

Application for Federal Assistance SF-424

* 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	* 2. Type of Application: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	* If Revision, select appropriate letter(s): <input type="text"/> * Other (Specify): <input type="text"/>
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* 3. Date Received: <input type="text" value="Completed by Grants.gov upon submission."/>	4. Applicant Identifier: <input type="text"/>
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5a. Federal Entity Identifier: <input type="text"/>	5b. Federal Award Identifier: <input type="text"/>
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State Use Only:

6. Date Received by State: <input type="text"/>	7. State Application Identifier: <input type="text"/>
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8. APPLICANT INFORMATION:

* a. Legal Name: <input type="text" value="Kansas Department of Health and Environment"/>	
* b. Employer/Taxpayer Identification Number (EIN/TIN): <input type="text" value="48-1124839"/>	* c. UEI: <input type="text" value="CGSTLVM57LM5"/>

d. Address:

* Street1: <input type="text" value="1000 SW Jackson St"/>
Street2: <input type="text"/>
* City: <input type="text" value="Topeka"/>
County/Parish: <input type="text" value="Shawnee"/>
* State: <input type="text" value="KS: Kansas"/>
Province: <input type="text"/>
* Country: <input type="text" value="USA: UNITED STATES"/>
* Zip / Postal Code: <input type="text" value="66612-1368"/>

e. Organizational Unit:

Department Name: <input type="text" value="Health and Environment"/>	Division Name: <input type="text" value="Public Health"/>
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f. Name and contact information of person to be contacted on matters involving this application:

Prefix: <input type="text" value="Mrs."/>	* First Name: <input type="text" value="Lainey"/>
Middle Name: <input type="text"/>	
* Last Name: <input type="text" value="Faulkner"/>	
Suffix: <input type="text"/>	
Title: <input type="text" value="Director, Bureau of Health Promotion"/>	
Organizational Affiliation: <input type="text" value="Kansas Department of Health and Environment"/>	
* Telephone Number: <input type="text" value="785-296-6752"/>	Fax Number: <input type="text"/>
* Email: <input type="text" value="kdhe.BHPGrants@ks.gov"/>	

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Centers for Medicare & Medicaid Services

11. Assistance Listing Number:

93.798

Assistance Listing Title:

Rural Health Transformation Program

*** 12. Funding Opportunity Number:**

CMS-RHT-26-001

* Title:

Rural Health Transformation Program

13. Competition Identification Number:

CMS-RHT-26-001-117822

Title:

Rural Health Transformation Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

KS RHTP SF424 Item 14 Areas Affected by Pro

Add Attachment

Delete Attachment

View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Kansas Rural Health Transformation Plan

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant

* b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

* a. Start Date:

* b. End Date:

18. Estimated Funding (\$):

* a. Federal	<input type="text" value="199,856,092.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="199,856,092.00"/>

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

- a. This application was made available to the State under the Executive Order 12372 Process for review on
- b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

Yes No

If "Yes", provide explanation and attach

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name:
Middle Name:
* Last Name:
Suffix:

* Title:

* Telephone Number: Fax Number:

* Email:

* Signature of Authorized Representative:

* Date Signed:

**SF424 Item 12 Areas Affected by Project (Cities, Counties, States, etc.)
Kansas Department of Health and Environment**

Kansas

Counties: All Kansas counties with the exception of those located in Metropolitan Statistical Areas (Johnson, Wyandotte, Leavenworth, Miami, Linn, Douglas, Shawnee, Jefferson, Osage, Jackson, Wabaunsee, Riley, Geary, Pottawatomie, Sedgwick, Bulter, Harvey, and Sumner) will be affected by the Kansas Rural Health Transformation Plan.

SF424 Descriptive Title of Applicant's Project

Title: Kansas Rural Health Transformation Plan

Short Description: In partnership with rural stakeholders, the State of Kansas will implement its Rural Health Transformation Plan with five initiatives focused on expanding primary and secondary prevention programs, securing local access to primary care, building a sustainable rural workforce, enabling value-based care, and harnessing data and technology.

SF424 Item 16 Congressional Districts
Kansas Department of Health and Environment

Congressional Districts in the Proposed Project

- Kansas
 - KS-001, KS-002, KS-003, KS-004

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2028

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Assistance Listing Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. CMS-RHT-26-001 Rural Health Transformation Program	93.798	\$ 0.00	\$ 0.00	\$ 199,856,092.00	\$ 0.00	\$ 199,856,092.00
2.						
3.						
4.						
5. Totals		\$ 0.00	\$ 0.00	\$ 199,856,092.00	\$ 0.00	\$ 199,856,092.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
	CMS-RHT-26-001 Rural Health Transformation Program				
a. Personnel	\$ 229,660.00	\$	\$	\$	\$ 229,660.00
b. Fringe Benefits	98,664.00				98,664.00
c. Travel	9,144.00				9,144.00
d. Equipment	0.00				0.00
e. Supplies	5,384.00				5,384.00
f. Contractual	110,504,104.00				110,504,104.00
g. Construction	0.00				0.00
h. Other	88,079,151.00				88,079,151.00
i. Total Direct Charges (sum of 6a-6h)	198,926,107.00				\$ 198,926,107.00
j. Indirect Charges	929,985.00				\$ 929,985.00
k. TOTALS (sum of 6i and 6j)	\$ 199,856,092.00	\$	\$	\$	\$ 199,856,092.00
7. Program Income	\$	\$	\$	\$	\$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. CMS-RHT-26-001 Rural Health Transformation Program	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 199,856,092.00	\$ 49,964,023.00	\$ 49,964,023.00	\$ 49,964,023.00	\$ 49,964,023.00
14. Non-Federal					
15. TOTAL (sum of lines 13 and 14)	\$ 199,856,092.00	\$ 49,964,023.00	\$ 49,964,023.00	\$ 49,964,023.00	\$ 49,964,023.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b)First	(c) Second	(d) Third	(e) Fourth
16. CMS-RHT-26-001 Rural Health Transformation Program	\$ 199,856,092.00	\$ 200,000,000.00	\$ 200,000,000.00	\$ 200,000,000.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	\$ 199,856,092.00	\$ 200,000,000.00	\$ 200,000,000.00	\$ 200,000,000.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: \$198,926,107	22. Indirect Charges: \$929,985
23. Remarks:	

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Project Abstract Summary

This Project Abstract Summary form must be submitted or the application will be considered incomplete. Ensure the Project Abstract field succinctly describes the project in plain language that the public can understand and use without the full proposal. Use 4,000 characters or less. Do not include personally identifiable, sensitive or proprietary information. Refer to Agency instructions for any additional Project Abstract field requirements. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

Funding Opportunity Number

CMS-RHT-26-001

Assistance Listing Number(s):

93.798

Applicant Name

Kansas Department of Health and Environment

Descriptive Title of Applicant's Project

Kansas Rural Health Transformation Plan

Project Abstract

Project Goals: Transform Kansas' rural health care delivery system by (1) realizing meaningful reductions in chronic disease rates and avoidable hospitalizations for complications related to chronic disease in rural Kansas; (2) substantially reducing the number of rural Kansas hospitals with negative operating margins; (3) improving provider-to-population ratios for primary care, dental and mental health disciplines and ease nursing and allied health shortages in rural Kansas; (4) having 100% of Medicare and Medicaid beneficiaries in rural Kansas in accountable care relationships by 2031; (5) and enabling rural Kansas providers to meaningfully engage in data sharing, analysis of aggregated patient and outcome data, expanded use of telehealth and remote monitoring, appropriate use of artificial intelligence, and utilization of consumer-facing technologies. Total Budget Amount: \$200 million per year for five years.

Description of How Funds Will Be Used: The State of Kansas' Rural Health Transformation Plan includes five initiatives tied to the to the Rural Health Transformation Program's five strategic goals and fully addressing the ten initiative-based factors specified by CMS: (1) expand primary and secondary prevention programs; (2) secure local access to primary care; (3) build a sustainable rural workforce; (4) enable value-based care; and (5) harness data and technology. For each initiative, the State has developed programs and projects to achieve the initiative's objectives. The Plan is comprehensive in scope, reaching all rural communities in the state and all types of rural providers.

Key programs include (1) financial incentives for rural providers to implement and sustain evidence-based practices; (2) support for transformative projects to form or expand regional partnerships; (3) a statewide Accountable Food Is Medicine program supported in part by deployment of community health workers; (5) a focused behavioral health services program including integration of behavioral in primary care and embedding behavioral health supports in emergency departments and nursing facilities; (6) a comprehensive remote patient monitoring program using cutting-edge technologies; (7) deployment of consumer-facing technologies to support healthy lifestyles and manage chronic conditions; (8) new transportation models and innovative patient care resources to ensure patients receive the right care in the right place at the right time; (9) specific interventions to help rural providers improve revenue and reduce operating costs; and (10) targeted training and recruitment programs to address specific rural workforce challenges. The initiatives include several additional programs and projects to drive transformation and make rural America healthy again.

The Plan, developed with significant stakeholder input, includes a detailed implementation plan with an aggressive timeline, a comprehensive evaluation plan, and a practical sustainability plan. Every dollar in the budget is committed to helping rural communities thrive through better health.

Project Narrative File(s)

* Mandatory Project Narrative File Filename:

06_KS_RHT_26_001_Project Narrative.pdf

Add Mandatory Project Narrative File

Delete Mandatory Project Narrative File

View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File

Delete Optional Project Narrative File

View Optional Project Narrative File

Project Narrative

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

I. Rural Health Needs and Target Population

Rural Demographics

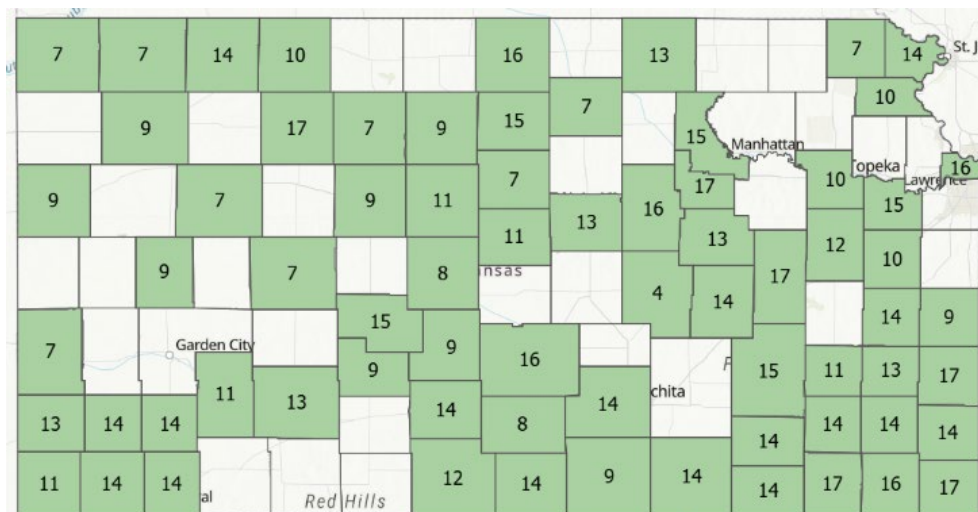
Population Size and Density	Kansas has 105 counties with a total population just under 3 million. ⁱ Of that population, about 860,000 (29.2%) reside in one of Kansas’ 85 rural counties (i.e., those outside a metropolitan statistical area). ^{ii,iii} Nearly two-thirds (61) of rural Kansas counties are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

Project Narrative

Health Outcomes

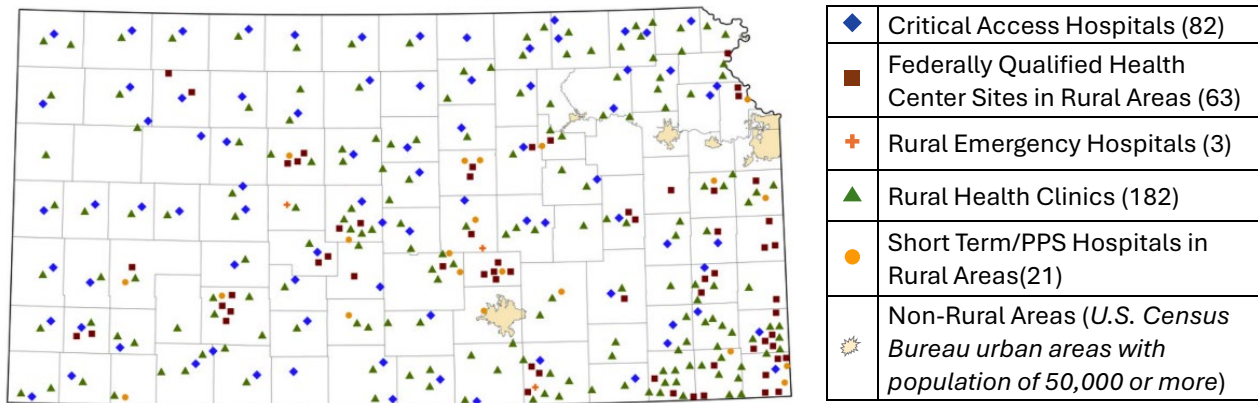
Chronic Conditions	56.5% of Kansas adults report having at least one chronic condition, compared to 54.3% nationally. 10.3% of Kansas adults have three or more chronic conditions, compared to 10.1% nationally. ^{xi} Kansas adults experience obesity and hypertension at a higher rate (35.9% and 34.7%)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

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



Project Narrative

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



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

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

Project Narrative

Ranking of 2023 Median Financial Metrics to U.S. States

Lower Score Better

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

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

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

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

Project Narrative

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

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

II. Rural Health Transformation Plan: Goals and Strategies

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

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

Project Narrative

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

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

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

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

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Plan Objectives

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

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



Four Core Values Drive All Plan-Related Decision-Making

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

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

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

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

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

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

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

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

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

Project Narrative

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

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

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

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

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

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

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

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

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

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

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

Project Narrative

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

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

Other Required Information

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

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III. Proposed Initiatives and Use of Funds

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

The following summarizes the seven programs under Initiative 1.

1. *Accountable Food is Medicine + Community Health Worker Deployment Program.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The following summarizes the six programs under Initiative 2.

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

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

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

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

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

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

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

Project Narrative

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

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

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

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

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

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

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

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

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

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

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

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

The following summarizes the four programs under Initiative 3.

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

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

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

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

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

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

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

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

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

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

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

The following summarizes the four programs under Initiative 4.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The following summarizes the five programs under Initiative 5.

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

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

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

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

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

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

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

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

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

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

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

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

IV. Implementation Plan and Timeline

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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V. Stakeholder Engagement

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

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

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

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

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

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

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

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

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

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

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

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

V. Metrics and Evaluation Plan

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

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

Initiative 1 Metrics and Evaluation Plan		Expand Primary and Secondary Prevention Programs
Metrics	Description	Parameters
1 Accountable Food Is Medicine (FIM) Outcomes	Participation, health outcomes, impact on total cost of care	<ul style="list-style-type: none"> - Report quarterly at county and state levels on (1) number of placed community health workers, (2) number of individuals newly enrolled in FIM, (3) number of enrollees completing FIM curriculum <p><i>Target:</i> meet projected number of CHWs each year, 2,000 enrollees by 2030, 100% completion rate for FIM curriculum</p> <ul style="list-style-type: none"> - Report at regional and state level for enrollees who complete curriculum pre- and post-intervention comparison for weight, blood pressure, and blood glucose levels (data collected from monitoring device data, EHRs) <p><i>Target:</i> All enrollees completing curriculum within normal range for weight, blood pressure, and blood glucose levels</p> <ul style="list-style-type: none"> - Report at state level for Medicaid enrollees who complete curriculum year-over-year comparison of total cost of care <p><i>Target:</i> 10% year-over-year reduction in total cost of care for Medicaid enrollees who complete curriculum</p>
2. Consumer-Facing Tech Adoption	Utilization and outcomes	<p>Report semi-annually at state level vendor-reported utilization in rural Kansas counties and vendor-reported outcomes for rural Kansas users</p> <p><i>Baseline:</i> pre-implementation data from vendors, if any; <i>Target:</i> 20% of rural adults using one or more technologies by 2031</p>
3. Dual Eligible Participation in Integrated Care	Engagement	<p>Report semi-annually at state level (1) number of PACE-eligible individuals in rural Kansas counties enrolled in PACE, and (2) number of non-PACE enrolled dual eligibles in rural Kansas counties receiving intensive care management services</p> <p><i>Baseline:</i> 2025 dual eligible and PACE enrollment data. <i>Target:</i> 20% increase in PACE enrollments; 20% of rural non-PACE-enrolled dual eligibles receiving care management services through Care Collaborative</p>

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

Initiative 2 Metrics and Evaluation Plan		Secure Local Access to Primary Care
Metrics	Description	Parameters
1. Rural Hospital Sustainability	Hospital operating margins	Report at individual rural hospital level year-over-year changes in operating margins reported on Medicare cost reports <i>Baseline:</i> 2024 cost report data. <i>Target:</i> Fewer than 20% of rural hospitals with negative operating margins by 2031.
2. Access to Care	Rural residents' perception of access to care and quality of care	Report bi-annually at regional and state level on rural resident survey results <i>Baseline:</i> 2026 survey. <i>Target:</i> Year-over-year statistically significant improvements
3. Grant Program Participation	Number of awardees and awardee performance for Regional Partnerships and REH Conversion/Transformational Capital Investments Grant Programs	<ul style="list-style-type: none"> - Report at state level for each application cycle number of applicants and funded projects - Report annually on individual grantee's adherence to implementation timeline and reported outcomes <i>Target:</i> Award full amount budgeted for each application cycle to meritorious applications, 100% awardee compliance with implementation and reported outcomes

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4. Anchor Hospital Advancement Program	Anchor hospital engagement	<ul style="list-style-type: none"> - Report quarterly at individual hospital level utilization of Anchor Hospital Advancement Program services by type of service - Report annually on results of survey of rural anchor hospital CEOs' perceptions of program participation and effectiveness <p><i>Target:</i> All rural anchor hospitals reporting positive operating margins by 2031; 100% hospital CEO satisfaction with program</p>
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Initiative 3 Metrics and Evaluation Plan		Build a Sustainable Rural Workforce
Metrics	Description	Parameters
1. Physician Pipeline	<p>Expanded physician training opportunities in rural communities</p> <p>Impact on rural provider-to-patient ratios</p>	<ul style="list-style-type: none"> - Report annually at state level (1) increase in rural physician residency programs/tracks by specialty; and (2) number of medical students assisted with housing during rural rotations. <p><i>Baseline:</i> 2026 survey. <i>Target:</i> New programs in 5 specialties by 2031, 200 medical students per year by 2028</p> <ul style="list-style-type: none"> - Report County Health Rankings & Roadmaps Project year-over-year changes in provider-to-patient ratios in rural Kansas counties. <p><i>Baseline:</i> 2026 report. <i>Target:</i> year-over-year statistically significant reductions</p>
2. Education and Training	Impact of training and education projects on allied health workforce shortages	<ul style="list-style-type: none"> - Report semi-annually at state level number and types of allied health scholarships awarded with RHT Program funds - Report quarterly at state and regional level (1) number of training sites and number of participants in mobile simulation labs; (2) participant-reported skill improvement on post-training survey. - Report year-to-year changes in allied health staff shortages reported in Kansas Hospital Association's Kansas Health Work Force Report (reported at state level). <p><i>Baseline:</i> 2025 Work Force Report. <i>Target:</i> year-over-year statistically significant reductions in reported allied health staff shortages</p>

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3. Recruitment and Retention	Impact of recruitment and retention projects on workforce shortages	<ul style="list-style-type: none"> - Report annually marketing campaign’s social media reach and impressions - Report at state level year-to-year changes in nursing and allied health staff turnover rates reported in KHA Kansas Health Work Force Report - Report annually at state and county level number of students trained at new clinical sites by job category and number of behavioral health apprenticeships created with RHT Program funds. <p><i>Baseline:</i> 2025 Work Force Report. <i>Target:</i> year-over-year statistically significant reductions in nursing and allied health staff turnover rates</p>
4. Career Exploration	K-12 student engagement	Report annually at state level number of rural HOSA chapters created and number of rural schools offering the health science CTE pathway using RHT Program funds

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

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<p>3. Medicaid Provider Incentive Payments</p>	<p>Provider engagement in care management/care coordination services</p>	<ul style="list-style-type: none"> - Report quarterly on county and state level number of incentive payments made to PCPs for engaging eligible Medicaid beneficiaries in care management/care coordination services - Report quarterly on progress towards inclusion of rural provider incentive payments for care management services for defined populations in MCO contracts for 2028-2030 period <p><i>Target:</i> All MCOs providing rural provider incentive payments beginning in 2028 with year-over-year growth in provider participation in 2029 and 2030</p>
<p>4. Transportation – Resolution of Challenges</p>	<p>Reported status of transportation-related challenges</p>	<p>Report annually at regional and state level results of surveys of rural hospital CEOs regarding status of transportation challenges (facility-to-facility and behavioral health-related transports)</p> <p><i>Baseline:</i> 2026 survey. <i>Target:</i> Zero reported challenges by 2031</p>
<p>5, Transportation – Total Cost of Care</p>	<p>Estimated savings</p>	<p>Report annually on state level Medicaid savings generated by EMS payments for treat-in-place and transport to alternate location</p> <p><i>Baseline:</i> 2026 spending. <i>Target:</i> 10% reduction in Medicaid EMS transport costs by 2031</p>

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Initiative 5 Metrics and Evaluation Plan		Harness Data and Technology
Metrics	Description	Parameters
1. Remote Monitoring Outcomes	Clinical performance measures for hospitals performing monitoring	Report year-over-year at individual hospital level changes in Medicare Inpatient Quality Reporting Program safety of care measure scores, complication rates, mortality rates, lengths of stay, and readmission rates at hospitals implementing remote monitoring <i>Baseline:</i> 2025 reported data. <i>Target:</i> statistically significant improvements on year-over-year basis
2. Telehealth Coordinators	Access to specialist services (pulmonology, rheumatology, neurology, psychiatry)	Report annually at regional and state level results of survey of rural PCPs regarding access to specialist services for their patients <i>Baseline:</i> 2026 survey results. <i>Target:</i> statistically significant improvements on year-over-year basis
3. Emerging Technologies	Technology utilization	Report annually at regional and statewide level results of survey of rural PCPs, rural hospital CEOs, and rural nursing facility CEOs regarding use of consumer-facing technology and AI solutions for patient care delivery, <i>Baseline:</i> 2026 survey results. <i>Target:</i> Year-over-year 10% increase
4. Health Information Exchange	Utilization and utility	<ul style="list-style-type: none"> - Report at state level year-over-year changes in rural provider HIE utilization (reported by state-certified HIEs) - Report annually at regional and statewide level results of survey of rural PCPs and rural hospital and CCBHC CEOs regarding utility of HIE connectivity for clinical care and/or revenue cycle <i>Baseline:</i> 2026 survey results. <i>Target:</i> all rural providers connected to HIE by 2031, year-over-year improvements in reported utility of HIE connectivity
5. Data Infrastructure	Rural providers' perception of data infrastructure	Report annually at regional and statewide level results of survey of rural PCPs and rural hospital and rural CCBHC CEOs regarding perception of secure access to relevant data for patient care purposes <i>Baseline:</i> 2026 survey results. <i>Target:</i> year-over-year improvements in PCP and CEO perception of data accessibility

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VII. Sustainability Plan

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

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

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

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

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

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

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

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

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

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

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

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

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End Notes

These pages do not count toward 60-page limit

- ⁱ America Community Survey 5-Year Summary 2019-2023 Table B03002, available at <https://www.census.gov/data/developers/data-sets/acs-5year.html>
- ⁱⁱ U.S. Department of Agriculture Economic Research Service County-Level Data Sets – Population, available at <https://data.ers.usda.gov/reports.aspx?ID=4049>
- ⁱⁱⁱ Office of Management and Budget Bulletin No. 23-01 July 2023, available at <https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf>
- ^{iv} U.S. Department of Agriculture Economic Research Service County-Level Data Sets – Population, available at <https://data.ers.usda.gov/reports.aspx?ID=4049>
- ^v American Community Survey 5-Year Summary 2019-2023 Table S2403, available at <https://www.census.gov/data/developers/data-sets/acs-5year.html>
- ^{vi} Available at https://www.zipdatamaps.com/counties/state/economics/map-of-current-unemployment-rate-for-counties-in-kansas#google_vignette
- ^{vii} Available at <https://www.bls.gov/eag/eag.ks.htm>
- ^{viii} Available at https://www.khi.org/wp-content/uploads/2025/05/Annual-Insurance-Update-2025_web.pdf
- ^{ix} Medicaid State Fact Sheet May 2025 Kaiser Family Foundation, available at <https://files.kff.org/attachment/fact-sheet-medicaid-state-KS>
- ^x Available at <https://www.kff.org/state-health-policy-data/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market>
- ^{xi} Kaiser Family Foundation. Analysis of the Centers for Disease Control and Prevention 2023 Behavioral Risk Factor Surveillance System, available at. <https://www.kff.org/state-health-policy-data/state-indicator/adults-ages-18-64-who-report-having-chronic-conditions/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- ^{xii} U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, available at <https://www.americashealthrankings.org/explore/measures/>
- ^{xiii} Available at <https://mhanational.org/wp-content/uploads/2025/09/State-of-Mental-Health-2025.pdf>

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^{xiv} U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death by Single Race Files via CDC WONDER Online Database, 2020-2022, available at https://www.americashealthrankings.org/explore/measure/teen_suicide

^{xv} County Health Rankings, available at <https://www.countyhealthrankings.org/health-data/kansas?year=2025>

^{xvi} Id.

^{xvii} ^{xvii} County Health Rankings and Roadmaps 2019-2022, available at <https://www.countyhealthrankings.org/>

^{xviii} Available at <https://kdhe.maps.arcgis.com/apps/webappviewer/index.html>

^{xix} Available at <https://www.kumc.edu/documents/son/nursing-work-force/Access-to-Maternity-Care-Report.pdf>

^{xx} Available at <https://cdn.ymaws.com/communitycareks.site-ym.com/resource/resmgr/documents/2025-membermap-ccnk-4-15-25.pdf>

^{xxi} Available at <https://www.khanet.org/CriticalIssues/FinancialStability/FinanceResources/d175175.aspx?type=view>

^{xxii} Available at <https://www.chartis.com/insights/2025-rural-health-state-state>

^{xxiii} Hospital tracking data maintained by the Kansas Hospital Association.

^{xxiv} TUKHS' success under its CMS Innovation Center Award is detailed in Mathematica's program evaluation report, available at <https://downloads.cms.gov/files/cmimi/hcia2-yr3evalrpt.pdf>.

^{xxv} ^{xxv} Available at <https://pso.ahrq.gov/pso/kansas-clinical-improvement-collaborative-patient-safety-organization>

^{xxvi} Available at <https://www.ohsu.edu/sites/default/files/2023-01/How-Many-Hospitals-Might-Convert-to-a-Rural-Emergency-Hospital.pdf>

Budget Narrative File(s)

* Mandatory Budget Narrative Filename:

To add more Budget Narrative attachments, please use the attachment buttons below.

Budget Narrative - Administrative Expenditures

The following table summarizes SF-424A administrative expenditures:

Category	Year 1	Year 2	Year 3	Year 4	Year 5
A. Personnel & Fringe	\$328,324	\$400,190	\$417,643	\$435,997	\$455,268
B. Travel	\$9,144	\$9,144	\$9,144	\$9,144	\$9,144
C. Equipment	\$0	\$0	\$0	\$0	\$0
D. Supplies	\$5,384	\$200	\$200	\$200	\$200
E. Contract	\$2,613,704	\$2,557,568	\$2,695,426	\$2,557,568	\$2,695,426
F. Other	\$15,151	\$15,151	\$15,151	\$15,151	\$15,151
I. Direct Charges	\$2,971,707	\$2,982,253	\$3,137,564	\$3,018,060	\$3,175,189
J. Indirect @10%	\$297,171	\$298,225	\$313,756	\$301,806	\$317,519
Total	\$3,268,878	\$3,280,478	\$3,451,320	\$3,319,866	\$3,492,708

For the ten-month Budget Period 1 (December 31, 2025, to October 30, 2026), the State has budgeted the following amounts by category:

Personnel – Salary and Wages				
Position Title	Name	Annual Salary	Time	Amount Requested
Project Director	Janet Stanek	\$215,250	40%	\$0 (in-kind)
Chief Medical Officer	Dereck Totten, MD	\$134,524	15%	\$0 (in kind)
Bureau Director	Lainey Faulkner	\$106,790	10%	\$9,150
Section Director	Vacant	\$76,986	100%	\$64,160
Program Manager	Vacant	\$58,924	100%	\$49,100
Contract Specialist	Vacant	\$47,306	100%	\$39,420
Fiscal Analyst	Vacant	\$81,401	100%	\$67,830
Total Requested				\$229,660

The Secretary of the Kansas Department of Health and Environment (KDHE) will devote 0.40 FTE (in-kind) to the role of **Project Director** to provide oversight, facilitate partnerships, set goals, and monitor progress. The Project Director is committed to maintaining project staff and leveraging resources across the agency. KDHE’s **Chief Medical Officer** will devote 0.15 FTE (in-kind) and KDHE’s **Bureau Director** for Health Promotion and Public Health will devote 0.1 FTE to support the Project Director in performing these responsibilities.

The **Section Director** (1.0 FTE) will provide overall coordination, day-to-day program management, and facilitate coordination with internal and external partners. The Section Director will negotiate contracts and sub-recipient agreements and will work directly with vendors to ensure deliverables are met and invoices/expenditure reports are submitted appropriately and timely. The Section Director will support the development and submission of grant proposals and reports and will provide technical assistance to internal and external partners. In these efforts, the Section Director will be supported by a **Program Manager** (1.0 FTE), a **Contract Specialist** (1.0 FTE), and a **Fiscal Analyst** (1.0 FTE). The State also intends to pursue funding through the normal state budget appropriation process for four additional Program Managers to perform RHT Program responsibilities.

As detailed below, the State also has budgeted for fringe benefits for the personnel identified above.

Fringe Benefit	Rate	Salary Requested	Amount Requested
FICA	.07650	\$229,413	\$17,550.09
UIA	.00000		\$0
SLPA	.00470		\$1,078.24
Worker's Compensation	.00140		\$321.18
Retirement (KPERs)	.12680		\$29,089.57
Fringe Total	20.94%		\$48,039
Insurance	\$14,817 x FTE		\$50,625
Fringe/Ins Benefit Total			\$98,664

As detailed below, the State also has budgeted for fringe benefits for the personnel identified above. For subsequent Budget Periods, the State will request 12 months' salary for the personnel identified above with an annual 5% cost of living adjustment: Budget Period 2 – \$289,061; Budget Period 3 – \$303,514; Budget Period 4 - \$318,690; Budget Period 5 - \$334,625. Also, the State will request corresponding increases to fringe benefits using the formula detailed above: Budget Period 2 - \$60,529; Budget Period 3 - \$63,556; Budget Period 4 - \$66,734; Budget Period 5 - \$70,070.

Travel				
Purpose of Travel	Location	Item	Rate	Cost
On-Site Meetings	State-wide	Mileage	0.70/mile x 190 x 3 staff x 6 trips	\$2,394
CMS Conference	TBD	Airfare	\$600 round trip x 3 staff	\$1,800
		Lodging	\$450/night x nights x 3 staff	\$4,050
		Miscellaneous	\$100/day x 3 days x 3 staff	\$900
Total				\$9,144

Travel costs are calculated using current State of Kansas and GSA rates. In-state travel is intended for the Project Director, Section Director, and Program Manager to conduct RHT Program-related on-site meetings. Out-of-state travel is requested for CMS-hosted grantee meetings and/or national conferences for the same staff. All destinations are estimated to be in High-Cost Areas. Travel costs and justifications for Budget Periods 2-5 are the same as Budget Period 1.

Supplies		
Item	Rate	Cost
Laptops/monitors/keyboard/docking station	\$1,200 x 4	\$4,800
Office Supplies	\$50 x 4	\$200
Total		\$5,000

All supplies will be used for staff previously identified solely to perform RHT Program-related activities. Pursuant to established policy, all KDHE computers are leased on a four-year cycle; amounts requested are the per-year costs for the lease of standard-issue laptops, monitors, keyboards, and docking stations. Office supplies are standard items, e.g., pens, paper, printer ink.

Supply costs and justifications for budget periods 2-5 are the same as Budget Period 1.

The administrative expenditures listed under “Contract” relate to the sub-recipient agreement into which the State will enter with the University of Kansas Health System Care Collaborative, LLC.

1. **Method of Selection:** The Care Collaborative was selected based on proven leadership in rural health initiatives, strong working relationships with rural providers statewide, and engagement in Plan development (subject to KDHE purchasing protocols).
2. **Period of Performance:** January 1, 2026-September 30, 2031
3. **Scope of Work:** The Care Collaborative will serve as the RHT Program project management team. Responsibilities include coordination with Project Director and Kansas Rural Health Innovation Alliance to assure successful execution of the implementation plan, to report outcomes metrics, and to manage individual initiatives against approved annual budget.
4. **Method of Accountability:** Deliverables will be outlined in a signed subrecipient agreement. State officials will attend meetings, review and approve project deliverables, and discuss progress with the Care Collaborative team at least monthly. Payments will be made upon receipt of required deliverables and itemized invoices.
5. **Itemized Budget and Justification:** Dr. Robert Moser, MD, will serve as clinical lead, coordinating with rural providers, state leadership, and federal officials. A former Secretary of KDHE and inaugural Executive Director for the Center for Rural Health at the University of Kansas Medical Center, Dr. Moser served as a rural primary care physician for 22 years prior to joining the academic medical center. Martie Ross, JD, a healthcare consultant and former healthcare attorney most recently serving as Executive Director of the PYA Center for Rural Health Advancement, will manage program operations.

Personnel and Fringe								
Performance Year	Robert Moser, MD Program Executive		Martie Ross, JD Program Operations		Executive Assistant Vacant		Data Analyst Vacant	
	FTE	Salary	FTE	Salary	FTE	Salary	FTE	Salary
1	0.75	\$169,275	0.75	\$ 169,275	0.75	\$ 41,996	0.50	\$74,250
2	1.00	\$225,700	1.00	\$ 225,700	1.00	\$ 55,994	1.00	\$148,500
3	1.00	\$225,700	1.00	\$225,700	1.00	\$55,994	1.00	\$148,500
4	1.00	\$225,700	1.00	\$225,700	1.00	\$55,994	1.00	\$148,500
5	1.00	\$225,700	1.00	\$225,700	1.00	\$55,700	1.00	\$148,500
Performance Year	Fringe		Salary		Fringe		Salary	
1	0.25	\$42,319	0.25	\$ 42,319	0.25	\$ 10,499	0.25	\$18,563
2	0.25	\$56,425	0.25	\$ 56,425	0.25	\$ 13,999	0.25	\$37,125
3	0.25	\$56,425	0.25	\$56,425	0.25	\$13,999	0.25	\$37,125
4	0.25	\$56,425	0.25	\$56,425	0.25	\$13,999	0.25	\$37,125
5	0.25	\$56,425	0.25	\$56,425	0.25	\$13,999	0.25	\$37,125

Annual Travel Expense (Years 1-5)				
Purpose of Travel	Location	Item	Rate	Cost
On-Site Meetings	State-wide	Mileage	0.70/mile x 20,000	\$14,000
CMS Conference	TBD	Airline	\$600 round trip x2 staff	\$1,200
		Hotel	\$450/night x3 nights x2 staff	\$2,700
		Per diem	\$25 x2 staff x 3 days	\$150
Total				\$18,250

Annual Supplies Expense (Years 1-5)		
Item	Rate	Cost
Laptops/monitors/keyboard/docking station	\$2,500 x 3	\$7,500
Office Supplies	\$150 x 4	\$600
Total		\$8,100

Contracts: In its role as project manager, the Care Collaborative intends to contract with an external accounting firm at an estimated cost of \$300,000 for all five years of the project to provide KDHE with the documentation for rural incentive payments, vendor invoices, and grant payments. Additionally, an external marketing firm will be identified for development of a website and

marketing materials at an estimated cost of \$400,000 in Year 1. A statewide evaluation survey will be contracted for Year 1, Year 3 and Year 5. A metric reporting platform will be established in Year 1 and a grants management contract is budgeted for Years 1-4.

Item	Rate	Cost
Evaluation Survey	\$137,858 Y1, Y3, Y5	\$137,858
Metric Reporting Platform	\$181,000 Y1	\$181,000
Funding Pool Grants Management	\$1M Y1-Y4	\$1,000,000
Accounting	\$300,000	\$300,000
Marketing and Web Design/Hosting	\$400,000	\$400,000
Total		\$2,081,858

Budget Narrative – Initiative 1

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

The following table summarizes the SF424A expenditure plan for Initiative 1: Expand Primary and Secondary Prevention Programs for each of the five performance years.

Category	Year 1	Year 2	Year 3	Year 4	Year 5
A. Personnel/Fringe	\$0	\$0	\$0	\$0	\$0
B. Travel	\$0	\$0	\$0	\$0	\$0
C. Equipment	\$0	\$0	\$0	\$0	\$0
D. Supplies	\$0	\$0	\$0	\$0	\$0
E. Contract	\$35,742,766	\$37,433,147	\$39,621,871	\$40,270,595	\$40,798,560
F. Other	\$2,200,000	\$2,200,000	\$0	\$0	\$0
I. Direct Charges	\$37,942,766	\$39,633,147	\$39,621,871	\$40,270,595	\$40,798,560
J. Indirect Charges	\$248,585	\$248,585	\$248,585	\$248,585	\$248,585
Total	\$38,191,351	\$39,881,732	\$39,870,456	\$40,519,180	\$41,047,145

The following tables detail the expenditures for each of the contracts included under “Contract” in the above table.

Personnel			
Position	Rate	FTEs	Program¹
Community Health Workers	\$54,200	40-200	1
Nutritionists	\$48,454	6-29	1
Food System Specialists	\$157,671	4	1
Primary Care Practice Facilitators	\$89,000	6	3
Remote Patient Monitoring Staff	\$85,050	5	2
Certified DPP Trainer	\$48,000	1	2
Behavioral Health Case Managers	\$58,427	25	3
APRN .33 FTE per Hub x 6 Hubs	\$150,000	2	3
SUD screeners/patient navigators	\$104,000	5	3
Peer support specialists	\$75,000	10	3
Peer support supervisors	\$110,000	2	3
PACE personnel	\$962,000/year	1	4
Ambient RPM program manager	\$131,250/year	1	4

Travel			
Purpose	Miles @ .70/mile	Annual Rate	Program
Child psych screening training	4,900	\$7,000	3
Provider/patient engagement	9,100	\$13,000	3
RPM primary care engagement	8,400	\$12,000	4

Equipment			
Description	Price per unit	No.	Program
Refrigerated trucks	\$127,500	4	1
Care Coach technology	\$1.5M	1	4
PACE Center equipment	\$1.95M	1	4

Supplies			
Description	Cost	Number	Program
Remote patient monitoring units	\$300	400-2000	1
Remote monitoring glucose supplies	\$15.50 monthly	2000	1
Computers, software, relays	\$30,082	6	3
Pediatric psych training supplies	\$18,343	1	3
Data and cell phone communication	\$3,000	5 years	3
Office supplies	\$1,500	5 years	3
AI remote ambient monitoring devices	\$300	100-500	4
AI remote monitoring supplies	\$2,450	5 years	4

¹ The number listed under “Program” corresponds to the number assigned in the chart above to each of the programs that comprise Initiative 1. The same convention is used for the other initiatives.

Contracts			
Description	Cost	Duration	Program
Fitness and nutrition consumer-facing app	\$250,000	5 years	2
Computer-based cognitive behavioral health	\$6M	5 years	2
Diabetes Prevention Program (DPP) video production	\$120,000	6 months	2
Pharmacist DPP patient support services	\$7,396	5 years	2
Disease prevention and management consumer-facing app	\$2.635 M	5 years	2
Integrated behavioral health training	\$7.M	1 year	3
Behavioral health in nursing facilities	\$1.5M	3 years	3
Pediatric Psychiatric Access Program	\$1.2M	5 years	3

Other			
Description	Cost	Duration	Program
Behavioral health hub office leases	\$42,852/year	5 years	3
Data evaluation	\$100,000/year	5 years	3
Insurance, auditing, legal fees	\$500,000/year	5 years	3
PACE alternative care sites	\$500,000	4	4
PACE outreach/patient engagement	\$500,000	5 years	4
PACE center renovation	\$3M	1 year	4
Mobile cancer screening program	\$144,000	5 years	5
Tribal Health	\$2.2M	2 years	6

J. Indirect Charges			
Description	Cost	Duration	Program
Food Is Medicine/CHWs	\$42,852/year	5 years	1

Accountable Food Is Medicine and Community Health Worker Deployment Program includes 6 primary care practice facilitators, 5 remote monitoring staff, and 20 CHWs in Year 1, adding 20 more CHWs each year, all employed by the Care Collaborative. Kansas State University Research and Extension will employ 29 nutritionists, 4 regional food system specialists, and 20 CHWs in Year 1, adding 20 more CHWs each year. The budget includes the purchase of four refrigerated trucks for rural food delivery and remote monitoring technology at a rate of \$300 per patient per initial year and \$15.50 per month in monitoring fees, thereafter. Offsetting RPM revenues are budgeted in years 2-5: Year 2 projected at \$180,000; Year 3 at 360,000; Year 4 at \$720,000; and Year 5 at \$900,000.

The budget for the **Consumer-Facing Technology Program** is based on proposals received by the State, including YMCA 360 (platform accessibility and baseline data establishment; community deployment, content creation, marketing and installation at community sites; and AI integration, personalization of features and remote capabilities), Thrive Digital Mental Health (licensing and platform deployment; implementation and training; case management; and evaluation, data and outcomes monitoring), and LEAP Lifestyle Platform and Brain Health/My

ALZ (on-line tool to reduce the incidence of Alzheimer’s and dementia through lifestyle change together with resources and support for those recently diagnosed with these conditions). Funding for the Asynchronous Diabetes Prevention Program (DPP) supports development and editing of 12 patient education video modules; certified DPP contracted staff to support patient virtual visits and daily review of remote monitoring findings, and rural pharmacist chronic care management visits with participating DPP patients estimated at 144 per year.

Funding for the **Behavioral Health Services Program** includes (1) integrated behavioral health on-site training and workflow development to assist 80 rural primary care practices in the implementation of integrated behavioral health services, including an assessment of on-site vs. telehealth provider options; (2) development and expansion of a nursing facility embedded staff model through partnership with CCBHCs, which State leadership intends to incorporate into state funding streams by Year 4; (3) embedded case managers at behavioral health intervention hubs at six regional emergency departments, with 4.2 FTE case managers per site and a shared APRN per three hubs, along with operating expenses including computers, software and relay devices, and office leases at each hospital site; (4) the Kansas Psychiatric Access Program, with contracted expertise in child psychiatry, perinatal psychiatry, and behavioral pediatrician along with 1.5 social work care coordinators, .33 FTE training program coordinator, and .80 FTE training coordinator; and (5) a statewide SUD Referral and Stabilization Network to include 5 FTE screeners/patient navigators, 10 peer support specialists, plus two supervisory positions and 1 FTE Director, along with data/evaluation, insurance, auditing and legal fees.

The Integrated Care for Dual Eligible Beneficiaries Program includes expansion into four rural Alternative Care sites and two PACE Center rural expansions, plus expansion into western Kansas, where no current program exists, along with concentrated patient enrollment efforts. For those dual eligible beneficiaries for whom PACE is not an option, AI ambient monitoring will be furnished leveraging shared remote monitoring staff and offset by billable services (\$120,000 in Year 2; \$240,000 in Year 3; \$360,000 in Year 4 and \$480,000 in Year 5), with the budget including a contract Nurse Program Manager plus travel, marketing materials and supplies. Offsetting revenues are estimated.

The **Mobile Cancer Screening Program** utilizes existing investment by the Masonic Cancer Alliance in a mobile medical unit. The proposal extends its use to an additional 10 rural communities a year without access to dermatologists or urologists for routine cancer screenings at an estimated expense of \$14,400 per rural site per year.

The expenditure listed under “Other” in the table above relates to the **Tribal Health Program**, which includes \$200,000 for strategic planning for the four federally recognized tribes relating to development of primary and secondary prevention programs associated with their rural clinics, with \$2 million has been budgeted to support those programs.

Budget Narrative – Initiative 2

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

The following table summarizes the SF424A expenditure plan for Initiative 2: Secure Local Access to Primary Care for each of the five performance years.

Category	Year 1	Year 2	Year 3	Year 4	Year 5
A. Personnel and Fringe Benefits	\$0	\$0	\$0	\$0	\$0
B. Travel	\$0	\$0	\$0	\$0	\$0
C. Equipment	\$0	\$0	\$0	\$0	\$0
D. Supplies	\$0	\$0	\$0	\$0	\$0
E. Contract	\$16,285,550	\$16,885,550	\$16,085,550	\$18,279,550	\$16,079,550
F. Other	\$60,000,000	\$36,000,000	\$21,000,000	\$19,000,000	\$9,000,000
I. Direct Charges	\$76,285,550	\$52,885,550	\$37,085,550	\$37,279,550	\$29,079,550
J. Indirect Charges	\$0	\$0	\$0	\$0	\$0
Total	\$76,285,550	\$52,885,550	\$37,085,550	\$37,279,550	\$25,079,550

The following tables detail the expenditures for the contracts included under “Contract” in the above SF424A table.

Personnel			
Position	Rate	FTEs	Program
Direct-to Employer Professional	\$225,700	1	3
Anchor Hospital Managed Care Professional	\$225,700	.5	4
Coders, Billers and Denial Specialists	\$107,000	14	3
Credentialing Specialists	\$107,000	14	3
Certified Medical Assistants	\$67,500	5	5
Population Health Trainer/Manager	\$106,000/year	2	5
Primary care/public health planners	\$180,000/year	.5 x 2	6

Travel			
Purpose	Miles	Rate	Program
Public health/primary clinic site visits	5000/year	.70	6

Equipment			
Description	Price per unit	No.	Program
Credentialing platform	\$600,000	1	3

Contracts			
Description	Rate	Duration	Program
Commercial Rate Analysis	\$1.5M	2 years	3
Anchor Hospital On-Demand Experts	\$100,000/year	5	4
Anchor Hospital Revenue Support	\$200,000/year	5	4
Anchor Hospital AI/EMR Optimization	\$49M/total	5	4
Software and Maintenance	\$600,000/year	5	3
Data and Compliance	\$550,000/year	5	3
Technology Platform Maintenance	\$600,000/year	5	3
Public Health Data Platform	\$300,000/year	5	6

The following table details the expenditures listed under “Other” in the SF424A above table.

Other			
Description	Rate	Duration	Program
Legal Contracting and Collections	\$200,000/year	5	3
Data Security and Compliance	\$550,000/year	5	3
Reporting and CMS Analysis	\$100,000/year	5	3
Technical College Tuition, Books, Fees	\$25,000/year	5	5
Regional Partnership Grant Program	\$84M/total	4	1
REH/Transformational Capital Investment Grant Program	\$32M/total	3	2

The **Revenue Improvement Program** includes funding for a qualified consultant to complete a statewide commercial rate analysis comparing rural commercial rates as a percentage of Medicare for purposes of managed care negotiations and contracting and funding for recruitment of an experienced managed care professional to conduct direct-to-employer negotiations for rural organizations. This program also includes establishment of revenue cycle support and credentialing organization to serve rural providers. Start-up costs include launch and maintenance of technology platforms; software and maintenance; data security and compliance; development and sustainability of an all-payer scorecard; legal contracting and collections; staff onboarding and

annual training; and reporting and CMS analysis. A total of 14 revenue cycle FTEs and 14 credentialing FTEs is budgeted.

The **Anchor Hospital Advancement Program** supports rural anchor hospitals by making available performance analytics, EHR optimization, managed care consulting services, and on-demand resources. A shared managed care professional, on-demand resources from subject matter experts and revenue optimization support is budgeted. Funds for AI acquisition and implementation and EMR optimization is budgeted at \$7M in Year 1; \$8.2M in Year 2; \$9.6M in Year 3; \$11.2M in Year 4; and \$13M in Year 5.

The **Mobile Integrated Health Pilot Program** will include five rural sites staffed by Certified Medical Assistants (CMAs), the cost for which includes training at a Kansas technical college at \$25,000 per student (tuition, housing, books and fees) plus the cost of a population health instructor is budgeted in Year 1. In Year 2, CMAs will begin making Medicaid home visits at a cost of \$67,500 for each CMA. The State Medicaid program will evaluate whether to establish reimbursement for these services in Year 3 based on Year 2 results.

The three-phase plan for the **Rural Primary Care/Public Health Integration Program** includes assessment and planning in Year 1 at an estimated cost of \$300,000 for data infrastructure, \$180,000 in staff costs, \$3,500 for travel to rural sites, and lease expenses for the rural hubs. Year 2 focuses on “right-sizing” through six regional hubs, and Years 3-5 support ongoing implementation, maintenance of changes, and sustainability planning plus lease space in the rural hubs.

The budget includes significant funds to be available through the **Regional Partnership Grant Program** to facilitate innovative, collaborative relationships among rural providers. Similarly, the **Rural Emergency Hospital/Transformative Capital Investment Grant Program** is targeted toward those for whom dollars can assist in bridging the transition to a new model of care.

Budget Narrative – Initiative 3

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

The following table summarizes the SF424A expenditure plan for Initiative 3: Build a Sustainable Rural Workforce for each of the five performance years

Column A	Column B	Column C	Column D	Column E	Column F
Category	Year 1	Year 2	Year 3	Year 4	Year 5
A. Personnel and Fringe Benefits	\$0	\$0	\$0	\$0	\$0
B. Travel	\$0	\$0	\$0	\$0	\$0
C. Equipment	\$0	\$0	\$0	\$0	\$0
D. Supplies	\$0	\$0	\$0	\$0	\$0
E. Contract	\$16,171,334	\$20,952,570	\$22,978,370	\$25,021,996	\$28,069,929
F. Other	\$5,900,000	\$5,400,000	\$5,900,000	\$3,400,000	\$1,900,000
I. Direct Charges	\$22,071,334	\$26,352,570	\$28,878,370	\$28,421,996	\$29,969,929
J. Indirect Charges	\$0	\$0	\$0	\$0	\$0
Total	\$22,071,334	\$26,352,570	\$28,878,370	\$28,421,996	\$29,969,929

The following tables detail the expenditures for each of the contracts included under “Contract” in the SF424-A table above.

Personnel			
Position	Rate w/benefits	FTEs	Program
Kansas Bridging Program Manager	\$81,000	1	1
Medical Housing Program Manager	\$100,000	.5	1
Health Professions Scholarship Manager	\$100,000	1	2
Dental Scholarship Program Manager	\$100,000	.5	2
RN Nurse Trainer	\$118,750	1	2
Mobile Simulation Manager	\$93,750	1	2
Nurse Residency Program Managers	\$150,000	2	3
Nurse Preceptor Faculty	\$166,667	3	3
HOSA AHEC Staffing	\$150,000	1	4

Travel			
Purpose	Miles @ .70/mile	Annual Rate	Program
Mobile Simulation Vehicle	34,000	\$23,800	2

Equipment			
Description	Price per unit	No.	Program
Modified Recreational Vehicle	\$750,000	1	2
High-Fidelity Manikin	\$117,615	1	2
Trauma Limbs	\$40,000	1	2
Anatontage/Simulation	\$30,000	1	4

Supplies			
Description	Cost	Number	Program
Tracking Software	\$5,000	1	1
Virtual Headsets	\$6,392	8	2
Software and 15 Training Modules	\$140,060	1	2
Medical Training Supplies	\$90,000/year	5 years	2

Contracts			
Description	Cost	Duration	Program
Rural-Tract Residencies	\$6.72M	5 years	1
Nurse Residency Curriculum	\$200,000	5 years	3

The following table details the expenditures included under “Other” in the SF424A table above.

Description	Cost	Duration	Program
Housing Stipends	\$500,000/year		1
Health Professions Scholarships	\$2.6M/year		2
Dental Scholarships	\$650,000/year		2
Work in Rural Marketing Campaign	\$1.5M/year	2 years	3
Leadership/Workforce Days	\$50,000	3 years	3
New Member Dashboard	\$30,000	1 year	4
K-12 Health Science Career Program	\$266,500	5 years	4
Career Expos	\$40,000	5 years	4

Under the **Physician Pipeline Program**, funding is included to establish rural residencies in five high-need specialties: OB/GYN, Behavioral Health, Family Medicine, General Surgery, Psychiatry, and Orthopedics. The contract includes \$115,000 per resident, budgeted at a 5% increase annually, and the addition of an Associate Dean (\$225,700), administrative assistant (\$75,000) and clinic supervisor (\$75,000) to operate the programs. Funding for program expansion includes rural faculty and lease for rural residency space. Year 1 totals \$6.72M; Year 2 \$11.1M; Year 3 \$14.4M; Year 4 \$15.9M and Year 5 \$18.7M.

Expansion of the Kansas Bridging Program increases funding by \$20,000 per slot for current slots, bringing the total to \$30,000 per resident. The budget adds new slots in high-need specialties, all with a five-year service commitment. The budget also includes 1.0 FTE program manager and \$5,000 for tracking software. Total expenses for the program are \$695,000 in Year 1; \$855,000 in Year 2; \$955,000 in Year 3; \$957,578 in Year 4; and \$960,227 in Year 5.

Medical Student Rural Rotation Housing Assistance Program provides up to \$1,000 per week of housing stipend for an estimated 5 weeks per rural rotation. A total of 100 rotations are budgeted, annually, with program administration and reporting through a contracted .5 FTE.

The **Education and Training Program** includes the Health Professions Service Scholarship Program which establishes Undergraduate/Technical College scholarships of \$5,000 per year for 200 students; and Post-Graduate Health Professions Scholarships of \$15,000 year for 100 students. Program administration is budgeted at 1.0 FTE. The Rural Dentistry Scholarship Program includes 10 awards of \$50,000 each for dental students and 15 awards of \$10,000 each for hygiene students. A .5 FTE for program administration is budgeted.

Estimated expenses for the Mobile Simulation Lab include \$750,000 for customized vehicle; \$117,615 for high-fidelity manikin and \$40,000 for trauma limbs; \$140,060 for simulation software and 15 training modules; \$6,392 for virtual headsets; and \$90,000 for medical training supplies. Staffing includes a 1.0 FTE registered nurse trainer, a 1.0 FTE program manager, and a contracted physician trainer at a rate of \$1,500 per day for 34 trainings, totaling \$51,500 annually.

The **Recruitment and Retention Program** includes the “Work in Rural Kansas Health Care” marketing campaign designed to promote open opportunities in rural areas across the state, seeking to educate urban health care workforce on the benefits of rural work and rural life. A total of \$1.5M per year for two years is budgeted for the campaign.

Rural Nurse Residencies target hospitals with under 100 beds with a goal of 10-20 participating hospitals in Year 1 with 50 new graduate nurses. Participation is budgeted to increase to 50 hospitals by Year 3 and 150+ new graduate nurses enrolled in the program by Year 5. The budget includes acquisition of nurse residency curriculum at \$200,000 in Year 1; \$300,000 in Year 2; \$500,000 in Year 3; then incrementally for per-student resources to \$515,000 in Year 4; and \$530,450 in Year 5. Staffing includes 2.0 FTE program managers.

Clinical Instructor and Preceptor Incentives Program establishes a clinical faculty academy, training 50 nurse educators across 5-7 nursing schools and 10 rural hospitals in Year 1, increasing each year to a target of 150 in Year 5. Budget includes \$500,000 in Year 1 for adjunct faculty incentives at \$10,000 per nurse instructor; \$750,000 in Year 2; \$1M in Year 3; \$1.25M in Year 4; and \$1.5M in Year 5. Staffing and training include 3.0 FTEs nurse faculty.

The **Career Exploration Program** includes expansion of rural chapters of HOSA with the goal increasing the number of participating Kansas counties by 20% and connecting 75% of chapters to local health care organizations. Expenses include \$150,000 for 1.0 FTE contracted staff. \$200,000 is requested for two new Leadership Conferences and expansion of Workforce Days. The Year 3 budget seeks \$230,000 to offset additional costs of an Anatomage/simulating training program. In Year 4, \$230,000 is budgeted for the launch of a membership dashboard, and the Year 5 budget includes \$200,000 to deliver sustainability training through implementation of membership fees, conference registrations, exhibitor/vendor support, and health care partnerships.

The K-12 Health Science Career Technical Education Program launches in 5-10 rural schools in Year 1, expanding to 20 rural schools and an estimated 200 students in Year 2-3, scaling the program to 40 rural schools and partner hospitals with a goal of 400+ students impacted in Years 4-5. Total budget is estimated at \$24,000 per rural site including instructor stipend, student transportation, and training equipment. Student certification fees, estimated at \$165 per exam from the National Health Career Association, is budgeted at 10 students per location. An additional

\$40,000 per year is budgeted to support Regional Career Expos. The total budget is \$266,500 in Year 1; \$533,000 in Year 2; \$799,500 in Year 3 and \$1,066,000 in Years 4 and 5.

The Health Care Training Grants create an opportunity for rural communities to submit innovative and transformative ideas for implementation on a smaller scale. The budget also includes \$200,000 a year for Behavioral Health Apprenticeship funding, and High School Certification/Pre-Apprenticeships budgeted at \$200,000 annually.

Budget Narrative – Initiative 4

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

The following table summarizes the SF424A expenditure plan for Initiative 4: Enable Value-Based Care for each of the five performance years

Category	Year 1	Year 2	Year 3	Year 4	Year 5
A. Personnel and Fringe Benefits	\$0	\$0	\$0	\$0	\$0
B. Travel	\$0	\$0	\$0	\$0	\$0
C. Equipment	\$0	\$0	\$0	\$0	\$0
D. Supplies	\$0	\$0	\$0	\$0	\$0
E. Contract	\$27,591,000	\$40,057,000	\$53,015,000	\$50,311,000	\$54,780,000
F. Other	\$14,000,000	\$16,000,000	\$14,500,000	\$16,500,000	\$18,500,000
I. Direct Charges	\$41,591,000	\$56,057,000	\$67,515,000	\$66,811,000	\$73,280,000
J. Indirect Charges	\$246,229	\$252,746	\$259,422	\$266,362	\$274,471
Total	\$41,837,229	\$56,309,746	\$67,774,422	\$67,077,362	\$73,554,471

The following tables detail the expenditures for each of the contracts included under “Contract” in the SF424-A table above.

Personnel			
Position	Rate	FTEs	Program
Performance Improvement Specialist	\$116,250	1	1
Metrics Data Manager	\$134,759	1	1
Medicaid Practice Facilitator	\$131,250	1	4

Travel			
Purpose	Miles @ .70/mile	Annual Rate	Program
Performance Visits to Rural Sites	8,400	\$12,000	1
Medicaid Clinic Site Visits	9,100	\$13,000	4

Equipment			
Description	Price per unit	No.	Program
EMS Interfacility Transport Units	\$688,347	6	3

Contracts			
Description	Cost	Duration	Program
ACO Readiness Program	\$441,000	5 years	2
EMS Interfacility Transport Teams	\$400,390	5 years	3
Behavioral Health Crisis Transport	\$2.46M	5 years	3
Behavioral Health Crisis Transport – Indirect	\$246,000	5 years	3
Non-Emergency 911 Calls	\$3.25M	5 years	3

The following table details the expenditures included under “Other” in the SF424A table above.

Description	Cost	Duration	Program
Evidence-Based Practice Incentives	\$19,935,000	5 years	1

The **Evidence-Based Practice Incentive Program** will utilize a well-established quality reporting platform with which rural providers are familiar to support quarterly reporting across all five years of the program. Rural organizations will be eligible for up to \$50,000 per quarter per hospital and \$10,000 per quarter per primary care clinic and CCBHC for achieving population health targets. The budget for incentives increases each year, assuming growing participation and improved performance over time. Year 1 is forecast at \$19.9M; Year 2 at \$25.2M; Year 3 at \$30.1M; Year 4 at \$31.9M and Year 5 at \$33.2M. A performance improvement specialist and metrics data manager will staff the program all five years.

The **ACO Readiness Program** will be developed through agreement with a CMS-contracted value-based care organization. For budgeting, a successful national vendor under the Medicare Shared Savings Program and ACO REACH models estimated per member per month expense of practice benchmarking, data dashboards, provider education and 5-year training on value-based metrics. The budget includes primary care incentives of \$75 and \$125 for annual wellness and transition of care (post-hospitalization and emergency room) visits, mirroring best practice programs. The estimated cost is \$49 PMPM with 10,000 attributed beneficiaries projected by Year 5, totaling \$441,000 in Year 1; \$882,000 in Year 2; \$2.94M in Year 3; \$4.4M in Year 4 and \$5.9M in Year 5.

The **Transportation Program** includes funding to implement interfacility transport teams at two rural hubs per year over the first three years of the program. Annual operating costs of \$400,390 will support 8.4 FTEs staffing (24/7/365 paramedic and RN teams) per unit in each of the five contracted years. Acquisition of equipment and supplies for each regional emergency transport team will be the responsibility of local EMS organizations and are budgeted at \$668,347 per unit. Total cost is \$4.3M in Year 1; \$5.1M in Year 2; \$9.4M in Year 3; \$2.4M in Year 4; and \$2.4M in Year 5.

The contract for Behavioral Health Crisis Transports includes 5 FTEs for each of the five regions, plus 2 FTE accessors to conduct evaluation and referral to the appropriate setting and 4 FTE dispatch coordinators to provide coverage on a 24/7/365 basis. Staffing totals \$1,417,750 in Year one, increasing 3% annually with a benefits rate of 30% of annual salary. Contracted equipment and supply expenditures include five leased vehicles, vehicle operating expenses, and computer and cell communication capabilities. Total cost of behavioral health transport is \$2.46M in Year 1; \$2.53M in Year 2; \$2.6M in Year 3; \$2.66M in Year 4; and \$2.7M in Year 5.

The non-emergency 911 calls expense includes integration of technology in local call centers through a team of trained nurse navigators guiding patient transport to non-emergent resources, as appropriate. If hospital care is needed, the team will identify available beds, align with payer networks, secure authorizations and dispatch transport. Total costs for the 911 REACT contract is \$3.25M in Year 1, \$3.36M in Year 2, \$3.48M in Year 3, \$3.01M in Year 4 and \$3.14M in Year 5.

The **Non-Emergency Transportation Grant Program** recognizes some rural communities lack local transportation for medical services, resulting in patients not receiving needed care. To fill those gaps, without duplicating existing rural services, the budget includes \$7M in Years 1 and 2 to fund innovative and sustainable local solutions.

The **Medicaid Provider Incentive Payment Program** includes incentives for rural primary care providers who successfully connect patients to MCO care coordination services. Total expenditures are based on an average primary care clinic volume per week, per rural primary care clinic, with an escalating rate of adoption of 10 percent each year. A practice facilitator will incorporate patient identification and consent into clinic workflows at an annual contracted rate of \$131,250. Total budget for the program is estimated at \$7M in Year 1; \$9M in Year 2; \$11M in Year 3; \$13M in Year 4; and \$18M in Year 5.

Budget Narrative – Initiative 5

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

The following table summarizes the SF424A expenditure plan for Initiative 5: Harness Data and Technology for each of the five performance years:

Category	Year 1	Year 2	Year 3	Year 4	Year 5
A. Personnel and Fringe Benefits	\$0	\$0	\$0	\$0	\$0
B. Travel	\$0	\$0	\$0	\$0	\$0
C. Equipment	\$0	\$0	\$0	\$0	\$0
D. Supplies	\$0	\$0	\$0	\$0	\$0
E. Contractor	\$12,099,750	\$16,372,150	\$19,794,150	\$23,062,150	\$26,237,150
F. Other	\$5,964,000	\$3,000,000	\$3,000,000	\$0	\$0
I. Direct Charges	\$18,063,750	\$19,372,150	\$22,794,150	\$23,062,150	\$26,237,150
J. Indirect Charges	\$138,000	\$138,000	\$138,000	\$138,000	\$138,000
Total	\$18,201,750	19,510,150	\$22,932,150	\$23,200,150	\$26,375,150

The following tables detail the expenditures for each of the contracts included under “Contract” in the SF424-A table above.

Personnel			
Position	Rate	FTEs	Program
Telehealth CNA Coordinators	\$52,000	6.0	2
Telehealth Navigation Program Manager	\$84,000	1.0	2
Physician Principal Investigator	\$225,700	.20	3
Data Dock Program Manager	\$130,000	.50	3
Project Manager	\$85,000	1.0	3
Training Manager	\$85,000	1.0	3
Implementation Lead	\$80,000	1.0	3
Data Engineer	\$126,000	.50	3
Collaborative Care RN	\$104,000	1.0	3
Diabetes Educator	\$89,100	.50	3
Clinical Pharmacist	\$90,000	.50	3
Endocrinologist	\$225,700	.25	3
CCBHC Data Scientist	\$147,000	.25	3
Data Trust Data Engineer	\$150,000	.50	3
Rural Coordinators	\$75,000	2.0	3
Data Project Manager	\$150,000	1.0	3
Business Development Manager	\$150,000	1.0	3

Travel			
Purpose	Miles @ .70/mile	Annual Rate	Program
Telehealth Coordinator Staffing	12,000	\$8,400	2
Telehealth Navigation Manager	6,000	\$4,200	2

Equipment			
Description	Price per unit	No.	Program
Data Platform	\$180,000	1	3

Supplies			
Description	Cost	Number	Program
Computers, Dual Monitors, Cell	\$4,000/FTE	6	2

Contracts			
Description	Cost	Duration	Program
Remote Inpatient/Post-acute Monitoring	\$9.75M	5 years	1
All Payer Claims Database Intake	\$75,000	1 year	3
APCD Visualization/Analyst Access	\$650,000	4 years	3
Data Dock	\$1.38M	5 years	3
Data Dock – Indirect Costs	\$138,000	5 years	3

The following table details the expenditures included under “Other” in the SF424A table above.

Description	Cost	Duration	Program
Oracle Clinical AI Agent	\$2,964,000	2 years	4
Technology Grants	\$3M	2 years	4

Under the **Remote Monitoring Program**, wearable devices will be utilized for hospital inpatients and those recently discharged from the hospital, estimated to grow to a cumulative 125,000 patient encounters in Year 5. Cost estimates were furnished by a vendor that has successfully implemented monitoring programs in rural hospitals. Year 1 costs are at \$9.75M for initial deployment of the devices and staffing the monitoring hub; increasing to \$13M in Year 2; \$16.25M in Year 3; \$19.5M in Year 4; and \$22.75M in Year 5.

The **Telehealth Navigator Program** budget includes \$52,000 for 1.0 FTE Certified Nursing Assistant and \$84,000 for 1.0 FTE Program Manager (plus benefits) in Year 1. The program adds 3.0 FTE CNAs in Year 2, 5.0 FTE CNAs in Year 3, and 6.0 FTE CNAs in Years 4 and 5. Total budget includes \$4,000 per FTE for supplies including computer equipment, multiple scheduling monitors, and cell phone along with an estimated \$1,000 per month per FTE for travel to rural clinic sites. Total Year 1 budget \$152,000; \$404,000 in Year 2; \$576,000 in Year 3; and \$644,000 in Years 4 and 5.

The **Data Infrastructure Program** encompasses several projects, including an expanded All-Payer Claims Database for Kansas built on the successful Colorado model, rather than replicating foundational expense. Year 1 includes \$75,000 for data intake across 6 payers and training for 5 analysts (three current KDHE FTEs). A 1.0 FTE Senior Analyst/Program Manager and a 1.0 FTE Program Analyst are budgeted at \$225,700 including benefits. Year 1 budget totals \$526,400. With the addition of \$650,000/year in Years 2-5 for data intake, visualization and analyst access, subsequent budgets total \$1,101,400 annually.

The Data Dock currently aggregates data across continuous glucose monitors and EHRs, translating the data into information useful to physicians. Year 1 includes four rural primary care pilot sites, expanding to 30 additional sites in subsequent years, incorporating data from the Kansas Health Information Exchange. Year 5 includes expansion into chronic conditions beyond diabetes including hypertension, maternal health, behavioral health, heart failure and prediabetes. Budgeted expense includes .10 FTE of two physician principal investigators at \$225,700; .5 FTE program manager at \$130,000; 1.0 FTE project manager at \$85,000; 1.0 FTE training manager at \$85,000; 1.0 FTE implementation lead at \$80,000; .5 FTE data engineer at \$126,000; 1.0 FTE Collaborative Care RN at \$104,000; .50 FTE diabetes educator at \$89,100; .50 clinical pharmacist at \$90,000 and .25 FTE endocrinologist at \$225,700 including fringe benefits. Total budget for the contracted project is \$1.38M for all five years.

The CCBHC Data Center establishes a data warehouse to meet reporting requirements and continuous quality improvement needs. Data center development costs projected in Year 1 include \$180,000 for platform development. A .25 FTE data scientist contracted position, totaling \$36,750 per year, is budgeted across the five-year period.

The Kansas Data Trust combines healthcare data with education and workforce datasets to determine what investments lead to healthier outcomes. The Year 1 budget includes .5 FTE data engineer at estimated rate of salary plus benefits of \$150,000. Year 2 includes two 1.0 FTE rural coordinators at salary plus benefits of \$75,000 each and 1.0 FTE Data Project Manager at a contracted salary and benefits of \$150,000 per year. Year 4 adds a 1.0 FTE Business Development Manager responsible for securing outside funding partnerships and Year 5 further reduces expense as additional funding sources are identified. Total budget for Year 1 is \$75,000; Year 2 \$450,000; Year 3 \$450,000; Year 4 \$400,000; and Year 5 \$325,000.

Under **the Emerging Technology Program**, \$2,964,000 is budgeted to provide those Kansas rural clinics utilizing the Oracle Community Works platform designed for smaller hospitals (approximately one-half of all rural clinics) with access to Oracle's Clinical AI Agent. Based on a rate of \$1.50 per note, Year 1 cost is estimated at \$7,800 per rural provider. For remaining rural clinics using one of several EHR platforms, \$3M is budgeted in Year 1 to provide technology grants for AI and other optimization strategies, with a total of \$3M budgeted for both programs in Years 2 and 3.

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

OMB Number: 4040-0013
Expiration Date: 06/30/2028

1. * Type of Federal Action: <input type="checkbox"/> a. contract <input checked="" type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. * Status of Federal Action: <input type="checkbox"/> a. bid/offer/application <input checked="" type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. * Report Type: <input checked="" type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change
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4. Name and Address of Reporting Entity:

Prime SubAwardee

* Name:

* Street 1: Street 2:

* City: State: Zip:

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency: <input type="text" value="Centers for Medicare & Medicaid Services"/>	7. * Federal Program Name/Description: <input type="text" value="Rural Health Transformation Program"/> Assistance Listing Number, if applicable: <input type="text" value="93.798"/>
---	--

8. Federal Action Number, if known: <input type="text"/>	9. Award Amount, if known: \$ <input type="text"/>
--	--

10. a. Name and Address of Lobbying Registrant:

Prefix * First Name Middle Name

* Last Name Suffix

* Street 1 Street 2

* City State Zip

b. Individual Performing Services (including address if different from No. 10a)

Prefix * First Name Middle Name

* Last Name Suffix

* Street 1 Street 2

* City State Zip

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

* Signature:

* Name: Prefix * First Name Middle Name
* Last Name Suffix

Title: Telephone No.: Date:

Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)
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Project/Performance Site Location(s)

Project/Performance Site Primary Location I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country:

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Project/Performance Site Location 1 I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country:

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Project/Performance Site Location 2 I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country:

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s)

Other Attachment File(s)

* Mandatory Other Attachment Filename:

[Add Mandatory Other Attachment](#)

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To add more "Other Attachment" attachments, please use the attachment buttons below.

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STATE OF KANSAS

CAPITOL BUILDING, ROOM 241 SOUTH
TOPEKA, KS 66612



PHONE: (785) 296-3232
GOVERNOR.KANSAS.GOV

GOVERNOR LAURA KELLY

October 30, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Oz,

On behalf of the State of Kansas, I want to express my strong support for the Kansas Rural Health Transformation (RHT) Plan. This initiative is a bold, collaborative effort to improve rural health systems across our state. It aims to ensure that every Kansan, no matter their ZIP code, has access to high-quality, sustainable care.

The Kansas Department of Health and Environment (KDHE), led by Secretary Janet Stanek, will be the lead agency responsible for managing and implementing the RHT Plan. KDHE has worked closely with the Kansas Division of Health Care Finance, our State Medicaid agency, the State Office of Rural Health, the Office of Tribal Affairs, and stakeholders involved with rural hospitals, community health centers, behavioral health providers, and local public health agencies to develop this application. This teamwork has been key in shaping the strategies and goals in our plan.

I established and appointed the stakeholders to the Kansas Rural Health Innovation Alliance (KRHIA), an advisory group that will be vital in executing the RHTP initiatives. This coalition of various health care associations and systems will remain an essential body for recommending and overseeing the implementation of transformational strategies, as outlined in our application.

The State of Kansas and KRHIA are dedicated to taking the necessary steps to ensure the success of the RHT Plan. This commitment includes ongoing collaboration among agencies, adjustment to regulatory and policy frameworks, and, when needed, seeking legislative support to ensure long-term results. Our administration understands that making real improvements in rural health care requires not only federal cooperation but also state-level responsibility and innovation.

I also certify that the State will not expend any award funds on activities prohibited under 42 U.S.C. 1397ee(h)(2)(A)(ii), and that all expenditures will comply with applicable federal funding limitations and requirements.

Finally, Kansas is committed to ensuring that RHT funding benefits rural residents throughout the entire state. Our plan includes strategies that reflect all Kansas' rural communities, from frontier counties and critical access hospitals to regional networks and local health departments. Every region will have the chance to thrive through a revitalized, resilient rural health system.

Thank you for your partnership and support of this vital work. Together, we can help Kansas lead efforts to strengthen rural health care for generations.

Respectfully,

A handwritten signature in blue ink, appearing to read "Laura Kelly".

Laura Kelly
Governor of Kansas

STATE AND LOCAL GOVERNMENT RATE AGREEMENT

EIN: 48-1124839
 ORGANIZATION:
 Kansas Department of Health & Environment
 Internal Management
 Curtis State Office Building
 1000 SW Jackson Street, Suite 570
 Topeka, KS 66612-

Date: 07/01/2025
 FILING REF.: The preceding
 agreement was dated
 10/08/2024

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

RATE TYPES:	FIXED	FINAL	PROV. (PROVISIONAL)	PRED. (PREDETERMINED)	
	<u>EFFECTIVE PERIOD</u>				
<u>TYPE</u>	<u>FROM</u>	<u>TO</u>	<u>RATE(%)</u>	<u>LOCATION</u>	<u>APPLICABLE TO</u>
FIXED	07/01/2024	06/30/2025	11.00	All	Restricted Programs (a)(see Special Remarks Section)
FIXED	07/01/2024	06/30/2025	16.10	All	All Other Programs (b)
FIXED	07/01/2025	06/30/2026	15.60	All	All Other Programs (b)
FIXED	07/01/2025	06/30/2026	6.90	All	Restricted Program (a)(see special remarks section)
PROV.	07/01/2026	06/30/2029			Use same rates and conditions as those cited for fiscal year ending June 30, 2026

***BASE**

(b) Total direct costs excluding capital expenditures (buildings, individual items of equipment; alterations and renovations), that portion of each subaward in excess of \$25,000 and flow-through funds.

SECTION III: GENERAL

A. LIMITATIONS:

The rates in this Agreement are subject to any statutory or administrative limitations and apply to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rates is subject to the following conditions: (1) Only costs incurred by the organization were included in its indirect cost pool as finally accepted: such costs are legal obligations of the organization and are allowable under the governing cost principles; (2) The same costs that have been treated as indirect costs are not claimed as direct costs; (3) Similar types of costs have been accorded consistent accounting treatment; and (4) The information provided by the organization which was used to establish the rates is not later found to be materially incomplete or inaccurate by the Federal Government. In such situations the rate(s) would be subject to renegotiation at the discretion of the Federal Government.

B. ACCOUNTING CHANGES:

This Agreement is based on the accounting system purported by the organization to be in effect during the Agreement period. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this Agreement require prior approval of the authorized representative of the cognizant agency. Such changes include, but are not limited to, changes in the charging of a particular type of cost from indirect to direct. Failure to obtain approval may result in cost disallowances.

C. FIXED RATES:

If a fixed rate is in this Agreement, it is based on an estimate of the costs for the period covered by the rate. When the actual costs for this period are determined, an adjustment will be made to a rate of a future year(s) to compensate for the difference between the costs used to establish the fixed rate and actual costs.

D. USE BY OTHER FEDERAL AGENCIES:

The rates in this Agreement were approved in accordance with the authority in Title 2 of the Code of Federal Regulations, Part 200 (2 CFR 200), and should be applied to grants, contracts and other agreements covered by 2 CFR 200, subject to any limitations in A above. The organization may provide copies of the Agreement to other Federal Agencies to give them early notification of the Agreement.

E. OTHER:

If any Federal contract, grant or other agreement is reimbursing indirect costs by a means other than the approved rate(s) in this Agreement, the organization should (1) credit such costs to the affected programs, and (2) apply the approved rate(s) to the appropriate base to identify the proper amount of indirect costs allocable to these programs.

BY THE INSTITUTION:

Kansas Department of Health & Environment Internal Management

(INSTITUTION)

Amy L. Penrod
(SIGNATURE)

Amy L. Penrod
(NAME)

Deputy Secretary, Fiscal Services
(TITLE)

8/13/25
(DATE)

ON BEHALF OF THE GOVERNMENT:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(AGENCY)

Olulola O. Oluborode
(SIGNATURE) Digitally signed by Olulola O. Oluborode -S
Date: 2025.07.21 10:07:25 -04'00'

Olulola Oluborode
(NAME)

Director, Cost Allocation Services
(TITLE)

07/01/2025
(DATE)

HHS REPRESENTATIVE: Wanda Rayfield

TELEPHONE: (212) 264-2069

CMS Business Assessment of Applicant Organization

Applicants review and answer the business assessment questions outlined below. There are eleven (11) topic areas labeled A-K, with a varying number of questions within each topic area. **Applicants MUST provide a brief substantive answer to each question (and supporting documentation, as applicable. Singular web links are not acceptable).** If the answer to any question is not- applicable, please provide an explanation.

Please note: If CMS cannot complete its review without contacting the applicant for additional clarification, the applicant risks selection for award.

A. General Information

1. Provide organization's:
 - a. Legal name: Kansas Department of Health and Environment
 - b. EIN (include PMS prefix and suffix, if applicable-ex. **1-12356789-A1**): 1481124839-C5
 - c. Organizational Type: US State Government Agency
2. What percentage of your organization's capital is from Federal funding? (percentage = total Federal funding received in previous fiscal year / organization's total gross revenue in previous fiscal year).
 - a. 61.4 percent of the agency's funding comes from Federal sources.
3. Does/did your organization receive additional oversight (examples include: Correction Action Plan, Responsibility and Qualification (R/Q) findings, reimbursement payments for enforcement actions) from a Federal agency within the past 3 years due to past performance or other programmatic or financial concerns with the organization)? Yes.
 - a. If yes, please provide the following information: Name of the Federal agency and the reason for the additional oversight as explained by the Federal agency
 - b. If resolved, please indicate how the issue was resolved with the Federal agency.
 - KDHE Bureau of Facilities and Licensing (BFL) operates as the Centers for Medicare & Medicaid Services (CMS) designated State Survey Agency under the CMS 1864 Agreement and follows all applicable federal statutes, internal control requirements, and program integrity standards. KDHE BFL since 2020 operates under a standard CMS State Performance Standards System (SPSS) Corrective Action Plan (CAP), which is a routine federal oversight tool frequently utilized across state survey agencies nationwide. This CAP is performance-focused, not financial in nature, and does not indicate any findings of fiscal mismanagement nor impose any limitations on KDHE's eligibility to receive or manage federal funds. KDHE BFL remains in good standing with CMS and continues to meet all federal internal control, documentation, and compliance expectations. All required remediation under the SPSS CAP is actively underway and progressing within CMS-approved timelines.
 - KDHE Division of Health Care Finance is currently under a CMS Corrective Action Plan pertaining to Home and Community-Based Services. The CAP was issued by CMS to monitor Kansas' compliance

with federal regulations regarding conflict-of-interest. KDHE continues to work with its sister agency, the Kansas Department for Aging and Disability Services to resolve the issues CMS has identified and participates in regular CAP monitoring calls with CMS.

- MCO Capitation Payments to Deceased Beneficiaries: In audit A-07-20-05215 the Office of the Inspector General issued findings regarding capitation payments made in error for deceased beneficiaries. KDHE did not have adequate policies and procedures in place to prevent these occurrences. Remediation has occurred and KDHE is currently awaiting a determination from CMS as to whether the CAP can be closed.
 - FY 2024 Single State Audit identified issues regarding review of supporting documentation of qualifications. CMS recommended that KDHE conduct training of all staff members to properly verify that supporting documents evidencing the qualification of individuals performing utilization control reviews are maintained. This CAP is closed.
 - PERM RY22: Eligibility errors were discovered in the PERM review for 2022. KDHE was required to report bi-monthly with updates on the progress of all recommendations that were addressed in the audit. The final update was submitted in October 2025. The CAP has been resolved.
4. Does your organization currently manage grants with other U.S. Department of Health and Human Services components or other Federal agencies?
 - a. Yes
 5. Explain your organization's process to ensure annual renewal in SAM.gov including R/Q and Reqs and Certs.
 - a. The agency's CFO is responsible for ensuring the completion of the annual renewal in SAM.gov, including responding to registration questions and representations and certifications.
 6. Explain your organization's process to comply with (a) 2 CFR 200.113 "Mandatory Disclosures" and (b) your organization's process to comply with FFATA requirements.
 - a. In accordance with 2 CFR 200.113, when KDHE has credible evidence of the commission of a violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code or a violation of the civil False Claims Act, KDHE would make the disclosure in writing to the relevant Federal agency, the agency's OIG, and, if applicable, the pass-through entity.
 - b. KDHE complies with the FFATA and associated OMB guidance. KDHE fiscal staff collect all necessary information from subrecipients and enters required information into FSRs within 30 days of the subaward.
 7. Do you have conflict of interest policies? Does your organization or any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds? If yes, please explain and provide a mitigation plan.
 - a. Yes, KDHE has conflict of interest policies.
 - b. No. None of KDHE's employees have conflicts of interest.
 8. Does your organization currently, or in the past, had delinquent Federal debt in the

- last 3 years? If yes, please explain.
- a. No
9. Have you filed bankruptcy or entered into proceedings for bankruptcy, whether voluntarily or involuntarily?
- a. No
10. Has your organization obtained fidelity bond insurance coverage for responsible officials and employees of the organization in amounts required by statute or organization policy? What is that amount?
- a. The state of Kansas has a committee on surety bonds and insurance who determine the state officials who bonds need to be purchased for. Additionally, the Committee makes the purchases on behalf of the agencies. KDHE is unaware of the specific amounts that may be purchased by the Committee.
11. Do you have (and briefly describe) policies and procedures in place to meet the requirements below? If not, explain your plan and estimated timeline for establishing these policies and procedures if selected for award.
- Yes. (attachment A.11. Grant_Award_Compliance_Monitoring_SOP_Manual)
 - a. Determinations between subrecipients versus contracts in accordance with 2 CFR 200.331?
 - The agency’s Grant Award Compliance Monitoring SOP Manual includes the definitions of “subrecipient,” “contractor,” “beneficiary,” and “pass-through entity”. Additionally, the Manual contains links to checklists to assist agency staff in determining how to categorize an entity.
 - b. Compliance with 2 CFR 200.332 “Requirements for pass-through entities”?
 - The agency’s Grant Award Compliance Monitoring SOP Manual includes explanation of the requirements and responsibilities for pass-through entities.
 - c. Manage, assess risk, review audits, and monitor the subrecipients as necessary to ensure that subawards are used for authorized purposes in compliance with laws, regulations, and terms and conditions of the award and that established subaward performance goals are achieved (2 CFR 200.331-200.333)?
 - The Grant Compliance section performs quarterly internal audit reports based on Federal Aid Payments to Counties, Cities, Districts, Public Schools, Community Health Centers and Other Subdivisions of Local Government and Federal Aid to Qualified Non-State Organizations. Transactions coded with account codes 550100 and 550600 are reviewed and a sample selection are chosen for KDHE bureaus that made payments within that specified quarter. The Grant Compliance team sends a spreadsheet of the sample transactions chosen and requests program staff provide documentation for review for compliance with CFRs.
 - Link for Grant Award Compliance Monitoring SOP/Manual - https://www.kdhe.ks.gov/DocumentCenter/View/52669/A11-Grant_Award_Compliance_Monitoring_SOP_Manual

B. Accounting System

1. Does your organization have updated (last two years) written accounting policies and procedures to manage Federal awards in accordance with 2 CFR 200? Yes. (attachment B.1. Federal_Reporting_GuidebookFinal)
 - a. If no, please provide a brief explanation of why not.
 - b. Describe the management of Federal funds and how funds are separated (not co-mingling) from other organizational funds.
 - Federal funds are assigned individual budget units and identified with their ALN/CFDA numbers to maintain separation.
2. Briefly describe budgetary controls in effect to preclude incurring obligations in excess of:
 - a. Total funds available for an award.
 - A fiscal analyst assigned to the grant would provide monthly reports to program staff. These reports contain the total amount expended, obligated, and any projected expenditures as of the date of the report.
 - b. Total funds available for a budget cost category.
 - Program staff are responsible for monitoring budget categories to ensure that the agency is staying within the allowable budgets. Reporting can be modified to contain budget information for the program to review. While program staff have responsibility for ensuring budget cost category compliance, the assigned fiscal analyst works with the program to ensure compliance with budget and overall allocation.
3. Has any government agency rendered an official written opinion within the last 3 years concerning the adequacy of the organization's accounting system for the collection, identification, and allocation of costs under Federal awards?
 - No
 - a. If yes, please provide the name and address of the agency that performed the review.
 - b. Provide a summary of the opinion.
 - c. How did your organization resolve any concerns?
4. How does the accounting system provide for recording the non-Federal share and in-kind contributions (if applicable)
 - a. If the expenses for the non-Federal share and in-kind contributions are paid through the state's accounting system, they would be associated with a separate fund, budget unit, and project ID. If the non-Federal share and in-kind contributions aren't processed through the state's accounting system, program staff would be responsible for developing a method to track this information to be provided to the assigned fiscal analyst to include in any federal financial reports that are submitted for the federal funds.
5. Does the organization's accounting system provide identification for award funding by Federal agency, pass-through entity, Assistance Listing (CFDA), award number and period of funding? Yes.
 - a. If yes, how does your organization identify awards?

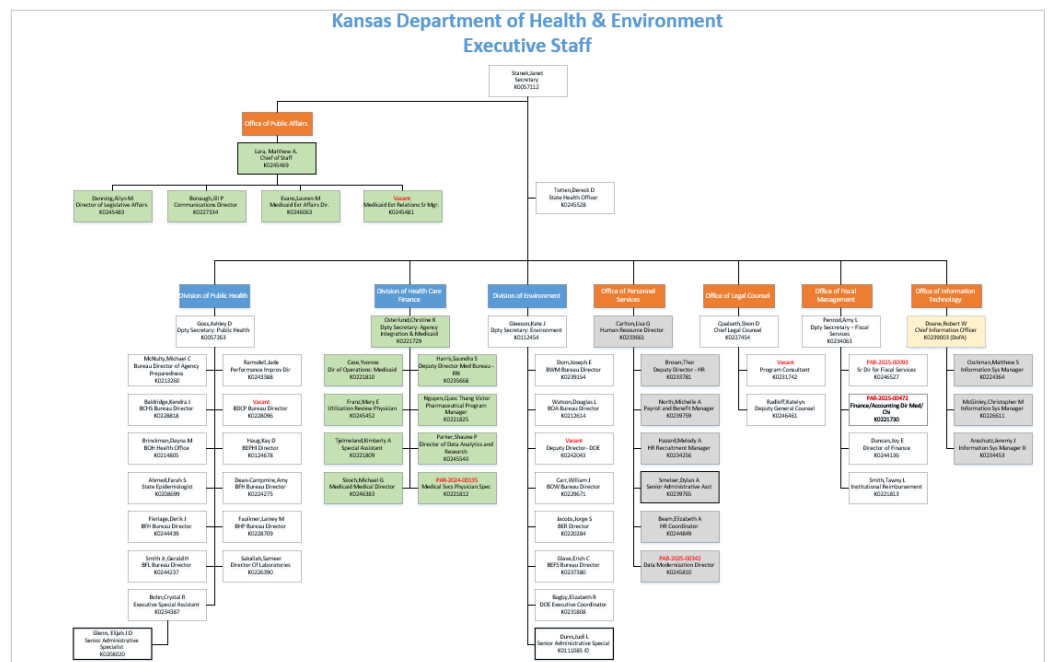
- Each ALN/CFDA is associated with a specific fund and budget unit. The agency then assigns a project ID to track the funds by the different budget periods for the grant.
- b. If not, please explain why not.
- c. Link for Federal Reporting Guidebook - <https://www.kdhe.ks.gov/DocumentCenter/View/52670/B1-Federal-Reporting-GuidebookFinal>

C. Budgetary Controls

1. What are your organization’s controls used to ensure that the Authorized Organizational Representative (AOR), as identified on the SF-424, approves all budget changes for the Federal award?
 - Processes are in place to ensure that any budgetary changes are reviewed by the required individuals prior to submission for approval.
2. Describe your organization’s procedures for minimizing the time between transfer of funds from the U.S. Treasury (e.g. Payment Management System) and disbursement for grant activities (See 2 CFR 200.305, “Federal Payment.”).
 - KDHE complies with the CMIA regulations. With the exception of Medicaid capitation payments, KDHE operates on a reimbursement basis in drawing Federal funds. For the Federal share of Medicaid capitation payments, the state requests a draw of funds not more than three business days prior to the day the agency makes the disbursements.

D. Personnel

1. Does your organization have a current organizational chart or similar document establishing clear lines of responsibility and authority?
 - a. If yes, please provide a copy. Yes



- b.
- c. Link to the organization chart as part of our roles and responsibility policies: <https://www.kdhe.ks.gov/DocumentCenter/View/52668/Organization-Chart>

2. Does your organization have updated (last two years) written Personnel and/or Human Resource policies and procedures? If no, provide a brief explanation.
Yes, we update our HR policies and procedures on an ongoing basis to assure that they are up to date and accurate.
3. Does your organization pay compensation to Board Members?
 - a. A Board does not govern KDHE. The Secretary of KDHE has formed committees and boards to oversee specific areas, such as the Family Advisory Council, and some members of those boards are compensated for their time and travel.
4. Are staff responsible for fiscal and administrative oversight of HHS awards (Grants Manager, CEO, Financial Officer) familiar with Federal rules and regulations applicable to grants and cooperative agreements (e.g. 2 CFR 200)?
 - a. Yes. All staff responsible for fiscal and administrative oversight have been provided and have access to the agency's Grant Award Compliance Monitoring SOP Manual (see attachment). In addition, Grant Compliance staff have provided training to programmatic staff responsible for grant oversight.
5. Please describe how the payroll distribution system accounts for, tracks, and verifies the total effort (100%) to determine employee compensation.
 - The state's payroll system accommodates the creation of multiple task profiles containing appropriate funding mixes according to the tasks being performed. Employees record their time in the payroll system according to the tasks to verify total effort and appropriately fund each employee's compensation.

E. Payroll

In preparation of payroll is there a segregation of duties for the staff who prepare the payroll and those that sign the checks, have custody of cash funds and maintain accounting records? Please describe.

- Yes. Kansas Department of Health and Environment staff prepare the payroll and the Kansas Department of Administration signs the checks.

F. Consultants

1. Are there written policies or consistently followed procedures regarding the use of consultants which detail the following (include an explanation for each question below):
 - a. Briefly describe your organization's method or policy for ensuring consultant costs and fees are allowable, allocable, necessary and reasonable.
 - b. Briefly describe your organization's method or policy to ensure prospective consultants prohibited from receiving Federal funds are not selected.
 - Use of consultants is limited to those vendors that are either on a statewide contract or those selected after a formal request for proposal (RFP) process. These procedures are outlined in the State's Office of

Procurement and Contracts Procurement Manual. Invoices from contracted consultants are reviewed upon receipt by the program managing the work to ensure that the charges are reasonable and stated deliverables have been met to approve payment of the invoice. Agency fiscal staff review the invoice to ensure that the charges are appropriate against the contract or task order in place.

- KDHE checks for suspension and debarment on all vendors, including contractors via SAM.Gov. Documentation of this verification is required to be attached in the agency's records.
- Link for State of Kansas Procurement Manual - <https://www.kdhe.ks.gov/DocumentCenter/View/52671/F1-SoK OPC Procurement Manual>

G. Property Management

1. Briefly describe the system for property management (tangible or intangible) utilized for maintaining property records consistent with 2 CFR 200.313. Refer to ([2 CFR 200](#)) for definitions of property to include personal property, equipment, and supplies.
 - Any asset procured by KDHE over \$5,000 is considered a capital asset and must be entered into the state's accounting system Asset Management Module. Once an asset over \$5,000 is purchased, the asset management module is a repository of information regarding the description of the asset, asset class, asset type, asset subtype, acquisition date, price/funding, depreciation attributes, and where the asset is located.
2. Does your organization have adequate insurance to protect the Federal interest in equipment and real property (see [2 CFR 200.310 "Insurance coverage."](#))? How does the organization calculate the amount of insurance?
 - The State of Kansas and Department of Health and Environment carry liability insurance on state agency vehicles and are otherwise self-insured.

H. Property Standards

Describe the organization's property standards in accordance 2 CFR 200.310-327 "Procurement Standards"? If there are no procurement procedures, briefly describe how your organization handles purchasing activities.

- a. Include individuals responsible and their roles.
 - b. Describe the competitive bid process for procurement purchases of equipment, rentals, or service agreements that are over certain dollar amounts.
- KDHE maintains an inventory of its assets in the state's accounting system in an Asset Management Module. When an asset over \$5,000 is purchased, the asset is recorded with a description of the asset, asset class, type and subtype, along with the acquisition date, price and funding, depreciation attributes and location of the asset. Procurement of all property follows the Federal regulations, as well as the State of Kansas requirements as outlined in the Office of Procurement and Contracts Procurement Manual. This includes obtaining appropriate bids from qualified vendors.
 - Procurement activities are overseen by the agency's CFO, Amy Penrod, the Director of Finance, Joy Duncan, and the Manager of Contracts and Procurement, Amy Hart.

- The competitive bid process begins with the development of a Scope of Work, informed by any benchmarking or market research that can aid in that development. All procurements for Information Technology projects are required to undergo a Business Risk Assessment by the Kansas Information Technology Office (KITO) and, if determined necessary, will be monitored throughout the procurement process. The Office of Procurement and Contracts (OPC) reviews and approves procurement documents and specifications and posts solicitations, managing all related activities, including pre-bid conferences, vendor questions, and any bid amendments or modifications. OPC receipts all proposals from vendors and reviews them to ensure they meet minimum qualifications before transmitting the proposals to the agency. Evaluations of the technical proposals are completed by the agency, though cost proposals remain sealed by OPC until the technical evaluations are complete. OPC provides the cost proposals once it has received a complete technical evaluation. Selected bidders can then be invited to negotiations, as necessary. All competitive bid processes are managed through the State’s OPC to ensure consistency and adherence to statutes and regulations.

I. Transportation Costs

1. Describe your organization’s written travel policy. Ensure, at minimum, that:
 - Attachment I. KDHE Travel Handbook is available to all agency staff.
 - a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates (see 2 CFR 200.474, “Transportation costs.”).
 - KDHE confirms compliance.
 - b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred.
 - KDHE confirms compliance.
 - c. Subsistence and lodging rates are equal to or less than current Federal per diem and mileage rates.
 - KDHE confirms compliance.
 - d. Commercial transportation costs incurred at coach fares unless adequately justified. Lodging costs do not exceed GSA rate unless adequately justified (e.g. conference hotel).
 - KDHE confirms compliance.
 - e. Travel expense reports show purpose and date of trip.
 - KDHE confirms compliance.
 - f. Travel costs are approved by organizational official(s) and funding agency prior to travel.
 - KDHE confirms compliance.
 - Link to KDHE Travel Handbook:
<https://www.kdhe.ks.gov/DocumentCenter/View/52666/I-KDHE-Travel-Handbook>

J. Internal Controls

1. Provide a brief description of your organization’s internal controls that will provide reasonable assurance that the organization will manage award funds properly. (see 2 CFR 200.303, “Internal controls.”)

- KDHE maintains separation of duties with regard to fiscal procedures. Budgets, federal reporting and monitoring, procurement and contracts, voucher entry, approvals to pay invoices, and purchase order approvals are duties that are appropriately separated with independent work units and workflow that provides for multiple checks and balances. The State’s accounting system is role-based and requires a separation of duties. Further, program staff are involved in monitoring budget activity and approval of payments, adding another layer of internal controls.
2. What is your organization’s policy on separation of duties as well as responsibility for receipt, payment, and recording of cash transactions?
 - Transactions and workflow within the State’s accounting system is role-based and requires a separation of duties between requisition and voucher entries and payment approvals.
 - Cash transactions are receipted by program staff and documented with receipts and completed deposit slips. The cash and documentation are provided to the Accounts Receivable staff for review and verification of totals, as well as completion of a deposit slip with the Office of the State Treasurer. Cash is deposited with the State Treasurer daily, whose staff also verify accuracy of the cash and documentation.
 3. Does your organization have internal audit or legal staff? If not, how do you ensure compliance with the award? Please describe.
 - Yes, KDHE has both internal audit and legal staff. Quarterly internal audits are conducted to evaluate compliance with federal subrecipient monitoring requirements per CFRs.
 4. If your organization has a petty cash fund how is it monitored?
 - KDHE does not keep a petty cash fund on-site. The agency does have an imprest checking account within which we maintain a \$5,000 balance and is reconciled with bank statements and receipts. It is monitored by the Chief Financial Officer and the Director of Finance. It is rarely used.
 5. Who in the organization reconciles bank accounts? Is this person familiar with the organization’s financial activities? Does your organization authorize this person to sign checks or handle cash?
 - Accounts Receivable staff, under the supervision of the Director of Finance, reconciles accounts. This staff is familiar with the organization’s financial activities. Fiscal Analysts within the agency also continually monitor fund balances, funding receipts/draws and expenditures for reconciliation and reporting purposes. The Accounts Receivable staff is not authorized to sign checks but does handle cash receipts to the agency (see response for J.2. for cash receipt process).
 6. Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?
 - No.

K. Audit

1. What is your organization’s fiscal year?
 - a. July 1 – June 30

2. Did your organization expend \$1,000,000 or more in Federal awards from **all** sources during its most recent fiscal year?

a. Yes

3. Has your organization submitted;

- an audit report to the **Federal Audit Clearing House (FAC)** in accordance with the Single Audit Act in the last 3 years? (see 2 CFR 200.501, “Audit requirements” and 2 CFR 300.218 “Special Provisions for Awards to for-profit organization as recipients.”) **or**

- an independent, external audit? If no, briefly explain.

If yes, address the following:

- The date of the most recently submitted audit report.
- The auditor's opinion on the financial statement.
- If applicable, indicate if your organization has findings in the following areas:
 - internal controls
 - questioned or unallowable costs
 - procurement/suspension and debarment
 - cash management of award funds, and
 - subrecipient *monitoring*.
- Include (if applicable):
 - a description of each finding classified as Material Weakness.
 - a description of each finding classified as Significant Deficiency.
- Yes, KDHE participates in the Statewide Single Audit each year. The Kansas Department of Administration oversees the audit on behalf of the state with an outside contracted audit firm.
- https://www.kdhe.ks.gov/DocumentCenter/View/52667/K3-Kansas_Single_Audit_FY24_Single_Audit_Report_final

4. Has your organization had corrective actions in the past 2 years for the findings identified above (3(iii))?

If yes, describe the status (closed or open) and progress made on those corrective actions.

- Yes, corrective action plans have been put in place for the audit findings from FY24.
 - Finding: 2024-006: A Subrecipient Agreement Submission Form was created 3/1/24 that has the required federal award information included with the subawards at the time of issuance.
 - Finding: 2024-007: KDHE has put in place internal controls that require suspension and debarment verification has been completed by checking SAM exclusions and maintain that documentation when the verification occurred and adding a clause regarding suspension and debarment status to agreement/contracts.

- Finding: 2024-008: Procedures have been put in place that ensure only required subawards are reported accurately to FSRS and that contractor agreements are not reported to FSRS as subawards.
- Finding: 2024-09: KDHE has put into place additional staffing and has emphasized completing Tier One workload requirements to ensure that recertification surveys are completed within the required timeframe and prior to Medicaid payments being made

State of Kansas Program Duplication Assessment

The State of Kansas confirms its responsibility to avoid program duplication. The State will ensure RHT Program award funds are not used to duplicate or supplant current federal, State or local funding, or be used as the federal share of Medicaid payments. The State will not use award funds to reimburse providers for goods and services already funded by federal sources, including:

- Medicaid
- CHIP
- Medicare
- CMS Innovation Center
- Indian Health Services
- TRICARE
- Health Resources Services Administration
- Substance Abuse and Mental Health Services Administration block grant
- Title V Block Grants
- Other federal discretionary grants or formula funds.

Further, the State of Kansas will not use award funds to duplicate or supplant funding made available through State-appropriated programs or local sources such as mill levies.

Application Process Review

As a part of this application process, identified programs and projects under each initiative have been evaluated, including a budget analysis to identify current funding streams the State is proposing to apply to State activities to ensure they do not duplicate or supplant current funding. In fact, the programs and projects have been selected and designed to ensure they build upon current programs, when applicable, while avoiding duplication.

As an example, the Kansas Department for Aging and Disability Services is the recipient of a multi-year SAMHSA grant – Primary Care Behavioral Health Integration (PCBHI) to advance whole person care. Integrated behavioral health care is one of the programs under Initiative 1: Expand Primary and Secondary Prevention Programs. RHT Program funds will not be used to support the same clinics or the same activities supported through the existing SAMHSA grant. Instead, the funds will be used exclusively to expand integrated behavioral health to rural providers for which PCBHI funding is not available.

Similarly, the Kansas Department of Health and Environment was awarded a \$33.9 million Public Health Infrastructure Grant (PHIG) from the Centers for Disease Control and Prevention to bolster the State’s public health infrastructure over a five-year project period from December 1, 2022, to November 30, 2027. More than \$25 million of the award is allocated to projects to expand the public health workforce. The State will not use RHT Program funds to support the same activities

as the PHIG award. Instead, the funds will expand the reach of successful programs the State developed under the PHIG award.

Kansas is one of 15 states selected for the Transforming Maternal Health (TMaH) Model, which requires the State to implement a value-based payment model for maternal health services by 2029. The state Medicaid agency will coordinate its work under the TMaH Model with the development of new MCO contract requirements for provider incentive payments in addition to the maternal health model.

With regard to Medicaid funding, activities have been analyzed against existing Medicaid billing codes to ensure there is no duplication. This includes ensuring that RHT Program funds are not utilized to duplicate funding or services incorporated within the state's Certified Community Behavioral Health Clinic (CCBHC) and Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) rates.

As an additional example, with the same integrated behavioral health care project supported through Initiative 1, the State will ensure RHT Program funds do not duplicate funding supported through existing Psychiatric Collaborative Care Model (CoCM) codes presently reimbursed by Medicare and the Kansas Medicaid program and the general behavioral health integration codes presently reimbursed by Medicare.

With respect to those initiatives intended to develop capacity to furnish specific services or participate in certain programs, the State has adjusted budgets to account for anticipated reimbursement or other payments from any source relating to such services.

Implementation Phase

To ensure program duplication and funding duplication does not occur during program implementation, the State of Kansas will put in place specific safeguards identify the risk of program duplication and to mitigate such risk. The State's Medicaid Governance Council will serve as the overarching body to assure duplication is avoided.

1. **New Medicaid Policies.** Add a program duplication question and risk assessment in assessing new Medicaid policies through the Medicaid Governance Council, and whether this impacts activities under the RHTP.
2. **Vendor Contracts.** Include in the negotiation and finalization of all vendor contracts relating to implementation of the RHT Program a review of whether the contract provides for payments to the vendor for which there is presently another source of payment available.
3. **Grant Awards.** Include language in any grant offerings through the RHT Program directing potential grantees to respond specifically to questions, such as:

- a. Is any expense requested under this grant paid for by another federal, State or local program, including Medicaid, Medicare, Title V, federal block grants or discretionary grants, or specified local funds?
 - b. Is any proposed activity a service that is already provided to targeted beneficiaries through Medicare or Medicaid reimbursement or other funding sources?
4. **Existing Grants or Agreements through Other Funding Sources.** In new grants or grant renewals from other relevant funding sources (e.g., Title V or the SAMHSA Behavioral Health Block Grant) new levels of review will be added requiring that grantees ensure no duplication of services or funding connected to the RHTP.
5. **Regular Program Reviews and Audits.** Regular program reviews and audits under the RHT Program and other grantee funding will continue to assess program duplication risks and take appropriate steps to mitigate risk. For example, if new reimbursement becomes available from any source for a service for which RHT Program funds are budgeted, the State will adjust the budget accordingly to account for such reimbursement.

The following attachment is not included in the view since it is not a read-only PDF file.

Upon submission, this file will be transmitted to the Grantor without any data loss.

12_KS_RHTP_26_001_Other Supporting Materials.pdf

Rural Health Transformation Program

CMS-RHT-26-001

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Nov. 2, 2025

The Hon. Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave., S.W.
Washington, D.C. 20001

Dear Administrator Oz:

Kansas rural communities will greatly benefit from federal financial support to transform key initiatives, projects and programs that serve the people and places currently underserved in rural communities. We, of the Kansas Rural Health Innovation Alliance (KRHIA), appreciate the opportunity to inform and champion the Kansas Rural Health Transformation Plan.

To fully engage stakeholders in the development the Plan, Governor Laura Kelly formed KRHIA, which includes the following statewide organizations and state agencies:

- Kansas Hospital Association
- Community Care Network of Kansas
- Association of Community Mental Health Centers of Kansas
- Kansas Association of Local Health Departments
- Kansas Rural Health Association
- Kansas Medical Society
- Kansas Academy of Family Physicians
- Kansas Chapter, American Academy of Pediatrics
- Kansas Health Institute
- LeadingAge Kansas
- Kansas Health Care Association
- Kansas Grantmakers in Health
- Kansas Department of Health and Environment
- Kansas Department of Aging and Disability Services

The team responsible for drafting the Plan, including the State of Kansas Interagency Task Force and the University of Kansas Health System Care Collaborative, presented a webinar for Alliance members and other stakeholders in late September regarding the requirements detailed in the Notice of Funding Opportunity and addressed attendees' questions. The team then held one-on-one meetings with leaders from each Alliance member as well as other stakeholders to solicit input on Plan initiatives. Next, Alliance members participated in two, two-hour virtual meetings in October to review, refine and approve the Plan's vision, mission, values and objectives and to discuss potential initiatives. Attendance at the virtual meetings was not limited to Alliance members; the meetings were announced publicly and livestreamed for the public. Recordings have been posted to the [State](#) website.

Alliance members then participated in a four-hour, in-person meeting in late October to review and provide feedback regarding the Plan initiatives and the specific programs and projects under each initiative, as well as the proposed governance and management structure to implement the Plan. Each organization was encouraged to have several individuals participate in these meetings. Alliance members and designees unable to attend in person were given the option to participate virtually, and the meeting was also livestreamed.

Going forward, the Alliance will continue to meet on a quarterly basis, at a minimum, through the term of the State's Cooperative Agreement with CMS to serve as the primary vehicle for stakeholder engagement in the Plan's implementation. Additionally, it is anticipated that several Alliance members will be directly engaged in several Plan initiatives to ensure the work being done meets the needs of rural providers and the communities that they serve.

As authorized, representatives of the organizations participating in the Alliance, the undersigned individuals, fully support the State of Kansas' Rural Health Transformation Plan. We believe the State was purposeful in soliciting input and gave, and will continue to give, proper consideration to the needs and concerns expressed by stakeholders. The Plan to be submitted to CMS responds to the needs of multiple constituencies within the rural Kansas population. The Plan's objectives are achievable given the shared commitment across these constituencies to the values that serve as the foundation for the Plan.

Each of us sees every day the challenges our State's rural communities face. But we also see the willingness on the part of providers to do the work necessary to transform our rural health delivery system. Each of our organizations is willing and able to support the Plan's implementation and to build the foundation for long-term sustainability. The collaboration among the State and rural health stakeholders that has produced our comprehensive and cohesive plan demonstrates our willingness and ability to collectively pursue true rural health transformation.

Chad Austin

Chad Austin (Oct 29, 2025 20:19:08 CDT)

signature

10/29/2025

date

Kansas Hospital Association

<u><i>Robert Stiles</i></u> signature	<u>10/30/2025</u> date	Community Care Network of Kansas
<u><i>Kyle Kessler</i></u> <small>Kyle Kessler (Oct 29, 2025 16:53:18 CDT)</small> signature	<u>10/29/2025</u> date	Association of Community Mental Health Centers of Kansas
<u><i>Randy Bowman</i></u> <small>Randy Bowman (Oct 29, 2025 17:11:42 CDT)</small> signature	<u>10/29/2025</u> date	Kansas Association of Local Health Departments
<u><i>T. Garetson</i></u> <small>Tina Garetson (Oct 29, 2025 17:27:17 CDT)</small> signature	<u>10/29/2025</u> date	Kansas Rural Health Association
<u><i>Rachelle</i></u> <small>Rachelle Colombo (Oct 30, 2025 10:31:01 CDT)</small> signature	<u>10/30/2025</u> date	Kansas Medical Society
<u><i>[Signature]</i></u> signature	<u>10/30/2025</u> date	Kansas Academy of Family Physicians
<u><i>Denise Cyzman</i></u> signature	<u>10/29/2025</u> date	Kansas Chapter, American Academy of Pediatrics
<u><i>Kar M Bruffett</i></u> signature	<u>10/30/2025</u> date	Kansas Health Institute
<u><i>Rachel Money</i></u> signature	<u>10/29/2025</u> date	LeadingAge Kansas
<u><i>Linda MowBray</i></u> signature	<u>10/30/2025</u> date	Kansas Health Care Association
<u><i>[Signature]</i></u> <small>David Jordan (Oct 29, 2025 19:06:52 CDT)</small> signature	<u>10/29/2025</u> date	Kansas Grantmakers in Health
<u><i>Janet Stanek</i></u> <small>Janet Stanek (Oct 30, 2025 07:51:27 CDT)</small> signature	<u>10/30/2025</u> date	Kansas Department of Health and Environment

Laura Howard

signature

10/29/2025

date

Kansas Department of Aging and Disability
Services

Congress of the United States

Washington, DC 20515

November 4, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Oz:

As members of the Kansas Congressional delegation, we write to express our strong and united support for the Rural Health Transformation Plan submitted by the State of Kansas in response to the Centers for Medicare and Medicaid Services (CMS) Notice of Funding Opportunity for the Rural Health Transformation Program.

The Kansas State Plan was developed through an extensive stakeholder engagement process. Its initiatives are strategically aligned with the program's core objectives: restoring and sustaining the health of rural America, ensuring sustainable access to care, strengthening the health care workforce, advancing innovative care models, and fostering technology-driven solutions.

Rural health care providers across Kansas recognize the urgent need for transformation. Yet, with many providers operating under persistent negative margins, they face significant barriers to making the critical investments necessary for regional collaboration, clinical integration, and modern technology solutions. The targeted initiatives supported by this Program will empower rural providers to move beyond the current "sick care" paradigm and toward a sustainable, value-driven system that enables every Kansan to live a healthier, more productive life.

We are confident that our state's rural health providers will enthusiastically embrace these initiatives to strengthen care delivery and improve health outcomes in their communities. Each member of our delegation stands ready to provide any assistance necessary to ensure the success of this plan.

We respectfully urge CMS to give full and favorable consideration to the Kansas Rural Health Transformation Plan. We believe it will not only benefit rural communities throughout our state but also serve as a national model for modernizing and sustaining rural health care delivery.

Thank you for your leadership and continued commitment to advancing innovation and health care outcomes in rural America.

Sincerely,



Jerry Moran
U.S. Senator



Sharice L. Davids
Member of Congress



Ron Estes
Member of Congress



Tracey Mann
Member of Congress



Derek Schmidt
Member of Congress

CC: The Honorable Robert Kennedy, Jr., Secretary of Health and Human Services

United States Senate

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., S.W.
Washington, D.C. 20001

Dear Administrator Dr. Oz:

I write to offer my personal support for Kansas's application for the Rural Health Transformation Program funding. The leadership team who prepared the Kansas application engaged healthcare stakeholders across the state in a series of meetings to identify meaningful programs and strategies to transform rural health care delivery. I have also met with many of these healthcare provider groups over the past few weeks, and I applaud them for their innovative ideas to pivot from sick care to healthcare. I do believe we can make Rural America Healthy Again.

As you and I have discussed, these funds are to be both transformative and rural-focused. I urge CMS to provide oversight to states to ensure that both tenants are enforced over the next five years. We have seen time and again that well-intentioned programs and funding mechanisms have been altered to benefit urban hospital systems or used to backfill negative margins due to poor management. I would also ask that these funds not be made available for Congressional Directed Spending, but left for the healthcare stakeholders to access based on merit. And finally, I am hopeful that both the state leadership and CMS will monitor metrics of population health outcomes over the five program years to ensure that the funds are in fact making positive and lasting changes.

As a physician who practiced in and managed a rural hospital, I understand the challenges these providers are facing. This funding opportunity is an incredible chance to transform our healthcare delivery system and I respectfully urge CMS to give favorable consideration to Kansas's application. My office stands ready to answer questions.

Sincerely,



Roger Marshall, MD
U.S. Senator, Kansas

Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration *	State-certified	SAMHSA	HRSA Rurality (Y/N)
Bert Nash CMH	200 Maine St., Ste. A	Lawrence	KS	66044	Bert Nash CMH	Y			N
Bert Nash CMH	364 Maine St.	Lawrence	KS	66044	Bert Nash CMH	Y			N
Bert Nash CMH	1000 W. 2nd St.	Lawrence	KS	66044	Bert Nash CMH	Y			N
Center for Counseling and Consultation	5815 Broadway Ave.	Great Bend	KS	67530	Center for Counseling and Consultation	Y			Y
Center for Counseling and Consultation	606 Topeka, Suite 101	Larned	KS	67550	Center for Counseling and Consultation	Y			Y
Center for Counseling and Consultation	217 E. Ave. N.	Lyons	KS	67554	Center for Counseling and Consultation	Y			Y
Center for Counseling and Consultation	602 South Buckeye	Stafford	KS	67578	Center for Counseling and Consultation	Y			Y
Central Kansas CMH	809 Elmhurst Blvd.	Salina	KS	67401	Central Kansas CMH	Y			Y
Central Kansas CMH	420 NE 10th	Abilene	KS	67410	Central Kansas CMH	Y			Y
Central Kansas CMH	1602 Aylward	Ellsworth	KS	67439	Central Kansas CMH	Y			Y
Central Kansas CMH	114 W. Court St.	Lincoln	KS	67455	Central Kansas CMH	Y			Y
Central Kansas CMH	817 A Argyle Ave.	Minneapolis	KS	67467	Central Kansas CMH	Y			Y
COMCARE	4035 East Harry St.	Wichita	KS	67218	COMCARE	Y			N
COMCARE	635 N. Main	Wichita	KS	67203	COMCARE	Y			N
COMCARE	1919 N. Amidon Ave.	Wichita	KS	67203	COMCARE	Y			N
COMCARE	940 N. Waco Ave.	Wichita	KS	67203	COMCARE	Y			N
Compass Behavioral Health	1111 E. Spruce	Garden City	KS	67846	Compass Behavioral Health	Y			Y
Compass Behavioral Health	1312 N. 7th St.	Garden City	KS	67846	Compass Behavioral Health	Y			Y
Compass Behavioral Health	2102 E. Spruce	Garden City	KS	67846	Compass Behavioral Health	Y			Y
Compass Behavioral Health	531 Campusview St.	Garden City	KS	67846	Compass Behavioral Health	Y			Y
Compass Behavioral Health	714 Ballinger	Garden City	KS	67846	Compass Behavioral Health	Y			Y
Compass Behavioral Health	304 E. Ave. A.	Syracuse	KS	67878	Compass Behavioral Health	Y			Y
Compass Behavioral Health	325-327 Campusview Court	Garden City	KS	67846	Compass Behavioral Health	Y			Y
Compass Behavioral Health	506 Avenue L	Dodge City	KS	67801	Compass Behavioral Health	Y			Y
Compass Behavioral Health	3000 N. 14th	Dodge City	KS	67801	Compass Behavioral Health	Y			Y
Compass Behavioral Health	309 Campus	Dodge City	KS	67801	Compass Behavioral Health	Y			Y
Compass Behavioral Health	107 N. Main	Cimarron	KS	67835	Compass Behavioral Health	Y			Y
Compass Behavioral Health	404 N. Baughman	Ulysses	KS	67880	Compass Behavioral Health	Y			Y
Compass Behavioral Health	301 Grant	Ulysses	KS	67880	Compass Behavioral Health	Y			Y
Compass Behavioral Health	410 Kansas St.	Elkhart	KS	67950	Compass Behavioral Health	Y			Y
Compass Behavioral Health	404 N. Chestnut St.	Johnson City	KS	67855	Compass Behavioral Health	Y			Y
Compass Behavioral Health	510 Bert St.	Johnson City	KS	67855	Compass Behavioral Health	Y			Y
Compass Behavioral Health	500 S. Monroe St.	Hugoton	KS	67591	Compass Behavioral Health	Y			Y
Compass Behavioral Health	210 W. 4th St.	Scott City	KS	67871	Compass Behavioral Health	Y			Y

Compass Behavioral Health	506 3rd St.	Tribune	KS	67879	Compass Behavioral Health	Y			Y
Compass Behavioral Health	325 W. Vine St.	Dighton	KS	67839	Compass Behavioral Health	Y			Y
Compass Behavioral Health	804 E. Fulton	Garden City	KS	67846	Compass Behavioral Health	Y			Y
Compass Behavioral Health	625 Colorado St.	Elkhart	KS	67950	Compass Behavioral Health	Y			Y
Compass Behavioral Health	211 East Earl St.	Leoti	KS	67861	Compass Behavioral Health	Y			Y
Crawford County Mental Health Center	911 E. Centennial	Pittsburg	KS	66762	Crawford County Mental Health Center	Y			Y
Crawford County Mental Health Center	3101 N. Michigan St.	Pittsburg	KS	66762	Crawford County Mental Health Center	Y			Y
Crawford County Mental Health Center	710 N. Broadway	Pittsburg	KS	66762	Crawford County Mental Health Center	Y			Y
Crawford County Mental Health Center	212 E. 5th Street	Pittsburg	KS	66762	Crawford County Mental Health Center	Y			Y
Crawford County Mental Health Center	3113 N. Michigan St. Suite B.	Pittsburg	KS	66762	Crawford County Mental Health Center	Y			Y
CrossWinds Counseling and Wellness	1519 Merchant St.	Emporia	KS	66801	CrossWinds Counseling and Wellness	Y			Y
CrossWinds Counseling and Wellness	1601 State St.	Emporia	KS	66801	CrossWinds Counseling and Wellness	Y			Y
CrossWinds Counseling and Wellness	214 N. Cottonwood St.	Strong City	KS	66842	CrossWinds Counseling and Wellness	Y			Y
CrossWinds Counseling and Wellness	109 N. 3rd. St.	Burlington	KS	66839	CrossWinds Counseling and Wellness	Y			Y
CrossWinds Counseling and Wellness	905 N. Main St.	Eureka	KS	67045	CrossWinds Counseling and Wellness	Y			Y
CrossWinds Counseling and Wellness	405 N. Union St.	Council Grove	KS	66846	CrossWinds Counseling and Wellness	Y			Y
CrossWinds Counseling and Wellness	701 Missouri St.	Alma	KS	66401	CrossWinds Counseling and Wellness	Y			Y
CrossWinds Counseling and Wellness	112 S. Main St.	Eskridge	KS	66423	CrossWinds Counseling and Wellness	Y			Y
CrossWinds Counseling and Wellness	310 Commercial St.	Emporia	KS	66801	CrossWinds Counseling and Wellness	Y			Y
CrossWinds Counseling and Wellness	608 Holliday St.	Osage City	KS	66523	CrossWinds Counseling and Wellness	Y			Y
Elizabeth Layton Center	2357 Eisenhower Rd.	Ottawa	KS	66067	Elizabeth Layton Center	Y			Y
Elizabeth Layton Center	25955 West 327th St.	Paola	KS	66071	Elizabeth Layton Center	Y			Y
Elizabeth Layton Center	204 East 15th St.	Ottawa	KS	66067	Elizabeth Layton Center	Y			Y
Elizabeth Layton Center	102 W. Baptiste Dr.	Paola	KS	66071	Elizabeth Layton Center	Y			Y
Family Service and Guidance Center	325 S.W. Frazier Ave.	Topeka	KS	66606	Family Service and Guidance Center	Y			N
Four County MHC	3354 U.S. 160	Independence	KS	67301	Four County MHC	Y			Y
Four County MHC	1601 West 4th Street	Coffeyville	KS	67337	Four County MHC	Y			Y

Four County MHC	22214 D. Street	Winfield	KS	67156	Four County MHC	Y		Y
Four County MHC	1101 Donald Ave.	Independence	KS	67301	Four County MHC	Y		Y
Four County MHC	437 North 6th St.	Fredonia	KS	66736	Four County MHC	Y		Y
Four County MHC	221 West Main St.	Sedan	KS	67561	Four County MHC	Y		Y
Four County MHC	101 S. 8th St.	Neodesha	KS	66757	Four County MHC	Y		Y
Four County MHC	813 South Union St.	Coffeyville	KS	67337	Four County MHC	Y		Y
High Plains	208 E. 7th St.	Hays	KS	67601	High Plains	Y		Y
High Plains	750 South Range Ave.	Colby	KS	66701	High Plains	Y		Y
High Plains	211 S. Norton Ave.	Norton	KS	67654	High Plains	Y		Y
High Plains	209 Harrison St.	Osborne	KS	67473	High Plains	Y		Y
High Plains	783 7th St.	Phillipsburg	KS	67661	High Plains	Y		Y
High Plains	215 E. 7th St.	Hays	KS	67601	High Plains	Y		Y
High Plains	205 E. 7th St.	Hays	KS	67601	High Plains	Y		Y
High Plains	770 Dylan Dr.	Colby	KS	67701	High Plains	Y		Y
High Plains	1412 E. 29th St.	Hays	KS	67601	High Plains	Y		Y
Horizons Mental Health Center	1600 North Lorraine, Suite 202	Hutchison	KS	67501	Horizons Mental Health Center	Y		Y
Horizons Mental Health Center	1901 East 23rd St. Suite 200	Hutchison	Ks	67502	Horizons Mental Health Center	Y		Y
Horizons Mental Health Center	602 East 2nd St.	Pratt	KS	67124	Horizons Mental Health Center	Y		Y
Horizons Mental Health Center	701 East D. Ave.	Kingman	KS	67068	Horizons Mental Health Center	Y		Y
Horizons Mental Health Center	102 South Main	Medicine Lodge	KS	67104	Horizons Mental Health Center	Y		Y
Horizons Mental Health Center	123 Pennsylvania	Anthony	KS	67003	Horizons Mental Health Center	Y		Y
Iroquois Center	610 E. Grant	Greensburg	KS	67054	Iroquois Center		Y	Y
Iroquois Center	709 Oak St.	Ashland	KS	67831	Iroquois Center		Y	Y
Iroquois Center	207 S. Washington	Coldwater	KS	67029	Iroquois Center		Y	Y
Iroquois Center	620 W. 8th St.	Kinsley	KS	67547	Iroquois Center		Y	Y
Iroquois Center	232 Main St.	Minneola	KS	67865	Iroquois Center		Y	Y
Iroquois Center	501 S. Pine	Greensburg	KS	67054	Iroquois Center		Y	Y
Iroquois Center	202 E. Nebraska	Greensburg	KS	67054	Iroquois Center		Y	Y
Johnson County MHC	6000 Lamar, Suite 130	Mission	KS	66202	Johnson County MHC	Y		N
Johnson County MHC	1125 West Spruce Ave.	Olathe	KS	66061	Johnson County MHC	Y		N
Johnson County MHC	6440 Nieman Rd.	Shawnee	KS	66203	Johnson County MHC	Y		N
Johnson County MHC	111 S. Cherry St.	Olathe	KS	66061	Johnson County MHC	Y		N
Johnson County MHC	11120 W. 65th St.	Shawnee	KS	66203	Johnson County MHC	Y		N
Kanza Mental Health and Guidance Center	909 S. 2nd Street	Hiawatha	KS	66434	Kanza Mental Health and Guidance Center		Y	Y
Kanza Mental Health and Guidance Center	2291 Linden Rd.	Hiawatha	KS	66434	Kanza Mental Health and Guidance Center		Y	Y
Kanza Mental Health and Guidance Center	510 Kansas Ave.	Holton	KS	66436	Kanza Mental Health and Guidance Center		Y	Y
Kanza Mental Health and Guidance Center	711 Nemaha St.	Seneca	KS	66538	Kanza Mental Health and Guidance Center		Y	Y

Kanza Mental Health and Guidance Center	117 N. Main Street	Troy	KS	66087	Kanza Mental Health and Guidance Center		Y		Y
Kanza Mental Health and Guidance Center	501 S. 14th Street	Sabetha	KS	66534	Kanza Mental Health and Guidance Center		Y		Y
Labette Center	1730 Belmont	Parsons	KS	67357	Labette Center	Y			Y
Pawnee Mental Health	2001 Clafflin Road	Manhattan	KS	66502	Pawnee Mental Health	Y			N
Pawnee Mental Health	1558 Hayes Dr.	Manhattan	KS	66502	Pawnee Mental Health	Y			N
Pawnee Mental Health	503 Grant Ave.	Clay Center	KS	67432	Pawnee Mental Health	Y			Y
Pawnee Mental Health	210 W. 21st St.	Concordia	KS	66901	Pawnee Mental Health	Y			Y
Pawnee Mental Health	814 Caroline Ave.	Junction City	KS	66441	Pawnee Mental Health	Y			Y
Pawnee Mental Health	1735 W. Ash St.	Junction City	KS	66441	Pawnee Mental Health	Y			Y
Pawnee Mental Health	122 W. Main St.	Mankato	KS	66956	Pawnee Mental Health	Y			Y
Pawnee Mental Health	2020 N. Independence	Beloit	KS	67420	Pawnee Mental Health	Y			Y
Pawnee Mental Health	510 US-24	Wamego	KS	66547	Pawnee Mental Health	Y			Y
Pawnee Mental Health	1836 M. Street	Belleville	KS	66935	Pawnee Mental Health	Y			Y
Pawnee Mental Health	423 Houston St.	Manhattan	KS	66502	Pawnee Mental Health	Y			N
Pawnee Mental Health	3019 Anderson Ave.	Manhattan	KS	66503	Pawnee Mental Health	Y			N
Pawnee Mental Health	321 C. St. Suite 102	Washington	KS	66968	Pawnee Mental Health	Y			Y
Pawnee Mental Health	406 N. 3rd St. Ste. 3	Marysville	KS	66508	Pawnee Mental Health	Y			Y
Prairie View	1901 Est.1st Street Box 467	Newton	KS	67114	Prairie View	Y			Y
Prairie View	508 S. Ash	Hillsboro	KS	67063	Prairie View	Y			Y
Prairie View	1102 Hospital Dr.	McPherson	KS	67460	Prairie View	Y			Y
Prairie View	7570 W. 21st St. North, Suite 1026-D	Wichita	KS	67205	Prairie View	Y			N
South Central Mental Health Counseling Center	2365 West Central	El Dorado	KS	67042	South Central Mental Health Counseling Center	Y			Y
South Central Mental Health Counseling Center	325 N. Vine	El Dorado	KS	67042	South Central Mental Health Counseling Center	Y			Y
South Central Mental Health Counseling Center	217 Ira Ct.	Andover	KS	67002	South Central Mental Health Counseling Center	Y			N
South Central Mental Health Counseling Center	450 N. 159th St.	Andover	KS	67002	South Central Mental Health Counseling Center	Y			N
South Central Mental Health Counseling Center	2821 Brookside Dr.	Augusta	KS	67010	South Central Mental Health Counseling Center	Y			Y
South Central Mental Health Counseling Center	430 N. Walnut St.	Augusta	KS	67010	South Central Mental Health Counseling Center	Y			Y
South Central Mental Health Counseling Center	9333 E. 21st, Suite 102	Wichita	KS	67206	South Central Mental Health Counseling Center	Y			N
Southeast Kansas Mental Health Center	1322 S. Grant	Chanute	KS	66720	Southeast Kansas Mental Health Center	Y			Y
Southeast Kansas Mental Health Center	401 Woodland Hills Blvd. Suite B and C	Fort Scott	KS	66701	Southeast Kansas Mental Health Center	Y			Y

Southeast Kansas Mental Health Center	212 State Street	Fort Scott	KS	66701	Southeast Kansas Mental Health Center	Y			Y
Southeast Kansas Mental Health Center	304 North Jefferson Ave.	Iola	KS	66749	Southeast Kansas Mental Health Center	Y			Y
Southeast Kansas Mental Health Center	505 West 15th	Pleasanton	KS	66075	Southeast Kansas Mental Health Center	Y			Y
Southeast Kansas Mental Health Center	1106 South Ninth	Humboldt	KS	66748	Southeast Kansas Mental Health Center	Y			Y
Southeast Kansas Mental Health Center	204 South Main	Yates Center	KS	66783	Southeast Kansas Mental Health Center	Y			Y
Southeast Kansas Mental Health Center	519 South Elm	Garnett	KS	66032	Southeast Kansas Mental Health Center	Y			Y
Southeast Kansas Mental Health Center	826 E. Madison Ave.	Iola	KS	66749	Southeast Kansas Mental Health Center	Y			Y
Southeast Kansas Mental Health Center	223 E. Main St.	Mound City	KS	66056	Southeast Kansas Mental Health Center	Y			Y
Southwest Guidance Center	333 West 15th St. P.O. Box 2945	Liberal	KS	67901	Southwest Guidance Center	Y			Y
Southwest Guidance Center	21 Plaza Drive	Liberal	KS	67901	Southwest Guidance Center	Y			Y
Southwest Guidance Center	1006 South Jackson	Hugoton	KS	67951	Southwest Guidance Center	Y			Y
Southwest Guidance Center	309 South Webb Street	Meade	KS	67864	Southwest Guidance Center	Y			Y
Southwest Guidance Center	301 South Derby Street	Sublette	KS	67877	Southwest Guidance Center	Y			Y
Spring River Mental Health	6610 SE Quakervale Rd.	Riverton	KS	66770	Spring River Mental Health	Y			Y
Spring River Mental Health	201 W. Walnut	Columbus	KS	66725	Spring River Mental Health	Y			Y
Sumner Mental Health	1601 W. 16th St.	Wellington	KS	67152	Sumner Mental Health		Y		Y
The Guidance Center	201 Main St. Suite 100	Atchison	KS	66002	The Guidance Center	Y			Y
The Guidance Center	500 Limit St.	Leavenworth	KS	66048	The Guidance Center	Y			Y
The Guidance Center	711 Marshall St.	Leavenworth	KS	66048	The Guidance Center	Y			Y
The Guidance Center	1102 Walnut	Oskaloosa	KS	66066	The Guidance Center	Y			Y
Valeo	330 SW Oakley	Topeka	KS	66606	Valeo	Y			N
Valeo	400 SW Oakley Ave.	Topeka	KS	66606	Valeo	Y			N
Wyandot Center	1301 North 47th St. Building A	Kansas City	KS	66102	Wyandot Center	Y			N
Wyandot Center	7840 Washington Ave.	Kansas City	KS	66112	Wyandot Center	Y			N
Wyandot Center	726 Armstrong Ave.	Kansas City	KS	66101	Wyandot Center	Y			N
Wyandot Center	1301 North 47th St. Building B	Kansas City	KS	66102	Wyandot Center	Y			N

All Kansas CCBHCs began as state-certified CCBHCs from 2022 to 2024 and all but Iroquois, Kanza, and Sumner transitioned to Medicaid Demonstration authority in 2025. Those three CCBHCs are slated to join the Medicaid Demonstration on 01/01/2026.

Rural Residency Programs

1 (Jan - March)	State awards grant for program implementation including tasks listed herein. Develop implementation plan, milestones, and evaluation framework. Begin outreach to hospitals and medical schools for rural residency partnerships.	5 (Jan - March)	Continue ACGME accreditation application preparation as necessary. Submit ACGME accreditation application. Faculty development ongoing.	9 (Jan - March)	Continue recruiting for residency programs. Expand rural residency capacity via applications to ACGME to 4-5 programs statewide. Add \$70,000 annual per-site offset funding for Sole Community Hospital reimbursement loss.	13 (Jan - March)	Sustain 5-6 fully operational residency programs	17 (Jan - March)	Complete 5-year analysis of program impact on rural physician supply. Issue final report and sustainability plan
2 (April - Jun)	Continue outreach to hospitals and medical schools for rural residency partnerships. Convene roundtable meetings with both allopathic and osteopathic Kansas residency programs, current residency sites, prospective residency sites, and other key stakeholders.	6 (April - Jun)	plan for implementation	10 (April - Jun)	Continue development/support of new residency cohorts and monitor rural hospital capacity.	14 (April - Jun)	Add final cohorts and evaluate specialty distribution (Family Medicine, OB/GYN, Surgery, Psychiatry, Orthopedics). Present outcomes to Kansas Legislature and RHTP Advisory Committee.	18 (April - Jun)	draft future sustainability plan
3 (July - Sept)	Identify and prioritize 3-5 potential rural sites for new ACGME-accredited residency programs (OB/GYN, Behavioral Health, Family Medicine, General Surgery, Psychiatry, Orthopedics). Begin identifying community physicians by specialty to support training locally.	7 (July - Sept)	plan for implementation	11 (July - Sept)	Onboard 1st cohort of residents (target: 15-20 total across tracks). Support expanded slots	15 (July - Sept)	support funded efforts	19 (July - Sept)	Transition program oversight from RHTP funding to permanent state funding or external partnerships.
4 (Oct - Dec)	Begin process to identify rural track assistant program director. Secure intent to proceed with 3-5 rural sites. Prepare and begin faculty development. Begin developing other program infrastructure. Begin ACGME accreditation application as applicable.	8 (Oct - Dec)	Secure ACGME approvals, and begin program marketing/recruitment for first cohort of 2-3 rural residencies.	12 (Oct - Dec)	support expanded slots	16 (Oct - Dec)	support funded efforts	20 (Oct - Dec)	data analysis for final grant reporting

Expansion of Kansas Bridging Plan (KBP)

1 (Jan - March)	State awards grant for program implementation including tasks listed herein. Develop implementation plan, milestones, and evaluation framework. Finalize staff job description; hire one FTE to manage.	5 (Jan - March)	Continue KBP expansion and begin issuing retention stipends to Year 2 residents; monitor physician service commitments.	9 (Jan - March)	Continue KBP expansion and retention payments; monitor physician service commitments.	13 (Jan - March)	ongoing support	17 (Jan - March)	Complete 5-year analysis of program impact on rural physician supply. Issue final report and sustainability plan
2 (April - Jun)	Increase incentive amounts to \$30,000. Add new residency slots (General Surgery, Orthopedics, 3 additional out-of-state primary care slots). Initiate data system enhancements for participant tracking.	6 (April - Jun)	ongoing support	10 (April - Jun)	Publish mid-point evaluation on physician placement outcomes and rural retention trends.	14 (April - Jun)	Present outcomes to Kansas Legislature and RHTP Advisory Committee.	18 (April - Jun)	draft future sustainability plan
3 (July - Sept)	Maintain KBP expansion and begin issuing retention stipends to Year 1 residents.	7 (July - Sept)	ongoing support	11 (July - Sept)	ongoing support	15 (July - Sept)	ongoing support	19 (July - Sept)	Transition program oversight from RHTP funding to permanent state funding or external partnerships.
4 (Oct - Dec)	ongoing support	8 (Oct - Dec)	ongoing support	12 (Oct - Dec)	ongoing support	16 (Oct - Dec)	ongoing support	20 (Oct - Dec)	data analysis for final grant reporting

Medical Student Rural Rotation Housing Assistance

1 (Jan - March)	State awards grant for program implementation including tasks listed herein. Develop implementation plan, milestones, and evaluation framework. Finalize staff job description; contract/hire 0.5 FTE to manage.	5 (Jan - March)	Evaluate impact of initial housing stipend program; adjust rural site participation as needed. Begin data collection and reporting to KDHE and CMS. Launch Medical Student Rural Rotation Housing Assistance stipends Year 2 (target: 100 rotations; \$1,000/week x 5 weeks).	9 (Jan - March)	Launch Medical Student Rural Rotation Housing Assistance stipends Year 3 (target: 100 rotations; \$1,000/week x 5 weeks).	13 (Jan - March)	Integrate housing assistance program with existing rural GME consortia to ensure sustainability. Launch Medical Student Rural Rotation Housing Assistance stipends Year 4 (target: 100 rotations; \$1,000/week x 5 weeks).	17 (Jan - March)	Issue final report and sustainability plan
2 (April - Jun)	Launch Medical Student Rural Rotation Housing Assistance stipends (target: 30 rotations; \$1,000/week x 5 weeks).	6 (April - Jun)	continue promotion and support	10 (April - Jun)	continue promotion and support	14 (April - Jun)	Present outcomes to Kansas Legislature and RHTP Advisory Committee. continue promotion and support	18 (April - Jun)	continue promotion and support
3 (July - Sept)	Continue stipends, targeting 35 rotations; \$1,000/week x 5 weeks.	7 (July - Sept)	continue promotion and support	11 (July - Sept)	continue promotion and support	15 (July - Sept)	continue promotion and support	19 (July - Sept)	Transition program oversight from RHTP funding to permanent state funding or external partnerships.
4 (Oct - Dec)	Continue stipends, targeting 35 rotations; \$1,000/week x 5 weeks.	8 (Oct - Dec)	continue promotion and support	12 (Oct - Dec)	continue promotion and support	16 (Oct - Dec)	continue promotion and support	20 (Oct - Dec)	data analysis for final grant reporting

Health Professions Service Scholarship Program	1 (Jan - March)	State awards grant for program implementation including tasks listed herein. Develop implementation plan, milestones, and evaluation framework. Establish application and tracking portal. Develop 5-year rural service agreements and reporting framework.	5 (Jan - March)	Continue open application/renewal for scholarships to fund 200 undergraduate/technical students and 100 post-graduate students this year.	9 (Jan - March)	Continue open application/renewal for scholarships to fund 200 undergraduate/technical students and 100 post-graduate students this year.	13 (Jan - March)	Continue open application/renewal for scholarships to fund 200 undergraduate/technical students and 100 post-graduate students this year. Introduce legislation in the state legislature to sustain scholarship programs past 2030.	17 (Jan - March)	Continue open application/renewal for scholarships to fund 200 undergraduate/technical students and 100 post-graduate students this year.
	2 (April - Jun)	Begin promoting scholarships to colleges, students, and stakeholders.	6 (April - Jun)	Continue evaluation of rural placement outcomes.	10 (April - Jun)	Continue promotion and support	14 (April - Jun)	continue promotion and support	18 (April - Jun)	Complete final evaluation of program reach, ROI, and workforce retention impact.
	3 (July - Sept)	Launch scholarships to fund 200 undergraduate/technical students and 100 post-graduate students in Year 1.	7 (July - Sept)	continue promotion and support	11 (July - Sept)	Prepare interim report on project reach and cost-per-outcome metrics.	15 (July - Sept)	continue promotion and support	19 (July - Sept)	Transition grant programs to sustainability model through philanthropy or state funding.
	4 (Oct - Dec)	Develop sustainability metrics and workforce data collection system.	8 (Oct - Dec)	continue promotion and support	12 (Oct - Dec)	continue promotion and support	16 (Oct - Dec)	continue promotion and support	20 (Oct - Dec)	continue support, data analysis for final grant reporting
Rural Dentist Scholarship	1 (Jan - March)	State awards grant for program implementation including tasks listed herein. Develop implementation plan, milestones, and evaluation framework. Establish application and tracking portal. Develop 5-year rural service agreements and reporting framework.	5 (Jan - March)	Continue awarding scholarships for new applications/renewal (10 dentists, 15 hygienists annually).	9 (Jan - March)	Continue awarding scholarships for new applications/renewal (10 dentists, 15 hygienists annually).	13 (Jan - March)	Continue awarding scholarships for new applications/renewal (10 dentists, 15 hygienists annually). Introduce legislation in the state legislature to sustain scholarship programs past 2030.	17 (Jan - March)	Continue awarding scholarships for new applications/renewal (10 dentists, 15 hygienists annually).
	2 (April - Jun)	Launch Rural Dentist Scholarship Program (10 dentists, 15 hygienists).	6 (April - Jun)	Continue evaluation of rural placement outcomes.	10 (April - Jun)	program support	14 (April - Jun)	program support	18 (April - Jun)	Complete final evaluation of program reach, ROI, and workforce retention impact.
	3 (July - Sept)	program support	7 (July - Sept)	program support	11 (July - Sept)	Prepare interim report on project reach and cost-per-outcome metrics.	15 (July - Sept)	program support	19 (July - Sept)	Transition grant programs to sustainability model through philanthropy or state funding.
	4 (Oct - Dec)	Develop sustainability metrics and workforce data collection system.	8 (Oct - Dec)	program support	12 (Oct - Dec)	program support	16 (Oct - Dec)	program support	20 (Oct - Dec)	continue support, data analysis for final grant reporting
Mobile Simulation Lab	1 (Jan - March)	State awards grant for program implementation including tasks listed herein. Develop implementation plan, milestones, and evaluation framework. Finalize staff job description; contract one FTE nurse trainer, one physician trainer, and one program manager.	5 (Jan - March)	Continue Mobile Simulation Lab visits (target 34 trainings during the year)	9 (Jan - March)	Continue Mobile Simulation Lab visits (target 34 trainings during the year)	13 (Jan - March)	Continue Mobile Simulation Lab visits (target 34 trainings during the year)	17 (Jan - March)	Continue Mobile Simulation Lab visits (target 34 trainings during the year)
	2 (April - Jun)	Purchase customized vehicle, high-fidelity manikin, trauma limbs, simulation software, training modules, virtual headsets, and medical training supplies.	6 (April - Jun)	continue trainings, program support	10 (April - Jun)	continue trainings, program support	14 (April - Jun)	continue trainings, program support	18 (April - Jun)	Complete final evaluation of program reach, ROI, and workforce retention impact. continue trainings, program support
	3 (July - Sept)	Deploy Mobile Simulation Lab to first rural communities (approx. 17 trainings).	7 (July - Sept)	continue trainings, program support	11 (July - Sept)	Prepare interim report on project reach and cost-per-outcome metrics.	15 (July - Sept)	continue trainings, program support	19 (July - Sept)	continue trainings, program support
	4 (Oct - Dec)	Continue Mobile Simulation Labs with approx. 17 trainings.	8 (Oct - Dec)	continue trainings, program support	12 (Oct - Dec)	continue trainings, program support	16 (Oct - Dec)	continue trainings, program support	20 (Oct - Dec)	data analysis for final grant reporting
Health Care Training Grants	1 (Jan - March)	State awards grant for program implementation including tasks listed herein.	5 (Jan - March)	Award first round of Health Care Training Grants to expand allied health programs and other rural community trainings including through rural satellite training sites and hybrid/online learning modalities (e.g., imaging, CHWs, EMS, respiratory therapy).	9 (Jan - March)	Review and approve applications for funding on an ongoing basis.	13 (Jan - March)	not budgeted in this calendar year. Add funding for an additional year if results show it is worth the investment.	17 (Jan - March)	Not budgeted in this calendar year. Evaluate allied health vacancy reductions in grantee communities.
	2 (April - Jun)	Initiate Health Care Training Grant program framework (application design, selection criteria).	6 (April - Jun)	Renew grant cycle for additional rural training expansions.	10 (April - Jun)	Review and approve applications for funding on an ongoing basis.	14 (April - Jun)		18 (April - Jun)	Sustain training programs with local college partnerships. Complete final evaluation of program reach, ROI, and workforce retention impact.
	3 (July - Sept)	Open applications to rural communities to submit innovative and transformative ideas for implementation.	7 (July - Sept)	Review and approve applications for funding on an ongoing basis.	11 (July - Sept)	Prepare interim report on project reach and cost-per-outcome metrics.	15 (July - Sept)	Begin development of a statewide Education and Training Outcomes Report.	19 (July - Sept)	Publish statewide Education and Training Outcomes Report.
	4 (Oct - Dec)	Review first batch of applications.	8 (Oct - Dec)	Review and approve applications for funding on an ongoing basis.	12 (Oct - Dec)	Review pilot projects that may lead to replicability across the state.	16 (Oct - Dec)		20 (Oct - Dec)	data analysis for final grant reporting

	2026	2027	2028	2029	2030
Work in Rural Kansas Health Care Campaign	1 (Jan - March) State awards grant for program implementation including tasks listed herein. Secure marketing firm to assist, develop campaign messages - finalize year long plan, milestones and evaluation framework.	5 (Jan - March) continue campaign	9 (Jan - March) not budgeted in this calendar year	13 (Jan - March) not budgeted in this calendar year	17 (Jan - March) not budgeted in this calendar year
	2 (April - Jun) launch campaign	6 (April - Jun) continue campaign	10 (April - Jun)	14 (April - Jun)	18 (April - Jun)
	3 (July - Sept) continue campaign	7 (July - Sept) continue campaign	11 (July - Sept)	15 (July - Sept)	19 (July - Sept)
	4 (Oct - Dec) evaluate results - adjust as needed - continue to run campaign	8 (Oct - Dec) run campaign, evaluate results and determine if funding in future years is warranted, data analysis for final grant reporting	12 (Oct - Dec)	16 (Oct - Dec)	20 (Oct - Dec)
Rural Nurse Residencies	1 (Jan - March) State awards grant for program implementation including tasks listed herein. Acquisition of curriculum from Vizient, develop program guidelines for participating nurses/hospitals, begin marketing opportunity to hospitals/nursing schools, hire 1 program manager. Develop implementation plan, milestones, and evaluation framework.	5 (Jan - March) support cohort 1 and 2, recruit cohort 3	9 (Jan - March) support cohort 3 and 4, recruit cohort 5	13 (Jan - March) support cohort 5 and 6, recruit cohort 7	17 (Jan - March) support cohort 7 and 8
	2 (April - Jun) launch first cohort of graduating nurses	6 (April - Jun) cohort 1 wraps up, support cohort 2, launch cohort 3	10 (April - Jun) cohort 3 wraps up, support cohort 4, launch cohort 5	14 (April - Jun) cohort 5 wraps up, support cohort 6, launch cohort 7	18 (April - Jun) cohort 7 wraps up, support cohort 8
	3 (July - Sept) support cohort 1, recruit cohort 2	7 (July - Sept) support cohorts 2 and 3, recruit cohort 4	11 (July - Sept) support cohorts 4 and 5, recruit cohort 6	15 (July - Sept) support cohorts 6 and 7, recruit cohort 8	19 (July - Sept) support cohort 8
	4 (Oct - Dec) Launch second cohort of graduating nurses, hire second program manager	8 (Oct - Dec) cohort 2 wraps up, launch cohort 4	12 (Oct - Dec) cohort 4 wraps up, launch cohort 6	16 (Oct - Dec) cohort 6 wraps up, launch cohort 8	20 (Oct - Dec) cohort 8 wraps up, data analysis for final grant reporting
Clinical Instructor and Preceptor Incentives	1 (Jan - March) State awards grant for program implementation including tasks listed herein. Adapt existing clinical faculty academy curriculum for rural use, contact with instructor for faculty academy, develop program guidelines for participating hospitals, market opportunity to hospitals/nursing schools. Develop implementation plan, milestones, and evaluation framework.	5 (Jan - March) program revisions based on lessons learned, 10 additional school/hospital partnerships added	9 (Jan - March) 20 additional instructors trained	13 (Jan - March) 20 additional instructors trained	17 (Jan - March) 20 additional instructors trained
	2 (April - Jun) initial hospital/school pilot partnerships formed, hold Clinical Faculty Academy	6 (April - Jun) hold Clinical Faculty Academy	10 (April - Jun) hold Clinical Faculty Academy	14 (April - Jun) hold Clinical Faculty Academy	18 (April - Jun) hold Clinical Faculty Academy
	3 (July - Sept) pilot test with 10 hospitals and 10 instructors launched during fall semester	7 (July - Sept) 20 additional instructors trained	11 (July - Sept) 20 additional instructors trained	15 (July - Sept) 20 additional instructors trained	19 (July - Sept) 20 additional instructors trained
	4 (Oct - Dec) pilot test continues, new partnerships identified	8 (Oct - Dec) hold Clinical Faculty Academy	12 (Oct - Dec) hold Clinical Faculty Academy	16 (Oct - Dec) hold Clinical Faculty Academy	20 (Oct - Dec) final data collection/evaluation

**Behavioral Health
Apprenticeship
Program**

1 (Jan - March)	State awards grant for program implementation including tasks listed herein. Collaborate with behavioral health organizations and educational institutions to identify potential roles for apprenticeships. Develop implementation plan, milestones, and evaluation framework.	5 (Jan - March)	continued promotion, quarterly networking session	9 (Jan - March)	continued promotion, quarterly networking session	13 (Jan - March)	continued promotion, quarterly networking session	17 (Jan - March)	continued promotion, quarterly networking session
2 (April - Jun)	contract with intermediary, for roles not currently registered, develop training/skills required and apply for registered apprenticeship status, start promotion of program to employers	6 (April - Jun)	continued promotion, quarterly networking session	10 (April - Jun)	continued promotion, quarterly networking session	14 (April - Jun)	continued promotion, quarterly networking session	18 (April - Jun)	continued promotion, quarterly networking session
3 (July - Sept)	continue prep work	7 (July - Sept)	continued promotion, quarterly networking session	11 (July - Sept)	continued promotion, quarterly networking session	15 (July - Sept)	continued promotion, quarterly networking session	19 (July - Sept)	launch last round of
4 (Oct - Dec)	launch first round of apprenticeships	8 (Oct - Dec)	continued promotion, quarterly networking session	12 (Oct - Dec)	continued promotion, quarterly networking session	16 (Oct - Dec)	continued promotion, quarterly networking session	20 (Oct - Dec)	final data collection/evaluation

	2026	2027	2028	2029	2030
Rural Chapters of HOSA - Future Health Professionals	1 (Jan - March) State awards grant for program implementation including tasks listed herein. Hire staff. Establish financial support for chapters program, planning for workforce development days, regional conferences	5 (Jan - March) Hold State Leadership Conference	9 (Jan - March) Hold State Leadership Conference, expand simulation training	13 (Jan - March) Hold State Leadership Conference, launch membership dashboard	17 (Jan - March) Hold State Leadership Conference
	2 (April - Jun) Hold Workforce Development Day, launch chapter support program	6 (April - Jun) Hold Workforce Development Day	10 (April - Jun) Hold Workforce Development Day	14 (April - Jun) Hold Workforce Development Day	18 (April - Jun) Hold Workforce Development Day
	3 (July - Sept) Hold Workforce Development Day	7 (July - Sept) Hold Workforce Development Day	11 (July - Sept) Hold Workforce Development Day	15 (July - Sept) Hold Workforce Development Day	19 (July - Sept) Hold Workforce Development Day
	4 (Oct - Dec) plan educational offerings for next year	8 (Oct - Dec) Hold Fall Leadership Development Conference, plan simulation training expansion, plan educational offerings for next year	12 (Oct - Dec) Hold Fall Leadership Development Conference, plan educational offerings for next year	16 (Oct - Dec) Hold Fall Leadership Development Conference, plan educational offerings for next year	20 (Oct - Dec) provide sustainability training for chapters, final data collection/evaluation
K-12 Health Science Career Technical Education (CTE)	1 (Jan - March) State awards grant for program implementation including tasks listed herein. Meet with KSDE to develop program guidelines for participating rural school districts, begin marketing opportunity	5 (Jan - March) students complete fall enrollment	9 (Jan - March) students complete fall enrollment	13 (Jan - March) students complete fall enrollment	17 (Jan - March) students complete fall enrollment
	2 (April - Jun) Identify curriculum needs, equipment needs to get programs off the ground, look at ways to help support expansion of existing programs	6 (April - Jun) continued promotion	10 (April - Jun) continued promotion, develop mechanism to track students upon graduation	14 (April - Jun) continued promotion, continued tracking	18 (April - Jun) continue tracking graduates
	3 (July - Sept) Commitment from 5-10 schools to be part of pilot project	7 (July - Sept) Launch 5-10 schools in pilot project	11 (July - Sept) Launch 10 additional programs	15 (July - Sept) Launch 10 additional programs	19 (July - Sept) Launch 10 additional programs
	4 (Oct - Dec) Schools build new track into enrollment information	8 (Oct - Dec) program revisions based on lessons learned, Schools build new track into enrollment information	12 (Oct - Dec) Schools build new track into enrollment information	16 (Oct - Dec) Schools build new track into enrollment information	20 (Oct - Dec) final data collection/evaluation
High school certification/pre-apprenticeship programs	1 (Jan - March) State awards grant for program implementation including tasks listed herein. Collaborate with KSDE and educational institutions to identify potential roles for apprenticeships	5 (Jan - March) students complete fall enrollment	9 (Jan - March) students complete fall enrollment	13 (Jan - March) students complete fall enrollment	17 (Jan - March) students complete fall enrollment
	2 (April - Jun) Identify curriculum needs, equipment needs to get programs off the ground, look at ways to help support expansion of existing programs	6 (April - Jun) continued promotion	10 (April - Jun) continued promotion	14 (April - Jun) continued promotion	18 (April - Jun) continued promotion
	3 (July - Sept) Commitment from 5-10 schools/employers to be part of pilot project	7 (July - Sept) Launch 5-10 schools/employers in pilot project	11 (July - Sept) Launch 10 additional programs	15 (July - Sept) Launch 10 additional programs	19 (July - Sept) Launch 10 additional programs
	4 (Oct - Dec) Schools build class into enrollment information	8 (Oct - Dec) program revisions based on lessons learned, Schools build new classes into enrollment information	12 (Oct - Dec) program revisions based on lessons learned, Schools build new classes into enrollment information	16 (Oct - Dec) program revisions based on lessons learned, Schools build new classes into enrollment information	20 (Oct - Dec) final data collection/evaluation
Regional Career Expo	1 (Jan - March) State awards grant for program implementation including tasks listed herein. Establish guidelines for career expo support	5 (Jan - March) promote support opportunities, goal of 4-6 events	9 (Jan - March) promote support opportunities, goal of 4-6 events	13 (Jan - March) promote support opportunities, goal of 4-6 events	17 (Jan - March) promote support opportunities, goal of 4-6 events
	2 (April - Jun) launch career expo support program, coordinate with HOSA and other applicable projects	6 (April - Jun) promote support opportunities	10 (April - Jun) promote support opportunities	14 (April - Jun) promote support opportunities	18 (April - Jun) promote support opportunities
	3 (July - Sept) promote support opportunities	7 (July - Sept) promote support opportunities	11 (July - Sept) promote support opportunities	15 (July - Sept) promote support opportunities	19 (July - Sept) promote support opportunities
	4 (Oct - Dec) share best practices	8 (Oct - Dec) share best practices	12 (Oct - Dec) share best practices	16 (Oct - Dec) share best practices	20 (Oct - Dec) share best practices, dfinal data collection/evaluation