenango (36017), Clinton (36019), Columbia (36012), Cortland (36023), Delaware (36025), Dutchess (36027), Essex (36031), Franklin (36033), Fulton (36035), Genesee (36037), Greene (36039), Hamilton (36041), Herkimer (36043), Jefferson (36045), Lewis (36049), Livingston (36051), Madison (36053), Montgomery (36057), Oneida (36065), Ontario (36069), Orange (36071), Orleans (36073), Oswego (36075), Otsego (36077), Putnam (36079), Rensselaer (36083), Schenectady (36093), Schoharie (36095), Schuyler (36097), Seneca (36099), St. Lawrence (36089), Steuben (36101), Sullivan (36105), Tioga (36107), Tompkins (36109), Ulster (36111), Warren (36113), Washington (36115), Wayne (36117), Wyoming (36121), Yates (36123).

## **RURAL HEALTH TRANSFORMATION PLAN: GOALS AND STRATEGIES**

NY envisions a rural health system that is resilient and sustainable—where every resident, regardless of geography, has timely access to high-quality, coordinated care. As such, NY’s RHTP is designed to address persistent disparities in rural health outcomes, workforce shortages, and infrastructure gaps by investing in innovative models, technology, and partnerships. Informed by input from nearly 170 stakeholder organizations and community partners, NY’s RHTP strategy seeks to improve health care access for rural patients and communities through a set of interrelated initiatives that strategically leverage local assets, regional partnerships, and statewide infrastructure. This proposal has the full support of the Commissioner of the NYS DOH and of Governor Hochul.

### **Improving Access and Outcomes**

As described in the “Proposed Initiatives and Use of Funds” section on page 18, NY’s RHTP initiatives are designed to address longstanding access barriers and transform care delivery across rural communities. NY’s RHTP is aligned with the Strategic Goals of the Notice of Funding Opportunity (NOFO) and aims to:

- **Expand access to primary and specialty care** by establishing collaborative networks anchored by hospitals, FQHCs, and essential providers, so that rural residents will experience “no wrong door” into the health care system. This will ensure timely triage, treatment, and navigation to appropriate care, reducing avoidable complications, and unnecessary emergency visits. Complementing this network will be investments and technical support for rural primary care practices, which will include assistance with obtaining and maintaining Patient-Centered Medical Home (PCMH) recognition and incorporating artificial-intelligence (AI) into core clinical and business operations. With strong evidence for PCMH’s role in improving access,

care coordination, and outcomes in rural settings, stabilizing and bolstering the primary care network will directly enhance the capacity of rural providers to meet community needs.

- **Improve health outcomes** with a focus on reducing rates of chronic disease, maternal and child health disparities, mental health crises, and preventable hospitalizations among rural residents. Enhanced care coordination and expanded telehealth services will support better management of conditions such as diabetes, heart disease, and behavioral health challenges. For example, EMS may utilize the telehealth platform to engage in NY’s treatment-in-place and transportation-to-alternative-destination programs. Learning collaboratives among rural primary care practices and their partners may include, but not be limited to, pediatric health, maternal health, behavioral health, geriatric health, nutrition education, oral health, and chronic disease management.
- **Strengthen the rural health workforce** by cultivating homegrown talent, expanding clinical rotations, and supporting employer-based training and recruitment pipelines. The implementation of the proposed remote learning platform for EMS ensures that qualified trainers are accessible to provide support for personnel in remote locations. NY’s RHTP will increase the availability of skilled providers for rural areas, helping to address specialty gaps and promote continuity of care.

### **Technology Use and Data Driven Solutions**

NY will harness data and technology to deliver high-quality health care services closer to rural patients’ homes through a multifaceted strategy. NY’s RHTP will emphasize deploying innovative digital health tools such as telehealth platforms, remote monitoring tools, and AI solutions. These technologies will streamline care delivery, enable remote consultations, and support data-driven decision-making, allowing rural providers to offer timely and integrated care without requiring patients to travel long distances. Additionally, NY will provide training and technical assistance to health care providers to ensure they are well-equipped to adopt and utilize these advanced

technologies. By integrating these solutions, NY aims to enhance patient outcomes and improve the overall efficiency of health care delivery in rural areas.

Additionally, NY's RHTP includes expanding remote monitoring capabilities and technological tools to allow primary care providers to electronically consult with specialists. This will reduce unnecessary referrals and support improved patient outcomes. The Statewide Health Information Network for NY (SHIN-NY) will be leveraged to enhance data exchange, real-time practitioner alerts, and population health tools, ensuring that rural providers can respond quickly to critical events and manage chronic conditions more effectively. Together, these efforts aim to create a resilient, technologically advanced rural health infrastructure across NY.

Evaluating the suitability of new technologies for rural providers and patients involves a comprehensive assessment of their specific needs and challenges. NY will fund projects and programs designed to test the effectiveness and usability of these technologies in real-world settings. Feedback from rural health care providers and patients will be crucial in this evaluation process. Furthermore, NY will analyze data on health outcomes, patient satisfaction, and cost-effectiveness to determine the impact of these technologies. These data will be leveraged to shape the future use of these technologies and the design and expansion of the overall program. For long-term sustainability, NY will develop a robust governance and project management structure, ensuring continuous support and maintenance of the adopted technologies. This includes investing in IT infrastructure, providing ongoing training, and fostering strategic partnerships with technology providers and other stakeholders over the 5 years of the program to ensure the technologies remain relevant and effective.

### **Partnerships**

NY's RHTP is designed to strengthen current collaborations and create new partnerships among health care institutions, community-based organizations, and workforce programs to improve rural

patients' access to health care services. The initiatives draw significantly on cross-continuum and multi-institutional partnerships to drive change at the community, county, regional, and state levels. New York proposes four major, complementary initiatives, each with subprojects that promote partnerships and support the state's overall transformation goals.

- 1) The *Rural Community Health Integration* initiative is fundamentally a formal partnership network that provides rural residents with a coordinated approach to health care. The networks will be anchored by traditional health care institutions such as hospitals, FQHCs, primary care and multi-specialty practices, sole community hospitals, rural emergency hospitals, and critical access hospitals. Early implementation of the initiative will draw on the existing infrastructure and capacity of anchor institutions to develop regional health networks, enhance coordination with community-based providers, integrating services and supporting needed community services such as EMS, and support the financial stability of struggling hospitals. The initiative will partner hospitals in-need with more stable hospitals or health systems, so that local care providers are proactively managing rural patients' access to services and supports. Partner organizations commit to supporting the network during and beyond the RHTP performance period, and the model will embed shared financial responsibility within the network.
- 2) The *Strengthening Rural Communities with Technology-Enhanced Primary Care (Strengthening Rural Communities)* initiative leverages formal and informal partnerships to accelerate rural primary care practices' adoption of PCMH recognition and utilization of advanced analytics to improve operational efficiency, quality, and financial sustainability. Key partnership components include formal cross-continuum care compacts that enable and incentivize co-management among primary care practices, hospitals, specialists, and patients. This proven-effective strategy is successful at managing chronic metabolic conditions and

behavioral health issues. Furthermore, developing collaboratives across rural NY will facilitate learning among practices and accelerate methods for risk identification and stratification, community-based collaboration, and remediating care gaps.

- 3) As part of the state’s long-term rural workforce strategy, the *Rural Roots: Building a Sustainable Rural Health care Workforce* initiative will expand and evolve partnerships among academic institutions, health care providers, Area Health Education Centers (AHEC), Boards of Cooperative Educational Services (BOCES), and Career and Technical Education (CTE) programs to support workforce development, training, and retention.
- 4) Additionally, NY’s *Investments in Technology Innovation and Cybersecurity Enhancements for Rural NY* initiative addresses the challenges of rural hospitals having outdated IT systems, limited access to telehealth, and insufficient cybersecurity measures that leave these hospitals vulnerable to operational disruptions and compliance challenges. Strategic efforts to partner health care facilities and practices with the SHIN-NY health information exchange, cybersecurity experts, and Artificial Intelligence-enablement are planned through this RHTP.

## **Workforce**

NY’s rural communities face a health care workforce crisis that demands urgent and transformative action. A recent report by the NYS Comptroller revealed that across 16 of NY’s most rural counties, the average number of primary care physicians is just 4 per 10,000 residents—less than half the statewide ratio of 8.1 and far below the national average of 8.4. The report also noted that pediatricians are even scarcer, with only 0.5 per 10,000 people compared to 2.8 statewide, and 3 of the 16 counties have no pediatricians at all. The shortage of obstetricians and gynecologists (OB-GYNs) is equally dire, with a ratio of 0.4 per 10,000—meaning some counties have no OB-GYNs, forcing pregnant individuals to travel long distances or rely on emergency rooms for care.

Mental health provider shortages are the most severe: all 16 counties in the report are federally designated as Health Professional Shortage Areas for mental health.<sup>xxiii</sup>

These workforce gaps translate directly into poorer health access and outcomes. Rural New Yorkers experience higher rates of chronic disease, preventable hospitalizations, and maternal and infant mortality. Economic hardships, limited transportation, and outdated infrastructure further compound these disparities, leaving communities without reliable care. Without bold investment, these trends will worsen, jeopardizing the health and well-being of NY's rural population.

NY considers the RHTP a critical opportunity to reverse these trends, strengthen the health care workforce, and ensure every rural resident has access to high-quality, sustainable care. As such, one of NY's signature initiatives for the RHTP is the *Rural Roots: Building a Sustainable Rural Health care Workforce (Rural Roots)* initiative. As described further on page 29, the *Rural Roots* initiative is a comprehensive strategy to recruit and train more practitioners for rural areas by combining planning, targeted education, and innovative support. NY's RHTP will use a data-driven approach to identify local specialty gaps, invest in early career exposure for students, support enhanced clinical rotations, strengthen employer-based training programs, and expand EMS education through new remote supported training technologies. The initiative will also establish a self-sustaining recruitment-to-service pipeline with practices contributing revenue to support future trainees. Through these interconnected methods, NY aims to create a resilient rural health care workforce that meets immediate needs and builds long-term capacity.

### **Cause Identification and Financial Solvency Strategies: Risks Facing Rural Hospitals**

Hospitals in rural NY are at risk of service reduction or closure due to several interrelated factors including workforce shortages, a high public payer mix, quality challenges, outdated infrastructure and technology, and fragmented service networks and care continuation.

- **Workforce Shortages:** Rural hospitals face persistent difficulties in recruiting and retaining clinical staff, including nurses, behavioral health professionals, and specialty providers, which limit hospitals' ability to maintain essential services. These shortages are exacerbated by geographic isolation, limited training opportunities, and competition with urban facilities. As a result, rural hospitals must often resort to part-time (or per diem), locums, or contract clinical staffing, which comes at a price premium. In NY, from 2019 to 2024, hospital labor expenses increased by nearly 40% overall and contract labor costs doubled.<sup>xxiv</sup>
- **High Public Payer Mix and Uncompensated Care:** Hospitals in rural communities often serve populations with a higher proportion of Medicaid, Medicare, or uninsured patients. A 2020 Health Affairs study by Bai et al. found stark differences in margins based on payer mix where rural hospitals with a higher share of private insurance and higher negotiated prices had significantly better profit margins than those reliant on government payers.<sup>xxv</sup> A lower payer mix leads to reduced reimbursement rates, higher levels of uncompensated care, and reimbursement models that may not adequately represent the actual cost of service delivery. According to the Rural Policy Research Institute, rural hospitals often have limited ability to cross-subsidize money-losing services such as emergency and obstetric services because of their payer mix and thin margins.<sup>xxvi</sup> These factors, in combination with low patient volumes, lead to financial instability that can force reductions in service lines or facility closures.
- **Quality Challenges:** The lower patient volumes often experienced by rural hospitals are associated with difficulties in maintaining high-quality care, meeting accreditation standards, and supporting robust care coordination. For example, an analysis by the University of Washington's Rural Health Research Center found that Medicare beneficiaries discharged from rural hospitals were significantly less likely to have timely post-hospitalization follow-up visits,

compared to those from urban facilities. Lack of robust care management can lead to higher emergency department use and readmissions in rural regions, as minor issues go unmanaged until they become serious.<sup>xxvii</sup>

- **Fragmented Service Networks:** Relatedly, the lack of integration or a lack of access to broader health and social care networks can result in inefficient care transitions,<sup>xxviii</sup> limited access to specialty services,<sup>xxix</sup> and missed opportunities for preventive care and chronic disease management. Even in areas with a hospital, fragmentation can cause preventive care to slip through the cracks, as rural patients often do not get consistent reminders or care navigation that integrated health systems provide.<sup>xxx</sup>
- **Infrastructure and Technology Gaps:** Many rural hospitals have outdated IT systems, limited access to telehealth, and insufficient cybersecurity measures that leave these hospitals vulnerable to operational disruptions and compliance challenges. A recent 2025 study by Anzalone et al. showed that in the outpatient realm, rural clinicians had significantly lower Promoting Interoperability scores than urban clinicians, highlighting ongoing gaps in effective use of health IT. In addition, 24.6% of rural hospitals still had less-than-basic EHR functionality, versus only ~15% of urban hospitals – a gap reflecting resource limitations and poor broadband connectivity in some areas.<sup>xxxi</sup> Such IT shortcomings translate to inefficiencies, potential errors in documentation, and difficulty engaging in modern quality improvement programs that rely on electronic data. These gaps hinder care coordination, data sharing, and the adoption of innovative care models.

These factors contribute to a cycle of declining revenue, high fixed and variable costs, workforce shortages, and reduced service availability resulting in negative operating margins that perennially place rural hospitals at heightened risk of reducing service lines or closure altogether.<sup>xxxii</sup>

## **Strategies to Address Service Reductions and Closure**

NY's RHTP proposes a multi-pronged approach to mitigate risks, bolster rural hospitals' sustainability, and avert further closures. The state's complementary initiatives will enable hospitals to make vital investments in technology, cross-continuum partnerships, care model transformation, and workforce that will lower costs, improve quality, and yield shared savings.

### ***Workforce Development and Retention***

Due to ongoing labor shortages and labor cost increases that have consistently outpaced inflation since 2019, NY's RHTP workforce plan will develop a comprehensive long-term strategy aimed at alleviating shortages of essential clinicians. As described in detail in the *Rural Roots* initiative on page 29, NY will implement early career exposure programs, enhanced clinical rotations, and employer-based training to cultivate local talent in rural areas. Recruitment-to-service pipelines with multi-year commitments will foster long-term staffing stability. This will, in turn, enable hospitals to develop a stable, local workforce, removing the need for expensive per diem clinicians. The two care transformation initiatives, *Strengthening Rural Communities* (described in detail on page 23) and *Rural Community Health Integration* (described in detail on page 18), are designed to expand care access and coordination among providers across the continuum.

The *Rural Community Health Integration* initiative will develop networks that include rural hospitals, FQHCs, Certified Community Behavioral Health Clinics (CCBHCs), primary care practices, non-primary outpatient providers, including EMS providers, specialty hospitals, and community service providers. Hospitals' central role in these networks will enable better and more coordinated access to the range of care that will keep rural New Yorkers healthier. Additionally, shared savings resulting from reduced acute care will be allocated strategically among network partners to promote the long-term financial stability and sustainability of the entire network.

The *Strengthening Rural Communities* initiative will expand and innovate upon the high-quality PCMH model in rural settings. A strengthened primary care environment enables hospitals to focus on serving higher-acuity needs without having to staff expensive emergency departments to serve non-acute patient volume. Further, by shifting care upstream to the primary care setting, rural hospitals can reduce uncompensated care.<sup>xxxiii</sup>

### ***Technology and Cybersecurity Investments***

NY will strategically invest in cybersecurity upgrades and develop regional strategies for compliance, risk-management, and preparedness to strengthen rural health facilities. As described in more detail on page 36, NY will fund digital health tools and telehealth platforms, such as the SHIN-NY, to promote greater care coordination, expand service offerings, and increase patient access. By pooling resources and leveraging shared infrastructure, NY aims to enhance service delivery, support the health care workforce, and respond to outbreaks in real time, while strengthening care delivery across the state’s most remote areas.

### **Legislative or Regulatory Action**

NY acknowledges the impact that state policies have on health care access, quality, and affordability in rural areas. NY is pleased to report ongoing advancements across multiple areas since the publication date of some of the external data sources CMS cited in the NOFO. On page 16 of “Other Supporting Documentation” please find a synopsis of NY’s current state policies for each of the eight state policy factors identified. In particular, please see updates for C.3 Certificate of Need (CON) and D.3 Scope of Practice.

### **OTHER REQUIRED INFORMATION**

NY has closely reviewed the data and sources provided in the RHTP NOFO (CMS-RHT-26-001) Table 4 “Data Source Definitions and Sources” and confirms that most of the data is sourced from

recent reporting and accurately reflects NY. As requested, NY provides the following updates for current state policies, Factor A.2, Factor A.7, and Factor F.2.

**State Policies:** Please refer to the NY State Policy table on page 16 of “Other Supporting Documentation” for the current state policies as related to the State Policy Actions Factor.

**Factor A.2: Certified Community Behavioral Health Clinics (CCBHCs):** Please see page 10 of “Other Supporting Documentation” for the full listing of CCBHCs, including the address of every active site of care in NY as of September 1, 2025.

**Factor A.7: Disproportionate Share Hospital (DSH) Payment:** Based on the most recently submitted and finalized 2021 CMS DSH Audit, 156 of the 162 hospitals (96.3%) in NY received DSH payments. Six hospitals did not receive payments because they either chose not to receive DSH or did not report any uncompensated care costs.

**Factor F.2: Transformed Medicaid Statistical Information System (T-MSIS) Data:** As of the August 2025 reporting month, NY data meets the Critical-Priority criterion and Expenditures data content category. NY is 2% below the  $\geq 99\%$  target for High-Priority criterion with 445 out of 458 high-priority checks meeting CMS expectations. NY is actively addressing the CMS identified data quality associated with the high-priority Outcomes Based Assessment compliance criteria to meet blue status. Closing 8 out of 13 issues will enable the state to achieve blue status, which is the highest level of compliance, by December of 2025.

## **PROPOSED INITIATIVES AND USE OF FUNDS**

### **Initiative 1: Rural Community Health Integration**

**Description:** The *Rural Community Health Integration* initiative is designed to address the unique challenges faced by rural communities in NY by strengthening the rural health safety net. The initiative assists rural hospitals and community providers in building or growing integrated health networks to enhance health care delivery, coordination, and outcomes in rural areas while increasing the financial sustainability of the rural health network by encouraging collaborative partnerships with other health care organizations.

Rural hospitals will collaborate with health care organizations to jointly apply for funding and technical support, based on eligibility criteria consistent with the NOFO and state law. The goal is to deliver health care services that address the basic needs of rural residents, including access to quality medical, maternal health, and behavioral health care, while also establishing a path toward financial sustainability for participating facilities. Each application will include an anchor institution and partner organizations. Anchor institutions are defined as those which possess strong institutional capacity, deep community ties, and a record of commitment to serving their constituents. Examples of anchor institutions include but are not limited to: hospitals including sole community hospitals, rural emergency hospitals, critical access hospitals, primary care or multi-specialty practices, FQHCs, Independent Practice Associations, participants in the Medicare Shared Savings Program, CCBHCs, EMS providers, and Managed Care Organizations. While the anchor applicants may be any of these organizations, an application must include a rural safety net hospital partner to ensure that patient care is well coordinated and that there is a path to improve the financial sustainability of the safety network, including the hospital.

Crucially, the *Rural Community Health Integration* initiative will establish new partnerships that allow organizations to act collectively while maintaining local autonomy. Applicants may request modest operating and/or capital funding (within the limitations of the NOFO) and may request certain state regulations be waived for the life of the project to support their proposals. Over five years, the initiative will allow for strategic planning of health care services to address community needs, balance patient volumes, and ensure long-term sustainability.

Organizations will jointly apply for funding based on eligibility criteria set forth in the NOFO, with the goal to keep care local unless a higher level of care is medically indicated. NY will work with applicants to help meet eligibility criteria through a rolling enrollment period over the 5 years of the cooperative agreement. Applications that promote partnership and are determined from scoring criteria to most likely sustain obstetrical care, maternal-child health care, and behavioral health care integration will be prioritized.

**Potential projects eligible for funding include:**

- Delivering technical and financial support for anchor institutions and partners to ensure access to comprehensive, longitudinal care and services.
- Providing seed funding to develop future-state solutions and mining local innovations for scalable best practices, and leveraging and expanding workforce programs, particularly for maternal health, pediatric care, and behavioral health care, and EMS.
- Supporting community providers in adopting care coordination and management information from the SHIN-NY, including training for primary care practitioners, post-acute rehabilitation providers, and skilled nursing facilities on using these resources to guide health interventions, while also working to enhance data accessibility given across providers' varying levels of technical capacity. This proactive approach will strengthen coordination, reduce preventable

hospitalizations and readmissions, ease transitions in care, and improve overall health outcomes for residents in rural communities.

- Working with community providers to utilize local capacity, including referrals to NY's 1115 Waiver Social Care Networks, for services such as food, transportation, and socialization.
- Developing and implementing a range of initiatives to maximize the contributions that EMS professionals can offer to rural health care partners.
- Engaging with rural school administrators to provide information on the benefits of School-Based Health Centers for communities and identifying the need for additional centers. Technical assistance will be provided to interested schools for workforce recruitment and retention strategies, the establishment of data collection capabilities, and the development of School-Based Health Center policies and procedures.
- Encouraging continuous quality improvement for rural health partnerships to develop deep understanding of their communities and deploy tailored education to address unmet needs.

The initiative is structured to be transformative relative to the current baseline, aiming to create a resilient, community-anchored rural health system that can sustain improvements and adapt to future medical and technological needs. Safety net hospitals and partnering community providers will be expected to demonstrate reduced funding dependence on the state after the five-year cooperative agreement ends.

**Main Strategic Goal:** This initiative aligns with the **Sustainable Access** strategic goal by building collaborative networks with hospitals, FQHCs, and essential providers to ensure a coordinated care

approach to health care. It promotes timely care for rural residents while helping facilities become efficient, sustainable access points through regional partnerships.

**Use of Funds:** A, D, F, G, H, I, J, K

**Technical Score Factors:** B.1, C.1, C.2, E.1, F.1, F.2

**Key Stakeholders:** Safety Net Hospitals and other hospitals in the 47-county rural region, other partnering hospitals and health systems, FQHCs, rural health clinics, primary care practices, behavioral health/substance use disorder providers, EMS agencies, social service agencies, local government agencies and departments of health, community-based organizations, NY State DOH, – including the State Office of Rural Health, Office of Mental Health, Office of Health Insurance Programs, Office of Addiction Services and Supports, and DOH Cyber Preparedness – and external partners (IT vendors, telehealth platforms, academic institutions).

**Outcomes:** The objective of the *Rural Community Health Integration* initiative is to establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health care and social needs. Below please find the key results and measurable outcomes the state will use to monitor the success of this initiative.

<b>Key Result 1: Increased access to the right care at the right time</b>				
<b>Measure</b>	<b>Definition</b>	<b>Baseline</b>	<b>Target</b>	<b>Relation to Initiative</b>
<b>Potentially Preventable Emergency Visits (PPV)</b>  *County-Level	The rate of emergency department visits defined as PPV per 100 people.  Denominator population base by county was identified through the use of proprietary Claritas files	20.90%	By Year 3, 25% gap closure between the rural rate and the non-rural rate.  By Year 5, 50% gap closure between the rural rate and the non-rural rate.  Please note: this measure will also be used to monitor the	PPVs are emergency visits for ambulatory sensitive conditions which should be able to be reduced/averted with adequate patient monitoring and follow-up. In general, the occurrence of high rates of PPVs represents a failure of the ambulatory care provided to the patient. In addition, when a PPV occurs shortly following a hospitalization, the PPV may

			effectiveness of the <i>Strengthening Rural Communities</i> initiative. As such, the target for this measure is more ambitious.	be the result of actions taken or omitted during the hospital stay, such as incomplete treatment or poor care of the underlying problem and/or poor coordination with the primary care or specialist physician.  A core measure to monitor the effectiveness of the hub's ability to avoid unnecessary acute care.
<b>Key Result 2: Decreased readmissions due to high quality discharge planning and post-acute supports</b>				
<b>Hospital-Wide All-Cause Unplanned Readmission</b>	A hospital-level, risk-standardized readmission rate of unplanned, all-cause readmission within 30 days of discharge from an index admission with an eligible condition or procedure.	0 hospitals reporting this measure	By Year 3, 50% sole community and critical access hospitals will be reporting this measure  By Year 5, 100% sole community and critical access hospitals will be reporting this measure	The measure is designed to capture unplanned readmissions that arise from acute clinical events requiring urgent rehospitalization within 30 days of discharge. While some readmissions are unavoidable due to worsening illness, appropriate transitional care and clear, monitored discharge procedures can reduce the risk of readmission.  Quality measure connected to the effectiveness of acute and post-acute care provided through network partners.
<b>Key Result 3: Increased preventative care spanning primary and specialty care</b>				
<b>Colorectal Screening</b>	Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer.	60.1%	By Year 3, 25% gap closure to the <a href="#">2030 Healthy People</a> goal  By Year 5, 50% gap closure to the <a href="#">2030 Health People</a> goal  Please note: this measure will also be used to monitor the effectiveness of the <i>Strengthening Rural Communities</i> initiative, but will be measured at the primary care practice level.	Screening for colorectal cancer is important for rural health as rural populations have higher rates of colorectal cancer incidence <sup>xxxiv</sup> and mortality. Rural populations face unique challenges such as limited access to providers and transportation.

Key Result 4: Successful establishment of school-based health centers (SBHCs)				
<b>Establishment of school-based health centers</b>	The number of schools engaged and newly established SBHCs	Baseline to be set in Year 1	Target number of schools engaged by Year 3  Target number of new SBHCs established by Year 5	This metric reflects access expansion to primary care for children and adolescents in rural communities. By tracking school engagement and SBHC establishment, NY can gauge the initiative's effectiveness in reaching underserved populations, improving comprehensive physical exam rates, and facilitating early intervention through screenings and care coordination. These measures are indicators of building sustainable, primary care infrastructure and ensuring rural students receive the preventive and ongoing health services they need to thrive.

**Impacted Counties:** This initiative will include all 47 rural counties, as listed on page 6.

**Estimated Required Funding:** Of the hypothetical \$200M annual award, this initiative will be approximately \$71-80M/year. Please see Budget Narrative for more information.

**Initiative 2: Strengthening Rural Communities with Technology-Enhanced Primary Care**

**Description:** The *Strengthening Rural Communities with Technology-Enhanced Primary Care (Strengthening Rural Communities)* initiative is designed to leverage and expand historic investments in primary care in rural NY. The initiative aims to expand the number of Patient-Centered Medical Home (PCMH)-recognized providers, no matter where the provider is in the recognition process at baseline. The PCMH model is evidence-based and has shown particular value in rural health care settings. Rural primary care practices that adopted PCMH have achieved outcomes comparable to their urban counterparts, including reduced hospital/emergency department use and improved quality indicators.<sup>xxxv</sup> A standout example is the Adirondack Medical Home Demonstration in upstate NY (a largely rural region): after becoming a PCMH, it

produced lower total cost per patient (i.e., downward trend in per member per month spending) and raised patient satisfaction from 76% to 81% in two years.<sup>xxxvi</sup> It also boosted primary care capacity locally, attracting 16 new physicians and enabling hiring of care managers – a critical, positive impact given rural provider shortages. Patients feel they get better access to care at PCMH practices versus non-PCMH practices.

Approximately one third of rural primary care practices in NY (617 of 2,295) are recognized as PCMHs. Despite this progress, there has been a decline in the overall number of rural and rural-serving primary care practices, including those with PCMH recognition. Rural community providers face mounting challenges as they manage increasingly large, clinically heterogeneous, and often socially isolated patient panels. This trend places additional strain on the health care infrastructure in rural areas and complicates efforts to deliver comprehensive, coordinated care.

Innovative advancements in Artificial Intelligence (AI), telehealth, and supportive state-level policies that promote distance-based care are creating significant opportunities for rural primary care practices. These developments have the potential to transform the delivery of value-based care and alter the trajectory of rural health care in a positive direction.

Given their constrained financial position, primary care practices often lack the capital to fully accommodate patients with accessibility challenges. With the support of the RHTP, the *Strengthening Rural Communities* initiative will also make targeted grants to primary care practices to assist with modest capital improvements and staff training on best care practices for patients with accessibility issues. These critical investments will help ensure all practices are Americans with Disabilities Act-compliant and decrease barriers to care. Accordingly, through the *Strengthening Rural Communities* initiative, the state proposes an ambitious, but practical approach to expand access and accessibility to high-quality sustainable rural primary care.

**Cohort 1 will be dedicated to guiding non-PCMH primary care practices onto the pathway to PCMH recognition.** Implementing PCMH in rural settings presents distinct challenges where smaller clinics often lack dedicated care coordination staff and robust health IT infrastructure, while geographic isolation further complicates the coordination that is central to the PCMH model. Overcoming these barriers requires specialized technical expertise and the involvement of a broad array of care providers and partners to establish effective, team-based care.

PCMH recognition offers rural primary care practices a framework for delivering high quality care and securing reimbursement streams. The state will provide technical assistance, support technology adoption, and promote workforce development. NY will also develop collaboratives to facilitate and accelerate education among primary care practices about topics such as risk identification and stratification, community-based networking, and remediating care gaps.

**Cohort 2 will push the frontier of existing PCMH primary care practices.** Existing PCMH practices have noted the high costs of operating in the current reimbursement environment, as well as insurmountable technical challenges and costs to integrate next-gen technologies such as AI and integrated electronic medical record systems. AI will enable chart note scanning to automate gap identification and documentation; chart preparation for every visit with a concise checklist; and submission of quality data. Technical consultants will be deployed to implement the technology and processes necessary to establish full functionality. In addition to receiving support from technical consultants, Cohort 2 PCMH practices will serve as champions, providing peer mentorship and practical guidance to help Cohort 1 practices successfully implement the technology-enabled PCMH model.

**Accordingly, for Cohort 2 practices, key activities include:**

- Deploying vendor-neutral AI and technical assistance to train PCMH practices to automate PCMH administration, communicate with patients between visits, and add 24x7 AI-supported triage with nurse escalation and guideline-based decision support at the point of care.
- Accelerating the adoption of virtual communications and telehealth, with a focus on ensuring access to provider-to-provider and patient-to-provider maternal health, behavioral health, and pediatric health care consults.
- Supporting the development of cross-continuum care compacts and integrated care to enable co-management among primary care practices, hospitals, specialists, and patients – a proven-effective strategy for managing chronic metabolic conditions and behavioral health issues.<sup>xxxvii</sup>
- Encouraging primary care practices to use community health workers and Social Care Networks, as authorized and supported by the state’s 1115 waiver, so that patients’ social needs can be addressed through lower cost, community-based resources. This approach will not only improve patients’ linkages to care but will also alleviate primary care practices’ burden from doing so.
- Advancing primary care practices’ uptake of encounter alert services provided by the SHIN-NY and training primary care practices to use the system and the proposed Care Coordination Management Hub that will be configured specifically for rural providers.

**Cohort 3 will help preserve and maintain PCMH recognition in rural primary care settings.**

Some rural primary care providers have lost their PCMH recognition due to a range of challenges, including workforce shortages, limited administrative capacity, insufficient data infrastructure, and the financial burden of maintaining compliance with evolving recognition standards. These barriers are often exacerbated by geographic isolation, lower patient volumes, and constrained

operating budgets, making it difficult for rural practices to sustain the documentation, quality improvement activities, and care coordination required for continued PCMH recognition.

To address these challenges and support sustainability, Cohort 3 Providers will receive targeted technical assistance tailored to the unique needs of each rural provider. This support may include subsidized access to health information technology systems, training on quality reporting and care coordination workflows, and peer learning collaboratives to share best practices. By investing in these supports, the state can help ensure that rural primary care practices not only regain but also maintain PCMH recognition, thereby strengthening the foundation for high-quality, patient-centered care in underserved communities.

By leveraging technology and a unified understanding of a technology-enabled PCMH model, practices will be able to collaborate more effectively and foster a robust data-driven rural health system. This approach empowers providers to deliver timely, high-quality care in maternal health, behavioral health, and pediatrics. As primary care providers manage increasingly complex patient panels, advanced AI-driven case analysis will enhance population-level risk assessment and expedite referrals to specialists, ensuring that patients with the greatest clinical and social needs receive appropriate care before their conditions worsen, while simultaneously alleviating precious time at primary care practices.

**Main Strategic Goal:** This initiative aligns with the **Make Rural America Healthy Again** strategic goal by expanding rural providers' capacity to deliver evidence-based models of preventive and chronic care.

**Use of Funds:** A, B, C, D, E, F, G, H, J, K

**Technical Score Factors:** B.1, C.1, D.1, E.1, F.1, F.2, F.3

**Key Stakeholders:** PCMH Primary Care Practices, Non-PCMH Primary Care Practices, Quality Improvement Advisors, National Committee for Quality Assurance, Academies of Medicine (various), Medical Society of the State of NY, American College of Physicians, American Academy of Family Practitioners, Commercial Payer Liaisons, NY State DOH – including the State Office of Rural Health, Office of Mental Health, Office of Health Insurance Programs, Office of Addiction Services and Supports, and DOH Cyber Preparedness.

**Outcomes:** The objective of the *Strengthening Rural Communities* initiative is to improve rural patient access to and utilization of high-quality primary care. Below please find the key results and measurable outcomes the state will use to monitor the success of this initiative.

<b>Key Result 1: Increased access to the right care at the right time</b>				
<b>Measure</b>	<b>Definition</b>	<b>Baseline</b>	<b>Target</b>	<b>Relation to Initiative</b>
<b>Potentially Preventable Emergency Visits (PPV)</b>  *County-Level	The rate of emergency department visits defined as PPV per 100 people. Denominator population base by county was identified through the use of proprietary Claritas files	20.90%	By Year 3, 25% gap closure between the rural rate and the non-rural rate.  By Year 5, 50% gap closure between the rural rate and the non-rural rate.  Please note: this measure will also be used to monitor the effectiveness of the <i>Rural Health Community Integration</i> initiative. As such, the target for this measure is more ambitious.	Please see description of PPV measure in Key Result #1 the <i>Rural Community Health Integration</i> initiative.  Patient connection to a PCMH has been shown to avert unnecessary utilization of the ED.
<b>Key Result 2: Increased number of PCMH-recognized primary care practices</b>				
<b>PCMH Recognition Gains</b>	Primary care practices that obtain PCMH recognition for the first time or obtain recognition after having lost it prior to the RHTP	1600 rural primary care practices that do not have PCMH recognition	By Year 3, onboarding at least 250 PCMH practices  By Year 5, onboarding at least 600 PCMH practices	Tracking the number of primary care practices that attain PCMH recognition or recertify after previously losing recognition, directly supports the initiative by measuring progress in expanding access to high-quality, patient-centered care.

Key Result 3: Improved chronic and preventative care				
<b>Colorectal Screening</b>	Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer	Baseline to be set at the primary care practice level by Year 2	Target to be set by Year 2  Please note: this measure will be used to monitor the effectiveness of the <i>Rural Community Health Integration</i> initiative but will be measured at the county level.	PCMH recognition is linked to better chronic condition management and preventative care. Screening for colorectal cancer is important as rural populations have higher rates of colorectal cancer and mortality. <sup>xxxviii</sup>
<b>Diabetes HbA1C Poor Control (&gt;9%)</b>	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Lower rate is better.	Baseline to be set at the primary care practice level by Year 2	Target(s) to be set by Year 2	PCMH recognition is linked with better chronic condition management and preventative care.

**Impacted Counties:** This initiative will include all 47 rural counties, as listed on page 6.

**Estimated Required Funding:** Of the hypothetical \$200M annual award, this initiative will be approximately \$30-\$40M/year. Please see Budget Narrative for more information.

**Initiative 3: Rural Roots: Building a Sustainable Rural Health care Workforce**

**Description:** *Rural Roots* is a comprehensive program designed to solve health care staffing shortages in rural NY communities. *Rural Roots* will implement connected strategies: growing local talent by introducing students in grades 6-12 to health care careers and expanding training opportunities at rural facilities, supporting workplace training programs and EMS education so that health care workers can build their skills and advance their careers without leaving their communities, and recruiting health professionals to rural areas through multi-year service commitments funded partly by the practices that benefit from these new providers. The program will build a data system that tracks health care workforce trends, needed specialties, and existing gaps in each rural county. Together, these strategies will amplify a positive cycle that addresses

both immediate staffing shortages and builds long-term workforce capacity, ensuring rural communities have ongoing access to quality health care that meets their specific needs.

### ***Surveying the Field: Workforce Planning***

Health care specialty needs differ widely among rural communities due to their distinct demographics, geography, and health issues. Effective solutions require ongoing data monitoring and adaptable strategies tailored to each community. Specialty gaps across rural communities most commonly occur in nursing, behavioral health, maternal care, oral health, and allied health professions. To guide the *Rural Roots* strategy with actionable data, the initiative will collect comprehensive rural health workforce data. This approach will ensure that *Rural Roots* expansion efforts are closely aligned with the realities of the unique priorities of each rural locality.

### ***Nurture Home Grown Talent and Attract Aspiring Health Care Professionals***

*Rural Roots* will address rural workforce shortages through a dual approach: nurturing local students from grades 6-12 with early career exposure and attracting trainees from across the state with enhanced rotations and training. *Rural Roots* will leverage the existing NYS Area Health Education Center's infrastructure and partnerships to offer comprehensive exposure programs for local 6-12 students and expand rotation sites for college and graduate students at targeted rural hospitals, FQHCs, and rural community-based organizations.

*Rural Roots* will emphasize specialty programming that meets rural communities' unique workforce needs including but not limited to medical, nursing, behavioral health, maternal care, oral health, and allied health professions. For example, *Rural Roots* will introduce students in grades 6-12 to addiction medicine and behavioral health careers, while building their understanding of substance use disorders through age-appropriate education, career exploration, and meaningful interactions with health care professionals. To address the maternal care deserts

prevalent in rural counties, *Rural Roots* will offer advanced training in pregnancy support, lactation counseling, and simulation-based obstetrics training for EMTs, nursing and medical students. *Rural Roots* programming will include housing assistance and community integration support to enable students to live, train, and experience rural culture.

***Rooted in Community: Strengthening Local Workforce Development***

*Rural Roots* is designed to reduce barriers to workforce growth in smaller towns and communities by supporting employer-based training programs that enable health care workers to build careers in NY, while ensuring rural populations have access to essential care. *Rural Roots* will address workforce shortages by supporting health care facilities including hospitals, diagnostic and treatment centers, skilled nursing facilities, and health systems in the creation or expansion of their workforce development initiatives. Such initiatives will help meet specific rural county health care demands in licensed or certified health care disciplines, from short-term certificate programs to long-term degree programs, including but not limited to nursing, behavioral health, allied health professions, and dentistry.

The *Rural Roots* initiative prioritizes building sustainable workforce pipelines by helping facilities establish self-reinforcing training ecosystems, creating a continuous cycle of development opportunities that facilities can maintain after initial grant funding concludes. Eligible funding will be based on the unique needs of participating facilities and may include, but not be limited to, tuition and related costs, license and certification fees, wage subsidies for workers engaging in professional development, equipment purchases that directly support expanded educational programming at rural facilities, and recruitment costs for both learners and educators. As the program demonstrates return on investment from such initiatives through reduced turnover and recruitment costs, facilities will be able to justify continued spending long after the grant ends.

### ***Lifeline Learning: Regional Remote Learning Hubs for Emergency Medical Services***

Building on *Rural Roots'* comprehensive workforce development framework, NY will develop Regional Remote Learning Hubs to address the critical shortage of EMTs and paramedics in rural communities by connecting students to accredited training institutions via synchronous, real-time, two-way video learning technology. This will allow busy volunteer and professional EMTs and paramedics to stay in their local region while receiving appropriate training to care for their communities. Each Learning Hub will host NYS Certified Lab Instructors and Certified Instructor Coordinators to oversee practical skills training and ensure instructional standards. By embedding remote training sites in colleges, universities, and course sponsors, the initiative will create pathways for micro-credentialing and degree program alignment, supporting both immediate workforce needs and long-term career advancement. This approach directly complements *Rural Roots'* emphasis on employer-based training and community integration by reducing economic and travel barriers for aspiring EMS professionals, while strengthening partnerships between educational institutions and rural health care providers. The model will promote sustainability through integration with academic systems, existing EMS reimbursement mechanisms, and expanded instructor development pipelines—creating the same self-reinforcing training ecosystem that *Rural Roots* prioritizes across all health care disciplines.

### ***Rural Recruitment-to-Service Pipeline***

The Rural Recruitment-to-Service Pipeline is designed to strengthen the rural health care workforce by supporting medical, dental, and behavioral health students in underserved regions. Under this initiative, funding will be provided for up to two medical or dental students interested in rural primary care annually over four years in up to five regions statewide. Recipients will

commit to a five-year period of post-training service within the same region, directly addressing local workforce shortages and improving continuity of care.

To address the full spectrum of rural health care needs, the program will be structured to support not only medical students pursuing primary care but also dental and behavioral health students, ensuring that rural communities benefit from a range of health care professionals. Primary care providers such as FQHCs and rural health systems will engage with medical and dental professional schools. Practices that benefit from these recruitment efforts will be required to contribute 5–10% of the student-now-practitioner’s revenue to a dedicated fund. This fund will be earmarked for supporting future trainees, creating a self-sustaining financial model that maintains ongoing recruitment and training efforts even after initial federal funding concludes.

By requiring practices to invest in future workforce development, the pipeline will be able to foster long-term sustainability and continuous support for rural health professions. This strategy complements broader initiatives aimed at increasing retention, skill transfer, and workforce diversity in rural communities, ensuring that recruitment efforts translate into lasting improvements in access and quality of care.

**Main Strategic Goal:** This initiative aligns with the **Workforce Development** strategic goal with a data-driven approach to identify and remediate specific health workforce gaps. Targeted partnership among health care providers and workforce education partners supports a durable and long-term strategy to recruit and retain specific health provider-types.

**Use of Funds:** D, E, G, H, I, K

**Technical Score Factors:** B.1, B.2, C.1, C.2, D.1, F.2.

**Key Stakeholders:** Center for Health Workforce Studies at University at Albany, NY State DOH, – including the State Office of Rural Health, Office of Mental Health, Office of Health Insurance

Programs, Office of Addiction Services and Supports, and DOH Cyber Preparedness – the Area Health Education Centers System and programs, Boards of Cooperative Educational Services (BOCES), K-12 school districts and administrators, Career and Technical Education programs, medical schools, and health care providers and facilities – such as Article 28 hospitals, clinics, skilled nursing facilities, and Certified Community Behavioral Health Clinics, School-Based Mental Health Clinics, Emergency Medical Services providers, and Community Health Workers.

**Outcomes:** The objective of the *Rural Roots* initiative is to create a self-sustaining cycle of workforce development that addresses both immediate staffing needs and long-term capacity building, ensuring NY's rural communities have continuous access to high-quality health care services tailored to their regional circumstances. A component of the initiative is the development of a comprehensive rural health workforce data system for the state to track the supply, capacity, and distribution of rural health care professionals across specialties, while identifying demand-side challenges in recruitment and retention. As noted earlier in this section, this data system will provide a clear snapshot of workforce conditions and evaluate the progress and outcomes funded by the RHTP to better understand what strategies are effective and what challenges remain to build a sustainable rural health care workforce. Below please find the key results and measurable outcomes the state will use to monitor the success of this initiative.

<b>Key Result 1: Partnerships – Rural health care facilities and orgs. across target counties are actively engaged as partners to identify their workforce challenges/successes</b>				
<b>Measure</b>	<b>Definition</b>	<b>Baseline</b>	<b>Target</b>	<b>Relation to Initiative</b>
<b>Number of health care facilities and organizations actively serving as partners.</b>	Count of the health care facilities and organizations actively serving as partners through participation in regularly scheduled meetings and data collection activities.	0 – health care facilities and organizations actively serving as partners	Adding at least 10 active partners per year starting in Year 2	Broad county-level representation ensures workforce strategies

<b>Number of rural counties represented by active partner participation.</b>	Count of the rural counties represented by active partner participation.	0 – rural counties represented	Year 1: 10% of target counties  Year 3: 60% of target counties  Year 5: Maintain or expand to 75% of rural counties	address the unique demographic profiles, geographic characteristics, and specialty needs across the state. Established network allows for self-sustaining, information sharing and collaboration.
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**Key Result 2: Programs/Trainees – Activities will provide workforce training and development opportunities across rural counties.**

<b>Number of program participants.</b>	Year-over-year percentage increase in the cumulative # of unique individuals who have participated in the <i>Rural Roots</i> program since program inception, including: <ul style="list-style-type: none"> <li>• <b>Long-term participants</b> (e.g., medical students in 3-year rural rotations, nursing students in 1-year preceptorships)</li> <li>• <b>Short-term participants</b> (e.g. students attending workshops and health care career events)</li> </ul>	0 participants	Each active program demonstrates a minimum 15-20% year-over-year increase in enrollment	Directly measures the initiative's foundational goal of establishing workforce development opportunities in rural communities.
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<b>Number of rural counties hosting a <i>Rural Roots</i> key initiative</b>	Count of target rural counties that have at least one health care facility, educational institution, or community organization actively participating in any of the <i>Rural Roots</i> workforce development programs	0 counties	Year 1: 10% of target counties  Year 3: 60% of target counties  Year 5: Maintain or expand to 75% of rural counties	
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**Impacted Counties:** This initiative will include all 47 rural counties, as listed on page 6.

**Estimated Required Funding:** Of the hypothetical \$200M award, this initiative will be approximately \$13-14M per budget period. Please see Budget Narrative for more information.

**Initiative 4: Investments in Tech Innovation & Cybersecurity Enhancements for Rural NY**

**Description:** The *Investments in Technology Innovation and Cybersecurity Enhancements for Rural NY* initiative will employ a two-pronged approach to advance rural health care in NY by investing in both innovative technologies and robust cybersecurity measures. The first prong centers on deploying innovative digital health tools and platforms that streamline care delivery, enhance patient access, and support data-driven decision-making for providers. The second prong focuses on fortifying the cybersecurity posture of rural health care facilities through advanced endpoint protection, multi-factor authentication, and comprehensive staff training, ensuring patient data remains secure while aligning technology standards across regions.

***Investing in Innovation to Improve Rural Access to and Quality of Care***

Rural health care facilities that provide both acute and long-term care can greatly benefit from investments in technology and digital health tools. Equipping these facilities with modern digital tools will help providers deliver more efficient, reliable, and patient-centered care, even in geographically isolated communities. Upgrading technological infrastructure not only enhances care delivery and data management but also ensures rural health care systems are resilient against cyber threats, safeguarding sensitive patient information and maintaining public trust. This commitment to innovation empowers rural providers to meet evolving health care standards and better serve their communities, creating a more level health landscape across the state.

### *Expanding Access to Telehealth and Telepsychiatry*

Expanding the use of telehealth and telepsychiatry offers significant benefits for rural communities in NY by breaking down barriers to care that often exist due to geographic isolation and limited specialist availability. Through virtual visits, residents can access timely medical and behavioral health services without the need to travel long distances, improving convenience and continuity of care. Rural providers can also collaborate more easily with specialists and mental health professionals, ensuring comprehensive support for patients while addressing critical gaps in local resources. Greater utilization of these technologies can lead to improved health outcomes, reduced health care costs, and a more level distribution of care across underserved regions. Health care facilities looking to expand their telehealth capabilities in rural areas are able to apply for funds to support infrastructure and software upgrades to strengthen their telehealth offerings. EMS providers and schools are also eligible for funding under this initiative to build out the infrastructure required to develop robust telehealth and telepsychiatry services.

Specific funding will be made available to health care providers who partner with school districts to offer within-school telemedicine services, allowing students to have virtual urgent care visits with a medical provider from the school nurse's office. These partnerships will provide real-time medical evaluation and treatment for common ailments, such as colds, flu, minor infections, and minor injuries, allowing students to return to class more quickly. Parents can participate in virtual appointments, and services will be billed through the student's health insurance. There is currently one upstate medical center in NY that provides these services across seven rural school districts. Under this initiative, this technology will be expanded to additional school districts in rural areas. Additionally, EMS is eligible for funding to develop their infrastructure, protocols, and training to support treatment-in-place and transport-to-alternative-destination technology solutions. These

will enable more appropriate patient care, increase the financial sustainability of emergency services and decrease emergency room congestion.

### ***Deploying eConsult Hubs***

Implementation of an eConsult service, a virtual communication between a treating provider and a specialist who provides expert consultation, will enable a patient's primary care provider to consult electronically with specialists, such as psychiatrists, ensuring that the patient's needs are prioritized and addressed timely and by the right provider (specialist or primary care), thereby supporting patient care, safety, and outcomes. This solution may also include the exchange of images with tertiary providers, allowing for more informed care decisions. These benefits are especially important for providers in resource-challenged rural and underserved areas who struggle to access specialty care for their patients. eConsults save time and reduce unnecessary patient referrals, while simultaneously decreasing travel and costs for patients.

An eConsult platform will be added to the existing SHIN-NY, the statewide health information exchange that is part of NY's Medicaid Enterprise System and which has established connections between health care providers across the state. The infrastructure will be created to enable virtual consultation allowing clinicians to interact and inform care decisions in a timely and cost-effective manner, reducing travel and delays in care, and improving care outcomes. NY will also fund Learning and Diffusion Networks throughout the rural regions. Learning and Diffusion Networks will play a key role in recruiting rural providers and health systems that provide specialty expertise to participate in the platform solution.

Also under this initiative, one or more of the SHIN-NY's Qualified Entities, the state's regional health information exchanges, will provide technical expertise, assistance, and training to

providers using the platform with ongoing, hands-on implementation support customized to the specific needs of providers and patients in rural and underserved areas.

### ***Remote Monitoring Technology***

By integrating advanced, virtual monitoring to link rural providers with specialized clinical expertise and coordinated patient management, NY can supplement in-person provider monitoring to deliver timely interventions, reducing complications and unnecessary admissions and readmissions. This approach not only addresses immediate provider shortages but also strengthens the entire rural health care infrastructure, ensuring sustainable, high-quality care.

The state has an existing model with a provider in upstate NY, which offers real-time patient monitoring to bridge gaps in access common in rural settings and the expertise needed to address those gaps. By integrating virtual intensive care, medical-surgical support, and tele-sitter monitoring, the provider has enhanced patient safety, demonstrated measurable and improved health outcomes, and addressed critical workforce shortages. Building on the success of this model, this initiative will fund the expansion of remote monitoring services into other rural areas of NY, allowing other health systems and providers to purchase the tools they need (hardware, software, digital integration) to implement remote monitoring technologies.

### ***Providing Access to Timely Health Information***

Encounter alert services notify providers in real time when their patients experience critical medical events, enabling exchange of necessary information and more coordinated care during and after the event. This proactive approach helps further reduce preventable readmissions and improves overall health outcomes for patients in rural communities.

Under this initiative, the SHIN-NY will engage with practices and train providers to best utilize encounter alert data they currently receive to improve care coordination and transitions of care.

The initiative will also encourage nursing homes and sub-acute rehabilitation facilities to use encounter alerts, as this is where the largest gap in patient care coordination information currently exists. Under this initiative, NY will also expand the number and types of facilities connected to the information system, including nursing homes and sub-acute rehabilitation facilities where older patients are often lost to follow-up. Many of the remaining unaffiliated facilities have limited funding and are not part of a larger health system.

The SHIN-NY has also deployed a successful population health tool in Western NY. This population health tool, HEALTHeOUTCOMES, aggregates community clinical data from the provider and claims data from regional health plans, offering comprehensive population health reporting. These tools help inform and improve practices' care coordination, population health management, and quality improvement efforts. Under this initiative, HEALTHeOUTCOMES will be expanded to rural and underserved areas outside of Western NY. Broadening the usage of this tool will help more practitioners improve the quality of care for their patients and monitor their health more closely, particularly for chronic conditions such as diabetes, hypertension, and behavioral health diagnoses.

### ***Strengthening the Cybersecurity Posture of Rural Facilities***

Governor Hochul has made cybersecurity a priority through her "whole-of-state" strategy, which includes creating a unified approach to safeguarding critical infrastructure, deploying new protection tools, and implementing legislation for mandatory training and incident reporting. In October 2024, NY adopted a robust set of cybersecurity requirements for hospitals,<sup>xxxix</sup> focused on identifying and assessing internal and external cybersecurity risks to non-public information and developing defensive infrastructure and policies and procedures to protect hospital systems, detect cybersecurity events, to comply with the Health Insurance Portability and Accountability

Act (HIPAA) Security Rule, and meet Office of the National Coordinator for Health Information Technology (ONC) standards for interoperability. Many jurisdictions still rely on aging, on-premise systems that simply pass data along and are vulnerable to cyber disruption. Meeting these requirements and providers' cybersecurity needs will require significant investment from hospitals and other rural facilities, such as FQHCs, nursing homes, and behavioral health providers, and EMS providers, already under financial pressures and having difficulty strengthening their cybersecurity posture.

This initiative supports rural facilities by providing funding opportunities to address gaps unique to rural health care facilities, align with industry-standard best practices, and adhere to relevant health care sector regulations. This will aid facilitates in conducting risk assessments, creating written policies and procedures, detecting and responding to cybersecurity events, implementing security measures including encryption and fraud protection, and deploying monitoring and controls systems. Under this initiative, procurement of required technologies, systems configuration, staff training, and support in developing and/or implementing policies, procedures, and incident response plans will be considered.

With implementation, rural providers will be supported to adopt regional approaches to cybersecurity, as they often face resource constraints that differ from those of urban facilities, such as limited budgets, staffing shortages, and fewer in-house experts. By collaborating across multiple facilities within a region, rural hospitals can pool resources, share expertise, and implement standardized technologies and protocols, which not only reduce individual facility costs but also strengthen collective defenses against cyber threats. This strategy enables rural providers to achieve a level of security and compliance that would be challenging to attain independently, aligning their capabilities more closely with those of larger urban institutions. Under this initiative,

rural facilities will have the opportunity to collaborate on response plans and processes, procurement, preparation and training, as well as oversight, monitoring, and reporting procedures, creating a sustainable, cost-effective approach to cybersecurity.

Through this initiative the state will provide targeted assistance to rural facilities to perform cybersecurity risk assessments and procure cybersecurity solutions or services. With financial support, facilities will be able to identify solutions and services suited to their unique risk profiles, including encryption tools, identity and access management, vulnerability management, endpoint detection programs, real-time monitoring systems, and systems to support emergency preparedness. By facilitating the acquisition and deployment of these technologies, the initiative aims to bolster defenses against cybersecurity threats, prepare for emergencies, and ensure that rural health care facilities can meet industry standard cybersecurity requirements despite limited budgets and staffing challenges. Additionally, NY will support systems with a cloud-native, AI-enabled, modular platform that generates actionable intelligence for rural health care providers.

**Main Strategic Goal:** This initiative aligns with the **Tech Innovation** strategic goal by accelerating the deployment of infrastructure and uptake of enabling technologies and raising the cybersecurity profile of rural providers to ensure data privacy and security.

**Use of Funds:** C, D, F, J

**Technical Score Factors:** B.1, C.1, C.2, F.1, F.2, F.3.

**Key Stakeholders:** Hospitals, FQHCs, behavioral health facilities, nursing homes and other long-term care facilities, NY State DOH, – including the State Office of Rural Health, Office of Mental Health, Office of Health Insurance Programs, Office of Addiction Services and Supports,

and DOH Cyber Preparedness – SHIN-NY, rural providers including subacute care providers, and rural school districts.

## Outcomes

<b>Key Result 1: Expanding access to care through telehealth</b>				
<b>Measure</b>	<b>Definition</b>	<b>Baseline</b>	<b>Target</b>	<b>Relation to Initiative</b>
<b>Number of Telehealth Access Points by community and school-based centers</b>	Count of telehealth access points created in schools, rural communities.	Baseline will be set in Year 1	By Year 5, 50% increase access points in schools, and a 10% increase in other settings.	By funding grants to hospitals and other health care facilities to improve their telehealth infrastructure, NY will improve access to care for rural residents.
<b>Key Result 2: Improving patient outcomes through eConsult partnerships</b>				
<b>Use of the secure virtual eConsult platform for provider/consultant partnerships</b>	Count of providers by region entering into partnerships with specialists for consults using the secure virtual eConsult platform	Baseline will be set in Year 1	By Year 4, 3 rural regions of the state covered by partnerships  By Year 5, 5 rural regions of the state covered by partnerships	Many rural providers have trouble accessing specialists and specialty care for their patients. Procuring an eConsult platform and providing technical assistance to providers will remove barriers to access and simplify the process for providers.
<b>Key Result 3: Increase in usable alerts in rural counties</b>				
<b>Engagement with Encounter Alert Services (by county)</b>	Count of rural providers utilizing encounter alert services available through the SHIN-NY. This will be analyzed by county.	Baseline will be set in Year 1	By Year 4, 100% SHIN-NY participants in the identified rural counties will have access to supported alerts.	Rural providers are often not connected to health information exchange major systems and do not have built in alerting through their technology. This service will better alert and connect their providers to information on their patients occurring in other networks.
<b>Key Result 4: Strengthening Cybersecurity of Rural Facilities – Ensure Data Privacy and System Security to Maintain Operations and Continuity of Care Delivery to the Citizens of NY</b>				
<b>Percentage of facilities meeting NY's cybersecurity goals</b>	Percentage of facilities meeting cybersecurity goals including: detecting and responding to cybersecurity events, implementing security measures including encryption and fraud	Reporting will be established in Year 1	By Year 3, 100% of sole community and critical access hospitals compliant  By Year 5, 50% of non-hospital	Cybersecurity compliance is a fundamental requirement for any initiative involving technology, serving as a baseline that must be met before further advancements can be considered. By strengthening system security and fostering trust in technological systems, NY creates the foundation

	protection, and deploying monitoring and controls systems.		facilities meeting industry standard	necessary to safely deploy additional technology- focused enhancements, especially in rural areas where the impact on health care delivery and patient outcomes can be significant. Without this commitment to cybersecurity, other innovations risk undermining both operational integrity and public confidence.
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**Impacted Counties:** This initiative will include all 47 rural counties, as listed on page 6.

**Estimated Required Funding:** Of the hypothetical \$200M annual award, this initiative will be approximately \$62-68M per budget period. Please see Budget Narrative for more information.

## IMPLEMENTATION PLAN AND TIMELINE

Please see associated Gantt chart on page 2 in the OTHER SUPPORTING DOCUMENTATION

	Rural Community Health Integration	Strengthening Rural Health	Rural Roots: Workforce	Investments in Cybersecurity & Technology
<p><b>FY26</b> Stage 0 <i>Planning</i></p>	<ul style="list-style-type: none"> <li>• <b>Partnership Networks</b> <ul style="list-style-type: none"> <li>• Finalize eligibility criteria</li> <li>• Stakeholder engagement</li> <li>• Develop rolling application process</li> <li>• Select Round 1 awards</li> </ul> </li> <li>• <b>School-based health centers (SBHC):</b> Contract with vendor to conduct schools’ readiness assessment; recruit and coordinate hospitals, clinics and FQHCs to act as operators</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Program-Wide:</b> <ul style="list-style-type: none"> <li>• Patient-Center Medical Home (PCMH) technical advisor contracting</li> <li>• Establish state Program Management Office. Finalize sub-recipient eligibility criteria and the practice selection process.</li> <li>• Execute master agreement with Qualified Vendor for Artificial Intelligence (AI) enablement services.</li> <li>• Americans with Disabilities Act (ADA)-compliance assessment, planning, and remediation project starts</li> <li>• Conduct comprehensive survey of rural primary care practices across the 47 counties to confirm cohort sizing, assess tech readiness, ADA compliance, and specific needs.</li> <li>• Launch first wave of applications for all three cohorts.</li> <li>• Onboarding the first wave of practices</li> </ul> </li> <li>• <b>Cohort 2</b> begins AI enablement program. Activities focus on tech</li> </ul>	<ul style="list-style-type: none"> <li>• Develop partnerships and collaboration with health care facilities, organizations, the Area Health Education Center (AHEC) system, and rural schools, across rural counties</li> <li>• Identify rural schools and clinical and/or non-clinical rotation sites for partnership/expansion and establish agreements</li> <li>• Conduct baseline assessment of rural health care workforce</li> <li>• Integrate data collection with current system architecture, establish data-sharing, and develop standardized protocols and metrics</li> <li>• Develop criteria and oversight processes for student financial support and facility grants</li> <li>• Establish oversight processes, program infrastructure and administrative systems for grant administration and program management</li> <li>• Design student support and mentorship programs</li> <li>• Recruit first cohort of students</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Telehealth Infrastructure:</b> Develop Request for Proposals (RFP) for infrastructure grants and establish internal oversight and administrative process.</li> <li>• <b>eConsult Hubs:</b> Technical and interoperability requirements’ gathering and identification of eligible specialists. Identify phased approach to develop or procure technology platform to be used for eConsult. Learning and Diffusion Networks to begin recruitment of providers to partner in eConsult use.</li> <li>• <b>Remote Monitoring Technology:</b> Develop procurement to expand model</li> <li>• <b>Timely Health Information:</b> Build alerts tailored to rural communities with community centric design that will be useful to rural providers. Begin connecting sub-acute rehabilitation providers to the SHIN-NY. The State Designated Entity will work with health information networks and payers to determine population health data needs.</li> </ul>

		<p>integration with EHR/HIE, data pipeline activation, and foundational training for practice staff.</p> <ul style="list-style-type: none"> <li>• <b>Cohort 3</b> begins a tailored PCMH re-attestation program, focusing on addressing specific challenges that led to lost recognition.</li> </ul>		<ul style="list-style-type: none"> <li>• <b>Cybersecurity:</b> Develop internal oversight and administrative process and RFP for statewide vendor.</li> </ul>
<p><b>FY27</b> Stage 1 Initial Launch</p>	<ul style="list-style-type: none"> <li>• <b>Partnership Networks:</b> <ul style="list-style-type: none"> <li>• Prepare to onboard hospital/partners</li> <li>• Contracting w/awardees</li> <li>• Select Round 2 awards</li> <li>• Collect Yr1 data</li> </ul> </li> </ul> <p><b>SBHC:</b> Vendor develops plan for cohort one - finalizing the # of schools, provide Technical Assistance (TA) to develop MOUs between schools and medical operators, scope of start-up costs for schools to retro-fit medical offices, purchase equipment, and recruit clinicians, the costs will not be capital improvements but rather non-permanent costs like equipment purchase.</p>	<ul style="list-style-type: none"> <li>• <b>Cohort 1:</b> First wave of practices submits for and achieves PCMH recognition; immediately begin AI (Implementation) program.</li> <li>• <b>Cohort 2:</b> First wave of practices completes their implementation year and transitions to Year 2 (Optimization), focusing on advanced features, workflow refinement, and driving outcomes. The larger second wave begins their Year 1 of AI (Implementation.)</li> <li>• <b>Cohort 3:</b> The first wave achieves PCMH re-recognition and begins Year 1 (Implementation) of AI enablement. A second wave begins the re-recognition process.</li> <li>• ADA-compliance remediation projects in process</li> </ul>	<ul style="list-style-type: none"> <li>• Identify recruitment and retention challenges, refine data collection processes, and evaluate and refine selection criteria based on insights and learnings from Year 1.</li> <li>• Implement data dashboard for participating organizations to track and report on program and grantee key metrics, outcomes, and progress</li> <li>• Enroll the first cohort of college/graduate students in enhanced clinical rotations.</li> <li>• Establish agreements with rotation sites to provide diverse training experiences.</li> <li>• Implement maternal care, behavioral health, and addiction medicine programs, utilizing existing AHEC frameworks</li> <li>• Launch a housing assistance program and community integration services to support trainees.</li> <li>• Implement training, mentorship programs, peer learning</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Telehealth Infrastructure:</b> Distribute first round of telehealth infrastructure funding. Select first rural urgent care in school hubs and approve workplan for delivering through school districts.</li> <li>• <b>eConsult Hubs:</b> Development and testing of the eConsult platform and development of a provider directory</li> <li>• <b>Remote Monitoring Technology:</b> Select projects for remote monitoring and set baseline for performance.</li> <li>• <b>Timely Health Information:</b> On-board ~75% of the rural providers identified in the environmental scan for encounter alerting functions and use of population health data. Determine specific population health use targets for prioritization</li> <li>• <b>Cybersecurity:</b> Fund cybersecurity risk assessments</li> </ul>

			<p>networks, and learning collaboratives</p> <ul style="list-style-type: none"> <li>Recruit second cohort of students</li> </ul>	<p>for each of the facilities in rural areas.</p>
<p><b>FY28</b> Stage 2 <i>Early Scale</i></p>	<ul style="list-style-type: none"> <li><b>Partnership Networks:</b> <ul style="list-style-type: none"> <li>Identify gaps/opportunities for continued expansion</li> <li>Develop feedback loop to identify successful models to scale</li> <li>Select Round 3 awards</li> <li>Collect Yr2 data</li> </ul> </li> <li><b>SBHC:</b> Phase 1 start-up costs provided to schools in cohort 1. Vendor recruits additional schools and operators to participate in cohort 2.</li> </ul>	<ul style="list-style-type: none"> <li><b>Cohort 1:</b> First wave transitions to Year 2 (Optimization) of AI. Most Cohort 1 sites are now actively in Year 1 of AI implementation.</li> <li><b>Cohort 2:</b> First wave of practices completes their second seed year. Deliverables are finalized, and these practices are prepared to transition to the self-management model. Most Cohort 2 sites are in Year 2 of AI (Optimization).</li> <li><b>Cohort 3:</b> First wave enters Year 2 (Optimization) of AI, while the second wave completes Year 1.</li> <li>ADA-compliance remediation projects in process, rolling completion.</li> </ul>	<ul style="list-style-type: none"> <li>Develop predictive modeling for future workforce needs and begin tracking training program return on investment metrics</li> <li>Expand 6-12 programs to multiple rural counties leveraging the Area Health Education Center network</li> <li>Establish intensive summer programs for high school students</li> <li>Expand clinical and non-clinical rotation capacity to additional sites</li> <li>Expand cohort of college/graduate students in enhanced rotations</li> <li>Recruit third cohort of students</li> </ul>	<ul style="list-style-type: none"> <li><b>Telehealth Infrastructure:</b> Distribute second round of infrastructure funding. Begin performance measurement in first school hub and expand to additional schools.</li> <li><b>eConsult Hubs:</b> On-boarding of provider partners that have agreements to work through the eConsult platform and develop the requirements for monitoring the use of eConsult from all participating providers.</li> <li><b>Remote Monitoring Technology:</b> Monitor performance of selected model providers/initiatives and determine scalability.</li> <li><b>Timely Health Information:</b> Alerts are scaled and rolled out through provider outreach and expansion efforts.</li> <li><b>Cybersecurity:</b> Fund projects identified in cybersecurity risk assessments.</li> </ul>
<p><b>FY29</b> Stage 3 <i>Implementation Midpoint</i></p>	<ul style="list-style-type: none"> <li><b>Partnership Networks:</b> <ul style="list-style-type: none"> <li>Select Round 4 awards</li> <li>Collect Yr 3 data</li> </ul> </li> <li><b>SBHC:</b> Vendor supports cohort 1 with ongoing technical assistance for implementation and</li> </ul>	<ul style="list-style-type: none"> <li><b>Cohort 1:</b> Final wave of practices in Year 1 of AI Implementation.</li> <li><b>Cohort 2:</b> Majority of practices fully deployed. Final wave completes Year 2 and transitions from seed funding.</li> </ul>	<ul style="list-style-type: none"> <li>Collect stakeholder feedback to refine data priorities</li> <li>Integrate data from all <i>Rural Roots</i> program components and create public-facing data visualization tools</li> </ul>	<ul style="list-style-type: none"> <li><b>Telehealth Infrastructure:</b> Distribute third round of infrastructure funding. Review performance of school hub in first region and expand to additional regions.</li> </ul>

	<p>sustainability (e.g., Medicaid billing), cohort 2 start up projects begin, vendor recruits cohort 3</p>	<ul style="list-style-type: none"> <li>• <b>Cohort 3:</b> Majority of practices are in or have completed AI Optimization phase.</li> <li>• ADA-compliance remediation projects in process, rolling completion</li> </ul>	<ul style="list-style-type: none"> <li>• Expand maternal care desert interventions to additional rural counties</li> <li>• Recruit fourth cohort of students</li> <li>• Evaluate practice satisfaction and patient care outcomes</li> <li>• Grow sustainability fund through practice contributions and begin planning for program continuation beyond grant period</li> </ul>	<ul style="list-style-type: none"> <li>• <b>eConsult Hubs:</b> Continue to gather data from providers on eConsult. On-board additional provider partners from regions across the state as they enter partner agreements</li> <li>• <b>Remote Monitoring Technology:</b> If viable, select additional regions or areas for scaling.</li> <li>• <b>Timely Health Information:</b> Full deployment of alerts; begin sustainability planning and measuring impact for rural providers. 100% of rural providers are participating in alerts and population health data</li> <li>• <b>Cybersecurity:</b> Fund projects identified in cybersecurity risk assessments.</li> </ul>
<p><b>FY30</b> Stage 4 <i>Near Completion</i></p>	<ul style="list-style-type: none"> <li>• <b>Partnership Networks:</b> <ul style="list-style-type: none"> <li>• Select Final awards</li> <li>• Collect Yr 4 data</li> </ul> </li> <li>• <b>SBHC:</b> Vendor supports cohorts 1 and 2 with ongoing technical assistance for implementation and sustainability. Phase 3 start-up projects begin</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Program-Wide:</b> <ul style="list-style-type: none"> <li>• All onboarding is complete. Programmatic activities focus on supporting the final waves of practices through their second seed year.</li> <li>• Prepare comprehensive analysis of multi-year outcomes in preparation for final reporting.</li> <li>• Final wave of practices (primarily from Cohort 1) completes Year 2 (Optimization) of their AI seed funding. State programmatic support</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Complete programmatic evaluation &amp; document processes</b> <ul style="list-style-type: none"> <li>• Complete final comprehensive evaluation of all <i>Rural Roots</i> initiatives</li> <li>• Document best practices and lessons learned</li> <li>• Create replication toolkit for other states</li> <li>• Evaluate impact on rural health care access and quality in participating regions</li> <li>• Assess program outcomes: recruitment, completion, and retention rates</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Telehealth Infrastructure:</b> Distribute fourth round of funding. Review performance of school hubs in current regions and consider further expansion.</li> <li>• <b>eConsult Hubs:</b> Continue to gather data from all providers in eConsult activity and continue to gather feedback on functionality of the platform or additional tools necessary.</li> <li>• <b>Remote Monitoring Technology:</b> If applicable, scale to additional regions.</li> <li>• <b>Timely Health Information:</b> Continue supporting practices</li> </ul>

		<p>concludes as they are prepared for self-management.</p> <ul style="list-style-type: none"> <li>• ADA-compliance remediation projects in process, rolling completion</li> </ul>	<ul style="list-style-type: none"> <li>• Recruit final Cohort of students</li> <li>• Develop 5-year outcomes report with recommendations</li> </ul>	<p>and facilities in using encounter and relevant alerts for care coordination or patient outreach. Monitor alert usage.</p> <ul style="list-style-type: none"> <li>• <b>Cybersecurity:</b> Fund projects identified in cybersecurity risk assessments.</li> </ul>
<p><b>FY31</b> Stage 5 <i>Fully Implemented</i></p>	<p><b>Program-Wide:</b></p> <ul style="list-style-type: none"> <li>• Submit final performance and outcome reports to CMS.</li> <li>• Integration of lessons learned and successful models into ongoing state policy.</li> </ul>			

## **Governance and Project Management Structure**

The RHTP implementation will be led by the DOH's Office of Health Care Delivery, Office of Primary Care and Health Systems Management, and Center for Health Care Policy and Resource Development. The Center for Health Care Policy and Resource Development includes the Charles D. Cook Office of Rural Health, the Office of Health care Workforce Innovation, and the Bureau of Policy and Standards Development. The Office of Health Insurance Program, NY's Medicaid Agency, is also within the DOH, under the Commissioner of Health. Please see the proposed organizational chart on page 3 of the "Other Supporting Documentation". Abbreviated resumes for key personnel are included on page 4 of the "Other Supporting Documentation".

**Karen Madden** (0.30 FTE): Director, Center for Health Care Policy and Resource Development, will serve as Principal Investigator and contribute her time in-kind. Ms. Madden will serve as advisor and provide guidance and support on RHTP implementation. Ms. Madden will collaborate with leaders from appropriate offices and divisions in the DOH, other state agencies, and stakeholders.

**Douglas Fish, M.D.** (0.05 FTE): Deputy Commissioner, Office of Health Care Delivery, and Medical Director, Office of Health Insurance Programs, will contribute his time, in-kind, on project oversight. Dr. Fish will serve as an advisor, providing program management guidance.

**Eugene Heslin, M.D.** (0.05 FTE): First Deputy Commissioner and Chief Medical Officer for NY State DOH, will contribute his time, in-kind. Dr. Heslin will serve as an advisor to the Strengthening Rural Health initiative, in particular, among others.

**Mark Hennessey**, (0.05 FTE): Deputy Director, Office of Primary Care and Health Systems Management, will contribute his time, in-kind, on project oversight. Mr. Hennessey will provide guidance and support on program management.

**Daniel Oliver**, (0.05 FTE): Director, Office of Health Services Quality and Analytics, will contribute his time, in-kind, as an advisor to Ms. Madden for grant administration and budget.

**John Arcuri**, (0.10 FTE): Director, Hospital Transformation and Planning, Office of Health Care Delivery, will contribute his time, in-kind. Mr. Arcuri will serve as an advisor on the *Rural Community Health Integration* initiative.

**Carrie Roseamelia, PhD**, (0.10 FTE): Director, Office of Health care Workforce Innovation, Office of Health Care Delivery will contribute her time, in-kind. Dr. Roseamelia will serve as an advisor on the *Rural Roots: Building a Sustainable Rural Health Care Workforce* initiative.

**Thurain Nyunt**, (0.10 FTE), Chief Information Security Officer, Office of Health Information Management, will contribute his time, in-kind. Mr. Nyunt will be an advisor on the *Investments in Technology Innovation and Cybersecurity Enhancements Cybersecurity* initiative.

**Project Director** (1 FTE): The Program Director will report to Ms. Madden and will coordinate with executive and program staff to ensure that the planning, implementation, operations, management, and evaluation of grant-funded activities occur timely; oversee the management of funded programs and contracts/subawards; and ensure all grant administration activities occur within CMS timelines. This position is critical to the project management of this award. This position will be hired in Year 1.

**Project Coordinator** (1 FTE): The Project Coordinator will assist the Project Director with project management, grant administration activities, and managing funded programs. This position will be hired in Year 1.

A Management Consultant will be contracted to provide expert consulting services related to implementation and operations of grant programs. This contract will provide administrative support for the grant subawards in the *Rural Community Health Integration, Strengthening Rural*

*Communities*, and *Rural Roots* initiatives. The Management Consultant will be procured in Year 1, and be contracted to provide specific subject matter expertise for the following activities: *Rural Community Health Integration Learning Collaborative(s)*, *Rural Community Health Integration School-Based Health*, *Rural Roots Recruitment-to-Service Pipeline*, *Investments in Technology Innovation and Cybersecurity Enhancements Telehealth and Telepsychiatry*, *Investments in Technology Innovation and Cybersecurity Enhancements Cybersecurity*, *Investments in Technology Innovation and Cybersecurity Enhancements Remote Monitoring*.

An Evaluation Consultant will be contracted to assess the effectiveness of initiatives and activities. The Evaluation Consultant will design and implement an evaluation plan, collect and analyze qualitative and quantitative data, and provide recommendations for mid-course correction as needed. This contract will be procured by Year 2.

The Principal Investigator and Project Director will coordinate with key staff in the DOH's Offices of Health Insurance Programs, Primary Care and Health Systems Management, Public Health, Office of Health Services Quality and Analytics, and other appropriate state agencies and external stakeholders throughout the RHTP, to receive continued feedback on program implementation, review progress, and discuss potential programmatic changes as needed.

Throughout the duration of the RHTP, coordination among state health agencies and external stakeholders will be maintained through a structured and collaborative approach. The DOH, which encompasses the Office of Rural Health and the Office of Health Insurance Programs, which administers the Medicaid program, will serve as the central coordinating body. As described further in section "Stakeholder Engagement Framework" on page 53, regularly scheduled program workgroup meetings will bring together representatives from within the DOH, and other state agency partners. These meetings will provide a platform for open communication and timely

information sharing on key programmatic elements, including tracking of milestones, and assessment of impact metrics.

To ensure effective engagement with external stakeholders, the program will establish regular communication channels (described further on page 54). A clearly defined decision-making process will guide all activities, ensuring transparency and accountability as the program adapts to changes and addresses emerging needs. This coordinated structure will facilitate seamless collaboration among agencies and stakeholders, supporting the program’s goal of delivering meaningful improvements for rural New Yorkers.

## **STAKEHOLDER ENGAGEMENT**

During the planning phase, NY consulted a wide array of external stakeholders including rural hospital Chief Executive Officers (CEOs) and hospital associations, primary care providers and representative professional societies, the community health center association and related organizations, and advocacy groups. NY is pleased to present 5 letters of support from various advocacy organizations and Legislative bodies (please see page 18 of the “Other Supporting Documentation”). Insights and feedback from these organizations helped shape program priorities and informed the design of the state’s key initiatives. To ensure ongoing engagement, NY will continue to involve these stakeholders through multiple formal mechanisms as described below. These structures will ensure that rural stakeholder voices guide decision-making, program adaptation, and continuous improvement throughout the life of the program.

NY has placed significant emphasis on the active participation of both internal and external stakeholders throughout every phase of the RHTP. The development of the RHTP has been a collaborative effort involving multiple offices within the DOH, particularly the Office of Rural Health, the Office of Health Insurance Programs, and the Office of Health Services Quality and

Analytics. Additional state agency partners include the Office of Mental Health, the Office of Addiction Services and Support, the Office for People with Developmental Disabilities, and the Office for the Aging.

### **List of Stakeholders that NYS Consulted**

During the planning phase, NY engaged a broad spectrum of external stakeholders, including: rural hospital CEOs and hospital associations, primary care providers and their professional societies, community health center associations and related organizations, as well as advocacy groups. The feedback and insights gained from these organizations have been instrumental in shaping program priorities and informing NY's key initiatives.

*Stakeholders engaged to-date include:* 14 NYS Agencies, 15 health networks/systems, 10 advocacy organizations, 10 health coalitions and committees, 9 rural hospitals, 8 other health-based organizations (such as EMS organizations, non-rural hospitals, and health plans), 8 educational entities, 5 health care provider organizations, 5 technology-based organizations, NYS legislative bodies, and 75 other organizations (for a more detailed list of stakeholders, please see page 30 of the "Other Supporting Documentation").

### **Stakeholder Engagement Framework**

To maintain meaningful engagement, NY will continue to involve stakeholders through several formal mechanisms. These processes are designed to ensure that rural stakeholder perspectives inform decision-making, guide program adaptation, and support continuous improvement throughout the duration of the RHT Program. The state will establish a formal, comprehensive stakeholder engagement process to facilitate a continuous feedback loop for the RHTP initiatives.

The framework will include:

- **RHTP Workgroups:** The state will create targeted workgroups focused on each of its four initiatives. Workgroups will involve subject matter experts from the DOH and other state partner

agencies, stakeholder partners, and technical advisors meeting regularly to address specific challenges and opportunities. The workgroups will also meet collectively to facilitate continued collaboration and problem-solving across initiatives. Workgroups will review progress against defined milestones, key performance indicators, and impact metrics, using data to guide decisions and resource allocation. By focusing on these programmatic aspects, workgroups will ensure that the program has a net positive impact on rural NY communities.

- **Rural Health Council Meetings:** The NYS Rural Health Council supports rural health care delivery and policy by working directly with the Commissioner, advising state leadership on rural health care related issues. The Council will continue meeting four times a year, with additional ad hoc meetings if needed, to support the state’s RHTP. Public comment will continue to be held during these meetings to provide opportunities for the public to share experiences, raise concerns, and propose solutions.
- **Integrating Patient, Provider, and Community Advocates’ Voices:** Patient representatives, rural providers, and community advocates will be invited to be active participants in the state’s RHTP. The state will also work directly with existing patient and provider organizations (e.g., Community Health Care Association of New York State, Iroquois Healthcare Association, Hospital Association of New York State, Greater New York Hospital Association, Medical Society of the State of New York) to prioritize geographic, demographic, and professional diversity to ensure they are representative of rural populations.
- **Feedback Mechanisms:** In addition to public comment opportunities, NY will establish lines of communication through online forums and a program-specific website and email inbox.
- **Transparent Decision-Making:** Meeting agendas, minutes, and decisions will be accessible to all stakeholders on DOH’s website, promoting transparency and accountability.

Engagement and program evaluation will be ongoing through the entirety of NY's RHTP. Stakeholder input will inform program adjustments, with feedback loops established to evaluate the effectiveness of engagement activities. These collective efforts will ensure that the voices of rural stakeholders are central to NY's RHTP decision-making and ongoing evolution.

## **METRICS AND EVALUATION PLAN**

### ***Milestones and Targets***

The evaluation framework for the RHTP will be grounded in the specific Objectives and Key Results outlined for each core initiative, ensuring that assessment activities are closely aligned with the intended outcomes of the program. The identified measures contain a mix of participating provider-submitted data as well as state health data systems. By systematically measuring progress toward these targets, the evaluation will provide a cohesive and comprehensive picture of the program's impact across all initiatives. This approach will facilitate ongoing performance monitoring and enable continuous improvement, while also supporting robust accountability and transparency throughout the funding period.

NY is committed to conducting a robust program evaluation for the RHTP. To ensure the evaluation is comprehensive and unbiased, NY will partner with an external vendor to effectively assess the program's progress and outcomes. NY will select an external evaluator and dedicate time and resources to refining a formal evaluation plan including the selection of additional overall program metrics. This plan will be designed to capture appropriate measures and milestones, aligning with both the program's objectives and reporting requirements. By establishing a rigorous evaluation framework early on, NY aims to generate actionable insights and support continuous improvement throughout the program's duration.

Additionally, NY confirms its willingness to cooperate fully with any CMS-led evaluation or external monitoring processes. This approach will ensure transparency, accountability, and the ability to compare outcomes across states, strengthening the overall impact of the RHTP.

## **SUSTAINABILITY PLAN**

Ensuring the long-term sustainability of NY's RHTP is a central priority that guides both its design and implementation. The program is committed to fostering lasting improvements in rural health systems by building initiatives and partnerships that will endure beyond the initial funding period. Through strategic investments in infrastructure, capacity building, and evidence-based models, NY aims to embed successful practices into its ongoing health policies and operations, thereby promoting continued progress and resilience in rural communities even after RHTP funding concludes. For each initiative, please find detailed sustainability considerations to ensure lasting impact of the RHTP.

The *Rural Health Community Integration* initiative is designed to ensure that rural anchor institutions and their partners can sustain the progress achieved through the RHTP even after the grant funding period ends. To promote long-term viability, the initiative encourages financial sustainability by leveraging value-based payment models already embedded in the NY state Medicaid program. It also supports the strategic shift of services to community-based providers, enhancing local capacity, and reducing dependency on centralized systems.

Applicants will be required to demonstrate a commitment to maintaining network operations and resource sharing beyond the funding window, reinforcing the initiative's emphasis on enduring collaboration. Additionally, the initiative utilizes existing statutory authority and budget appropriations to preserve flexibility and minimize reliance on temporary subsidies, ensuring a more stable foundation for rural health systems.

A key component of the initiative involves launching and scaling cost-effective care models. These models are not only tailored to meet the unique needs of rural communities, but are also designed to be replicable across other regions and adaptable to various payers, amplifying their impact and fostering broader health system transformation.

The *Strengthening Rural Communities* initiative develops sustainability across three domains: patients, primary care practices, and the statewide system. Patient sustainability depends upon health maintenance, preventive care, and patient satisfaction. A prevention-based approach emphasizes proactive care such as screenings, chronic disease management, and health education such as nutrition, healthy eating habits, and the value of exercise while ensuring timely access to primary care to improve outcomes, reduce costs, and enhance patient satisfaction.

Primary care practices' sustainability centers on the efficiency and well-being of primary care providers. By redesigning workflows and optimizing practice operations, clinics can reduce administrative burdens, improve care coordination, and enhance provider satisfaction. This leads to less burnout, better retention, and reduced primary care practice attribution churn, ultimately strengthening the foundation of the health system. Financially, by facilitating primary care practices' successful PCMH recognition, the *Strengthening Rural Communities* initiative will enable primary care practices to unlock enhanced, recurring per member, per month payments from Medicaid and commercial payers. In NY, Medicaid-recognized PCMH practices receive a base per member, per month payment, plus additional incentive enhancements—\$4.00 for Medicaid Managed Care and Child Health Plus for members under 21, and \$2.00 for adults, on top of the base rate. This means a PCMH-recognized practice can receive up to \$10.00 per Medicaid member, per month for children and \$8.00 per member, per month for adults, creating a predictable revenue stream that supports operational stability and long-term planning. Commercial

insurers also offer enhanced per member, per month payments, though typically at lower rates than Medicaid. These payments are tied to quality improvement, care coordination, and preventive services, incentivizing practices to maintain high standards and invest in practice transformation. At the system level, sustainability can be achieved through collaborative, value-based care models like Shared Savings Programs. When practices, payers, and communities use these models, they benefit from more efficient care delivery and shared financial rewards. These models foster alignment across stakeholders, ensuring the viability of the health care ecosystem.

The *Rural Roots* initiative aims to create a lasting framework for rural health workforce development and service expansion through collaboration and partnerships, thereby strengthening health care access, quality, and outcomes in rural communities beyond the RHTP funding lifespan. The primary goal is to institutionalize successful RHTP-funded initiatives, with a particular emphasis on rural workforce recruitment pathways and the development of sustainable trainer networks. The Recruitment-to-Service Pipeline project that strengthens the rural health care workforce by supporting medical, dental, and behavioral health students will be sustained by requiring practices to contribute 5–10% of the former student—now physician’s—revenue over 5 years of practice to a dedicated fund. This fund will be earmarked for supporting future trainees, creating a self-sustaining financial model that maintains ongoing recruitment and training efforts long after initial federal funding ends. By embedding these strategies into the fabric of NY’s health system, the state will foster continuous improvements in rural health services and outcomes.

By prioritizing recruitment pathways and trainer networks as the cornerstone of our sustainability strategy, NY will ensure that rural workforce development and service delivery models not only persist but thrive well beyond the RHTP funding period. This integrated approach will embed

lasting change and resilience in rural health systems, guaranteeing that our investment yields ongoing benefits for rural communities.

The *Investments in Technology Innovation and Cybersecurity Enhancements for Rural NY* initiative is a cornerstone for sustainability across all other initiatives. This short-term investment will be used to develop and maintain a cybersecurity infrastructure in rural communities, reducing the cost of future quality improvement, data security, and incident response costs. The training made available to facility staff will be a lasting investment in planful information security. The investments made in timely and interoperable health information exchange through the SHIN-NY can improve patient follow-ups and outcomes of care, reducing cost of care overall. Investments in eConsult hubs, school-based urgent care centers, and other telehealth infrastructure are intended to be short-term investments, in hopes of the services being sustainable through insurance billing once fully operational. For example, funding for EMS for treatment-in-place and transport-to-alternative-destination has been statutorily authorized by NY. Providing seed money for the technology and program development will help make these programs more sustainable by aiding in development of billing for those services. Funding will only be granted to recipients who can demonstrate their plan for sustainability. Additionally, remote monitoring technology is intended to reduce the cost of in-person care delivery in rural areas. These services aim to lower health care costs by providing early care and minimizing patient travel, which help prevent expensive emergency and inpatient admissions and reduce patients' inconvenience and expense.

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