Application for Rural Health Transformation Program

Project Narrative

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1.0 RURAL HEALTH NEEDS AND TARGET POPULATION

Rural Missouri lies at the heart of the Show-Me State's identity. From the Ozark hills to the northern prairies, our small towns and farm communities carry a legacy of self-reliance, civic pride, and deep connection to place. Generations of families have built their lives around local schools, churches, and main streets that hold history and resilience. These are communities where neighbors look out for one another and working together to keep local economies, traditions, and values alive. Yet, the health of many who live here is increasingly at risk. Nearly 2.5 million Missourians – about 40 percent of the population – reside in rural areas where they are facing widening health disparities along three interconnected dimensions:

Access to care

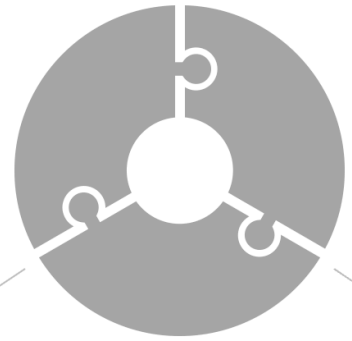
Rural residents often travel farther and wait longer for essential services.

Provider shortages and lack of affordable care contribute to unmet needs, especially in behavioral health, obstetrics, and chronic disease management.

Health outcomes

Chronic conditions, maternal health challenges, and behavioral health concerns are more prevalent in rural communities.

Delayed or deferred care leads to poorer outcomes that ripple through families and local economies alike.



Provider sustainability

Rural health systems – hospitals, clinics, FQHCs, and public health agencies – work tirelessly to serve our communities, but they operate under growing financial and operational strain. Many providers face workforce shortages, reimbursement pressures, and outdated infrastructure that make it difficult to sustain critical services.

These challenges are compounded by broader socioeconomic realities: lower household incomes, aging populations, limited broadband, and transportation access all

affect both the demand for and delivery of care. For these reasons, the rural healthcare ecosystem in Missouri is highly fragile despite the best efforts of those who care for Missourians. Addressing these challenges is not simply a health imperative; it is central to our State's economic and social future.

Table 1: Missouri Key Demographic and Health Statistics

Missouri Key Statistics		
Total Population[1]	6,168,181	
Rural Population[2]	2,485,747	
# of Rural Counties (definition)[3]	99 state-defined rural counties* 5 rural-adjacent counties as regional anchors for healthcare capacity: Buchanan, Cape Girardeau, Christian, Jasper, and Newton 104 out of a total of 114 counties in MO ** <150 residents per square mile and lacking at least 10% of a central city within an MSA*	
Key Metrics	***Non-Rural (avg.)***	***Rural (avg.)***
Rural demographics[4]		
Median household income	$76,391	$60,666
Unemployment rate	3.65% (statewide avg.)	6%
% below poverty line	10.8%	14.4%
% without a high-school diploma	4.5%	7.6%
% of uninsured population	7.8%	11.3%
Healthcare Access[5]		
Commercial insurance coverage	62.2%	48.7%
Avg distance traveled for hospital-based care[6]	9.2 miles	23.1 miles
Number of OBGYN per 100K	17.7	3.3
Health Outcomes[7]		
% diabetes prevalence	7.1%	10.0%
% hypertension prevalence	17.0%	23.5%
% obesity	36.9%	40.0%
% low birth weight	11.0%	8.4%
% depression	6.7%	8.5%
Rural Provider Financial Health		
# of hospital beds per capita (# of discharges)	391 (18,596,085)	192 (9,667,570)
% of hospitals operating at loss (avg. margin)[8]	29.3% (+2.4%)	54.4% (+0.4%)
# of hospital closures (since 2014)[9]	N/A	12

2.0 TRANSFORMATION PLAN: GOALS AND STRATEGIES

2.1 Vision and Objectives

The Rural Health Transformation Program (RHTP) offers Missouri an unprecedented opportunity to confront the longstanding challenges highlighted above. We will pursue a bold and comprehensive vision that will fundamentally shift the healthcare experience for our rural residents:

Our vision

Every rural Missourian has access to the high-quality care they need through a delivery system that is well aligned, community anchored, and built to last.

Our objectives

Expanding access to care	Improving health outcomes	Strengthening provider sustainability
Ensure rural Missourians can access primary and behavioral health providers close to home, community-based maternity options, with connections to specialists and complex care enabled by telehealth and provider interoperability	Strengthen healthcare quality through integrated care coordination, aligned incentives, and evidence-based practices – so that rural Missourians consistently experience seamless, high-value care	Reinforce the long-term sustainability of rural providers through targeted investments in infrastructure, adoption of innovative technologies, and payment models that reflect the realities of rural care delivery

2.2 Strategy: Transformation of Rural Community Health Care (ToRCH Care)

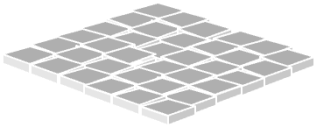
To bring our vision to life, Missouri is transforming how rural healthcare works through the **Transformation of Rural Community Health Care (ToRCH Care)** – a statewide network of healthcare “hubs” designed to bring care closer to home, make clinical and non-clinical services more seamless, and ensure that no rural resident is left behind.

ToRCH Care builds on Missouri’s successful Transformation of Rural Community Health (ToRCH) pilot, which proved that locally governed, data-driven collaboration can

improve both outcomes and financial stability. Participating hospitals and clinics achieved measurable results, including a 19.6% increase in controlled blood pressure and an 18% increase in behavioral-health follow-up after ED visits (see *Supporting Document*: Rural Missouri's Success).

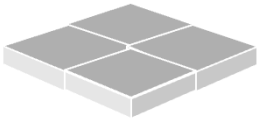
ToRCH Care builds on this proven foundation to create a statewide supporting framework for Missouri's rural healthcare system. It will operate at three connected levels - state, regional, and local - to ensure consistent standards and shared infrastructure while empowering communities to design solutions tailored to their needs:

Local Level



The **30 Local Community Hubs ("Hubs")** are the **front line**, where hospitals, behavioral health providers, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Local Public Health Agencies (LPHAs), EMS, pharmacies, and community organizations convene monthly to review data, identify shared challenges, and implement projects tailored to their populations. Each Hub brings care coordination down to the county level, ensuring decisions are grounded in community context.

Regional Level



The **7 Regional Coordinating Networks (RCNs)** provide the **scale and power** to make local action sustainable. Through an unprecedented level of partnership, Missouri's major healthcare associations (Missouri Hospital Association, Missouri Primary Care Association, Missouri Behavioral Health Council) will act jointly to anchor the RCN infrastructure. They will serve as strategic partners, providing coordination, subject matter expertise, and reporting to ensure impact. The RCNs also give smaller hospitals and rural providers access to expertise and capacity they could not afford on their own, creating *regional strength without losing local voice.*

State Level

The new **Rural Health Transformation Office (RHTO) within the Department of Social Services (DSS)** will oversee governance, align policy and financing, and serve as a **center of excellence** for rural health innovation. The Office will partner closely with the RCNs and Hubs to ensure development is consistent with best practices, while maintaining flexibility for local adaptation. The Office will also ensure accountability to state and federal priorities for the Rural Health Transformation Program.

Together, these layers replace fragmented efforts with coordinated action to accelerate innovation and deliver better outcomes. Critically, this model will create substantial savings that will be shared by those in the Hub, incentivizing participation and creating

enduring sustainability. ToRCH Care has been developed, piloted, and refined in partnership with many of the providers who would participate in this model, including Missouri's three major healthcare associations: Missouri Hospital Association (MHA), Missouri Primary Care Association (MPCA), and Missouri Behavioral Health Council (MBHC).

Over time, ToRCH Care will redefine how rural Missourians experience care: families will access primary and behavioral-health services close to home; expectant mothers will receive comprehensive maternity care safely and locally; older adults and people with chronic conditions will be supported by connected care teams; and rural providers will gain the stability, data insights, and partnerships they need to thrive long term.

2.3 Program Key Performance Objectives

Table 2: RHTP Key Performance Objectives

Key Performance Objectives [C: county-level measurement]	**Baseline**	**5-year target[10]**	**Expected Impact**
Access to Care			
% of rural population with access to care and coordination through Hub partners [C]	n/a	100%	Statewide coverage through 30 Community Hubs and 7 RCNs
Number of behavioral, maternal, and chronic care touchpoints supported through Hub partners [C]	n/a	≥ 60,000[11]	Expanded access across integrated community partners
Rate of hospitalizations and ED visits BH diagnosis, improved by preventative behavioral health access [C]	4.2%	3.8% (≥ 10% reduction)[12]	Early intervention, ED diversion, and behavioral health integration
Increase in rural primary care visits and touchpoints per rural resident	*Baseline in Y1*	≥10% increase[13]	Increased utilization through expanded Hub access
Healthcare Outcomes (leading indicators on health) All metrics apply to rural communities served through ToRCH Care			
ED visits per 1000 rural residents [C]	456	410 (≥ 10% reduction)[14]	Reduced preventable ED use through improved access and coordination
% of adults with uncontrolled hypertension (>130/80) [C]	56.7%	51% (≥ 10% reduction)[15]	Better chronic disease management through integrated care
% of diabetic patients with controlled diabetes (A1c < 9%) [C]	63.6%	57-60% (≥ 5-10% increase)[16]	Improved disease management and continuity of care

% of births with low birth weight (<2500g) [C]	8.4%	7.6% (≥ 5% reduction)[17]	Improved maternal and infant health through Hub interventions and doula workforce
Use of pharmacotherapy for opioid use disorder (OUD) in counties covered through Hub partners [C]	*Baseline in Y1*	≥ 5-10% increase[18]	Increased continuity of addiction treatment and recovery support
Sustainability			
Service access restored or preserved	Baseline in Y1	≥ 80% approved projects operational	Improves access for rural communities
Total earnings from APM participation [C]	n/a	To determine in Y1	Reinvestment of value-based payments into local systems

2.4 Alignment to Statutory Elements and Strategic Goals

Table 3: RHTP Alignment to CMS Statutory Elements

Statutory Elements	How Addressed
Improving Access and Outcomes	Access and outcomes are jointly advanced through the ToRCH Care model which expands local entry points for physical, behavioral, and social care. Hubs and RCNs connect all providers and partners through telehealth, mobile-integrated health, and pharmacy models, residents gain timely access to care and interventions that have proven to improve outcome of health.
Technology Use and Data-Driven Solutions	Digital Backbone establishes Missouri's statewide interoperability framework, connecting all rural providers through HL7 FHIR and USCDI v3 standards. It enables real-time data exchange, analytics, and tech-supported care management. Community Information Exchange (CIE) allows closed-loop referrals and performance tracking down to the county level, bringing data-driven insights to the local front line.
Partnerships and governance	ToRCH Care formalizes multi-level partnerships that strengthen financial stability, shared learning, and quality improvement. State Rural Health Transformation Office (RHTO) provides oversight and funding, while Missouri's healthcare associations (MHA, MPCA, MBHC) anchor RCNs to ensure consistency and technical support. Community Hub Boards provide framework for partnership and governance to jointly set priorities and allocate pooled funds.
Workforce Development	Rural Health Workforce Program initiative builds a sustainable pipeline through five complementary strategies: early career pathways in rural high schools, maternal health workforce expansion, medical clerkship placement in rural hospitals, coordinated investment in EMS, and workforce retention supports like childcare access, and temporary housing.
Financial Solvency Strategies	Alternative Payment Model (APM) creates a path to long-term financial stability by rewarding Hubs and providers with shared savings from improved outcome. Performance payments support reinvestment into local systems and sustain operations beyond the grant period. Provider Transformation investments fund strategic renovations, operational innovation, and technical assistance (TA) to stabilize rural hospitals and modernize care delivery.
Cause Identification	Missouri leverages a Hospital Stress Index and analogous provider stress measures to identify providers at risk of closure due to low volume, payer mix, or infrastructure challenges. Targeted grants address these root causes while ensuring that core services remain available.

Table 4: RHTP Alignment to CMS Strategic Goals

Initiative	Alignment to CMS Strategic Goals
Regional Coordinating Network and Hub Activation	1) Make rural America healthy again; 2) Sustainable access; 3) Workforce development; 4) Innovative care; 5) Tech innovation
Alternative Payment Models	2) Sustainable access
Digital Backbone	4) Innovative care; 5) Tech Innovation
Rural Health Workforce Programs	3) Workforce Development
Provider Transformation	1) Make rural America healthy again; 2) Sustainable access 4) Innovative care; 5) Tech innovation

2.5 Legislative or Regulatory Actions, Factors A.2 and A.7

Missouri's policies are well positioned to advance the health and wellbeing of rural residents. Under Governor Mike Kehoe's leadership, the State aligns with federal priorities to strengthen access, quality, and cost of care through targeted policy action. See State policy and commitments**,** Factor A.7) Hospitals that received Medicaid DSH payment in the appendix.

3.0 PROPOSED INITIATIVES AND USE OF FUNDS

ToRCH Care will be created and sustained through five key initiatives:

1. Regional Coordinating Networks and Hub Activation

Building the foundation of Regional Coordinating Networks and Local Community Hubs to coordinate local care delivery and expand entry points for physical, behavioral, and social services

2. Alternative Payment Models

Designing and launching alternative payment models to sustain ToRCH Care through rewarding collaboration and high quality and high value outcomes

3. Digital Backbone

Establishing the foundational layers of technology that enable ToRCH Care to function, including platform interoperability and data modernization

4. Rural Health Workforce Programs

Creating a talent pipeline that encompasses the cultivation, recruitment, training, and retention of rural clinicians and a broad array of healthcare professionals

5. Provider Transformation

Investing in operational innovations that modernize and increase the sustainability of rural providers while preserving access with strategic renovations

3.1 ToRCH Care: Regional Coordinating Networks and Hub Activation

Regional Coordinating Networks and Hub Activation			
Main Strategic Goal(s):	MRAHA; Sustainable Access; Innovative Care	**Use(s) of Funds:**	A, B, D, E, F, G, H, I, K
Technical Score Factors:	**Primary:** B.1, B.2, C.1, C.2, D.3 **Supporting**: E.1, F.1, F.2, F.3	**Estimated Funding:**	$167M
Impacted Counties:	104 counties defined for RHTP[3]		
Key stakeholders	Missouri Department of Social Services (DSS), Department of Health and Senior Services (DHSS), Office of Rural Health and Primary Care (MORHPC), Department of Mental Health (DMH), MHA, MBHC, MPCA, FQHCs, CCBHCs, hospitals, CAHs, RHCs, LPHAs, RCNs and Hubs, Emergency Medical Services (EMS), pharmacies, community-based organizations (CBOs).		

3.1.1 Initiative overview

This initiative builds on Missouri's proven foundation of collaboration among rural providers, established through the State's earlier ToRCH pilot, which demonstrated that hospitals, clinics, and community partners are ready to share infrastructure, data, and expertise to improve access and health outcomes. To build the central foundation of ToRCH Care, Missouri will establish a network of 30 Local Community Hubs ("Hubs") linked through seven Regional Coordinating Networks (RCNs) and overseen by the statewide Rural Health Transformation Office (RHTO). Each Hub will bring together partners comprised of hospitals, FQHCs, behavioral health agencies, pharmacies, EMS, LPHAs, and community-based organizations, with one serving as lead convener. RHTP funds (and shared savings) will flow only to providers and organizations participating in their Hub, reinforcing collaboration and adoption of the model[19]. Together, the RCNs and Hubs will form an integrated operating model that enables coordinated and improved care across providers with the ability to track outcomes and impact, ensuring that every rural Missourian can reach the right care without barriers. RCN and Hub

activation will occur through three key activities: (A) Core Teams, (B) Access Expansion, and (C) Localized Programs.

3.1.2 Key activities

A. Core teams: *Dedicated staff, experts, and partners committed to improving local health outcomes in their rural communities*

ToRCH Care will staff core teams across its 7 RCNs and 30 Hubs. RCN teams will provide the operational and analytic support for four to five Hubs, ensuring consistent standards, aligned data, and coordinated collaboration across the region. Led by a regional director and supported by data and fiscal managers, they will leverage the expertise of the State and Missouri's major healthcare associations while incorporating new, ToRCH Care-funded regional staff to foster cross-sector leadership.

At the local level, each Hub will convene partners to deliver integrated, whole-person care across two to four counties. Each Hub will employ a Program Manager and one or more Community Health Workers (CHWs) to convene and ensure active engagement amongst partners, manage referral pathways, and coordinate provider care[20]. Hub leadership will regularly review county-level data on core measures[21] spanning community health, using this information to set priorities, allocate funding for initiatives, and allocate shared provider incentives based on successful health outcomes.

B. Access expansion: *Building the Frontline of Population Health and Remote Care*

RCNs and Hubs will strengthen Missouri's population health infrastructure by expanding local and remote access points for care. Each Hub functions as a clinical and operational anchor that connects residents to a continuum of services - primary, behavioral, specialty, and social - delivered in person or virtually through an integrated

care network. Funding will support a portfolio of programs designed to provide partnerships and remote care services to close geographic and service-access gaps. Already identified programs include an expansion of telehealth and time-critical specialty coverage, mobile integrated healthcare and community paramedicine (MIH-CP), pharmacy-based clinical services, as well as maternal and child psychiatry consultation lines. These efforts will enable timely, localized interventions for at-risk populations, reduce avoidable ED and in-patient utilization, and ensure that rural residents can receive high-quality care within their communities. Through a unified referral and data system, Hubs will connect every participating organization, clinical or community-based, into a cohesive, technology-enabled network that advances whole-person, community-driven care.

C. Localized Programs: *Tailoring interventions to every rural Missouri community*

Each Hub will receive flexible sub-award funding to launch, expand, and/or enhance programs that directly address the needs of their specific community. Missouri has already identified a portfolio of programs that could be delivered through the Hubs such as perinatal home visiting, school-based health initiatives, nutrition-focused programming, non-emergency transportation needs, and wrap-around support for dually eligible Missourians. The dual-enrollee care navigation program pairs Hub CHWs and care coordinators with enrollees to assist with health-related social needs identification and TA programming such as nutrition, non-emergency transport, or home safety assessments. Additional programs may be developed and delivered as identified by Hubs. These projects will foster sustainable rural partnerships that extend care beyond clinic walls and into the homes and daily lives of residents.

ToRCH Care Integration: Technology, Coordination, and Sustainability

The RHTO, RCNs, and Hubs will work together to ensure all Hubs operate within Missouri's value-based, population health framework by aligning program design, data reporting, and interoperability standards. Each RCN and Hub will be equipped with the technology, data interoperability systems, and analytic tools necessary to identify community health needs, implement solutions, monitor outcomes in real time, and collaborate as cohesive care teams. Pooled and shared resources at the Hub and RCN level will enable organizations to achieve financial economies of scale. For additional details, see Sections 3.2 ToRCH Care: Alternative Payment Models and 3.3 ToRCH Care: Digital Backbone.

3.1.3 Implementation plan and timeline

Stage	Timing	Key activity/milestone
Stage 0 – Project Planning	**Q1–Q2 2026**	**Core team** • RHTO established within the Department of Social Services (DSS) with approved governance charter **Access expansion and Local programs** • RFPs and procurement requests are launched to ensure providers can expand service ahead of Hub launches **Integration** • ▲*Procurement for CIE and Digital Health Backbone vendors launched*
Stage 1 – Project Plan Created & Initial Work Begun	**Q3–Q4 2026**	**Core team** • 8 key personnel hired (RHTO director and supporting RCN directors) • Statewide implementation manual and Hub charter templates finalized • ▲*7 RCN and 30 Hubs boundaries and site selections are finalized* • Lead service providers for Hubs selected, onboarded, and trained **Access expansion and Local programs** • Selection of local programs for 2027 are finalized and prioritized by Hub leadership councils **Integration** • Business needs assessment and data standards completed • Data-sharing agreements are executed across RCNs and Hubs • Medicaid reimbursement policy changes are adopted to enable APM adoption

Stage 2 – Implementation underway	**2027**	**Core Team** • ▲7 RCNs and 30 Hubs are launched with Hub leadership councils established reaching 100% rural coverage • Hub level metrics are refined, tested, and validated for collection • Staffing scales to steady state level of ~125 FTEs **Access expansion and Local programs** • ▲*Telehealth pilot partnerships are launched providing 30-50% coverage of rural population* • ▲*Specialty access services (MIH, Maternal, Child Psychiatry) are expanded to additional regions leading 10-20% increase in yearly encounters to 8,000-12,000* • Selected Menu TA options (school clinics, nutrition, home visiting, transportation) are launched by Hubs • Pharmacy test-and-treat, care coordination pilot are launched at select Hubs **Integration** • ▲*Regional data exchange fully operational and Community Information Exchange (CIE) under implementation* • *APM contracts sequenced and executed with Medicaid, MCOs, and Commercial Payers, as applicable* • ▲*EHR/EMR upgrades are prioritized and performed for 25% of Hub-level providers (e.g., LPHAs, Pharmacies, EMS)*
Stage 3 –Halfway to Goals	**2028**	**Core Team** • Inaugural statewide performance dashboard is launched with operational metrics tracking toward stated goals • Annual evaluation summit by RCNs is hosted to disseminate key information to 30 Hubs and providers **Access expansion and Local programs** • ▲*Telehealth coverage expanded to 100% rural counties* **Integration** • Demonstrate operational integration, interoperability, and data exchanges across service lines (EMS, CHWs, LPHAs, Pharmacies, FQHCs) • Standardized workflows adopted for key processes incl. non-clinical closed loop referrals • Continue to pay out APM performance pools; refine design, as needed
Stage 4 – Deliverables Finalized	**2029–2030**	**Core team** • Full network functionality across 30 Hubs and 7 Networks is achieved with measurable progress at integrating workforce development improvements • Standard reporting is fully automated providing cadenced views of progress against metrics • ROI and policy recommendations are documented for model enhancements **Access expansion and Local programs** • ▲*Specialty access services (MIH, Maternal, Child Psychiatry) are expanded statewide, 15-25% increase in yearly encounters to 15,000* **Integration**

		• Statewide advanced analytics dashboards are operationalized • ▲*EHR/EMR upgrades are prioritized and performed for 40% of Hub-level providers (e.g., LPHAs, Pharmacies, EMS)*
Stage 5 – Full Implementation	**2031**	**Core team** • Hub/RCN funding is transitioned to State/MCO/APM performance pool • Final evaluation of RHT is published with stated goals achieved against outcome metrics • Hub peer learning collaboratives convened and active (best practices, plan sustainability) • Integration of APMs into Medicaid, MCO, and commercial payer contracts • Next-phase innovation agenda developed and endorsed **Access expansion and Local programs** • ▲*~60,000 total visits for behavioral, maternal, and chronic care are supported from expanded access to specialty access services (MIH, Maternal, Child)* **Integration** • ▲*>50% Hub-level providers in rural areas are connected to interoperable EHR/EMR* • ▲*Structured CIE workflows enable ~20% growth in non-clinical documentation and closed-loop social referrals*

3.1.4 Governance and project management structure

Lead agency and oversight: The Missouri DSS will serve as the lead agency**,** establishing a dedicated RHTO to manage program design, implementation, and fiscal oversight. This Office will support RCNs and Hubs to operationalize the model and ensure best practices are adapted to local realities.

Steering committee: A State Leadership Council – including representatives from DSS, major Missouri healthcare associations, state agency leads, and community organization lead representatives — will provide strategic direction, input on funding approval decisions, and policy alignment.

Staffing Plan: The ToRCH Care staffing model will include a workforce of over 100 FTEs distributed across the state RHTO, RCNs, and Hubs to enable consistent execution and successful program management, analytics, TA, and fiscal oversight.

Table 5: Proposed Staffing Plan for RHTO, RCNs, and Hubs

Proposed Staffing Plan			
Types of Roles	(1) State Director, (2) Regional Director, (3) Hub Program Coordinator, (4) Data & Analytics Manager, (5) Data Analyst, (6) Technical Assistance Coordinator, (7) Technical Assistance Specialist, (8) Workforce Development Program Manager, (9) Fiscal and Procurement Manager, (10) Community Partnership Liaison, (11) Communications Analyst, (12) Community Health Worker		
	Total FTEs	**Responsibilities**	**Job Roles Required**
Rural Health Transformation Office	~5-7	• Manage funding distribution • Oversee analytics and reporting • Coordinate technical assistance • Guide workforce development • Partner with other state agencies, RCNs, and Hubs	1, 4, 6, 8, 9, 10
Regional Coordinating Networks	~20-25	• Ensure implementation fidelity, financial compliance, and cross-Hub learning • Manage regional funding distribution • Provide technical assistance for Hubs • Build community engagement	2, 4, 7, 9, 10, 11
Local Community Hubs	~90	• Connect local residents to health and social services • Convene provider partners • Track performance metrics • Provide technical assistance for billing and programs	3, 5, 7, 12

DSS will establish and staff the RHTO, supported by existing administrative personnel and new hires, including a state director to be onboarded in Q1–Q2 2026, contingent on state legislative spending authority. The State will also allocate funding for RCNs and Hubs to hire or contract with technical assistance partners as needed, with all partners procured competitively in accordance with DSS procurement policies.

Coordination among State agencies and external stakeholders: The State will use this governance structure—linking the RHTO, RCNs, and Hubs—to maintain clear communication, coordination, and accountability across all implementation levels, engaging key stakeholders throughout the process.

Table 6: Stakeholder Representatives on Hub Councils

Stakeholders (non-exhaustive)	**Function**
Behavioral Health Providers	Integration of behavioral health and specialty access lines
Community-Based Orgs & CHWs	Addressing non-clinical barriers and closed-loop referrals

Consumer / Patient Advocates	Ensuring patient and community perspectives in design and accountability
EMS	Providing EMS home visits, response protocols, emergency utilization reduction
Hospitals / Clinics / FQHCs/ RHCs	Referral integration, specialty consult line coordination, discharge planning
LPHAs	Population health planning, data sharing, community assessment, outbreak and prevention integration
Opioid / SUD Providers	Behavioral health service delivery, medication management, specialty coordination
Pharmacists, FQHC Pharmacies	Clinical service delivery, medication management, screening, data exchange

3.1.5 Metrics and Evaluation Plan

Performance Measures and Outcomes, [C: county-level measurement]			
Outcome metrics	**Baseline**	**Target by Y5**	**How initiatives achieve the outcome**
% rural counties covered by a Hub [C]	*0*	*100%*	*State will drive creation of the RCNs and Hubs through RHTP funding, in partnership with providers*
% of diabetic patients with controlled diabetes (A1c< 9%) [C]	*63.6%*	*70.0%*	*10% increase in controlled diabetes direct driven by strong interventions at the local level by hub access (e.g., EMS MIH-CP program, maternal and child programs, school-based clinics, pharmacy)*
Overall rates of uncontrolled hypertension (>130/80) [C]	*56.7%*	*48.2%*	*15% decrease in uncontrolled hypertension driven by strong interventions at the local level by hub access (e.g., EMS MIH-CP program, maternal and child programs, school-based clinics, pharmacy)*
Low birth weight rates (<2500g) (HIDI, SFY 2025) [C]	*8.4%*	*7.6%*	*10% reduction driven by focused maternal health programs (incl. perinatal home visits, doula, maternal behavioral health) proven to lead to reductions in LBW esp. with earlier pregnancy engagement*
Rates of ED hospital utilization for BH diagnosis (HIDI, SFY 2025) [C]	*2.8%*	*2.5%*	*10% reduction in hospital ED visits for BH diagnosis driven by proven interventions incl. EMS MIH-CP, maternal health*
Rates of IP hospital utilization for BH diagnosis (HIDI, SFY 2025) [C]	*12.2%*	*11.0%*	*10% reduction in hospital IP days for BH diagnosis driven by proven interventions incl. EMS MIH-CP, maternal health*
Continuity of Pharmacotherapy for OUD [C]	*51.1%*	*57.1%*	*15% increase in continuity driven by focused interventions such as pharmacy point of care*
Reduction in ED visits for perinatal crises, pediatric behavioral health emergencies, and chronic disease flare-up [C]	*n/a*	*10% reduction*	*Measure is not yet being tracked but has direct interventions and tracking through the number of visits / touchpoints expected from the provider programming that will lead to reduction in preventable ED visits*
% of Hub-level providers connected to EMR [C]	*n/a*	*50%*	*Measure is not yet being tracked but has direct interventions and tracking through technology*

			enablement and coordination for enablement of EMR for non-traditional providers
Growth in structured non-clinical documentation and closed-loop social referrals [C]	*n/a*	*20%*	*Measure is not yet being tracked but has direct interventions and tracking through social care referral technology and local CBO partnerships*

Program Evaluation Plans

Baseline and program data on metrics above will come from the State and members of healthcare ecosystem, utilizing existing data infrastructure to aggregate patient data to the Hub level on health indicators such as, Emergency Department (ED) visits, hypertension, and diabetes. Program implementation metrics such as counties covered by hubs, growth in structured non-clinical documentation, and closed loop social referrals will be collected by Hubs and reported to the State through RCNs. ToRCH Care will be evaluated through (1) **Hub-Level Evaluation:** Each Hub will collect data regularly on program implementation and outcomes to continuously refine program and practices, (2) **RCN Quarterly Review:** RCNs will collect data from Hubs, highlighting participation gaps, access barriers, and successes to expand upon for State review, (3) **State-Level Oversight:** the RHTO conducts overall program assessment review with RCNs and Hubs.

3.1.6 Sustainability Plan

When RHTP funding ends, ToRCH Care will transition into a self-sustaining, value-based system in which Hub members share the savings generated through their coordinated efforts. The model will initially launch under Medicaid shared savings arrangements, with each Hub monitoring key health outcomes outlined earlier such as reduced ED use and hospitalizations. As performance improves, savings will be

redistributed among participating partners, creating a financial feedback loop that reinvests in the interventions, technology, and workforce initiatives driving better outcomes. Over time, this approach will prepare rural networks to progress toward more advanced alternative payment models that reward prevention, care coordination, and local accountability – ensuring lasting financial and operational sustainability across Missouri's rural health system (see Section 3.2: ToRCH Care: Alternative Payment Models).

3.2 ToRCH Care: Alternative Payment Models

Alternative Payment Model			
Main Strategic Goal(s):	Sustainable access	**Use(s) of Funds:**	A, B, C, D, F, I
Technical Score Factors:	**Primary:** E.1 **Supporting:** C.1, F.2	**Estimated Funding:**	$72M
Impacted Counties:	104 counties defined[3]		
Key stakeholders	Missouri DSS, Department of Health and Senior Services (DHSS), MHA, MPCA, MBHC, Missouri Department of Mental Health (DMH), Missouri payers (all types), all rural providers including clinics, LPHAs, participating members in Hubs		

3.2.1 Initiative overview

This initiative will support the development and adoption of an alternative payment model (APM) framework among rural providers in Missouri. Specifically, we will support the adoption of a payment model that will transform provider payment incentives (including Medicaid) to reward Hubs and participating providers, based on their effectiveness, that improve quality of care and reduce (or mitigate growth in) the avoidable cost of care.

Specifically, ToRCH Care will support the transition to payment models that reward outcomes rather than volume. These volume-based models have contributed to major financial strain – for example, 54.4% of Missouri's rural hospitals operate in a deficit,

and 12 of those have closed since 2014 (Section 1.0: RURAL HEALTH NEEDS AND TARGET POPULATION), indicating the significant cash flow pressures on rural Missouri providers.

This transforms provider payment incentives (including Medicaid) to reward Hubs and participating providers, based on their effectiveness in improving indicators of health outcomes and reducing (or mitigating growth in) the avoidable cost of care. This upside-only model compensating care improvements will provide strong incentive for providers to participate, moving rural Missouri closer to Category 3 of the Health Care Payment LAN framework[22].

3.2.2 Key activities

A. Incentive model design: In Year 1 (2026), the State will work with stakeholders to design a payment model that creates financial incentives that are tied to reductions in ED visits and inpatient admissions, as concrete proxies for avoidable cost of care, but effectuated through population health and prevention-focused measures. The State will lead a process to estimate the contributions of the “front-facing” population health measures that Hub leaders will be using for decision-making to the underlying cost-of-care savings attributable to improvements in such utilization measures, and to derive

from this a schedule of performance payments from participating payers to Hubs and their participating providers.

Quality and/or utilization metrics may be added or removed in the above portfolio during the initial design or in future releases such as, site of care, generic prescribing, elective C-section rates. The rationale for this approach is (1) to rely on data-driven relationships between population health and acute utilization so that rural providers and Hubs with small populations can engage with confidence; (2) to connect Hub leaders' strategic decisions with local performance data; and (3) to articulate the value of non-clinical partners and of the Hub itself. This approach has transformational potential, as it is unlike any existing APMs of which the State is aware. Missouri will create a national model to shift the paradigm of payment and sustainability of rural health delivery

A portfolio of clinical quality metrics will be selected, along with targets for achievement and/or improvement which must be met as a condition for receipt of payments based on improvements in clinical resource utilization. The state of Missouri intends to require all Medicaid Managed Care Organizations (MCOs) to adopt the same APMs based on the design determined by the State with input from the MCOs and other local stakeholders.

B. Performance pools: Performance will be measured for residents attributable to each Hub. The high-cost outlier problem in rural cost data will be solved by adjusting outliers at the state level and reducing the total combined pool available by the value of the removed outlier costs. Performance payments will be made by participating payers to Hubs. Hubs can use these payments to offset their operating expenses, distributing additional available funds to local providers and/or CBOs contributing to the Hubs' success under the APMs. Hubs may elect to consolidate clinical and administrative

activities and infrastructure at the regional level through management services agreements. In this way, the APMs will serve as an important catalyst for driving coordination within the Hub and encouraging the right level of collaboration between the Hubs and RCNs.

C. Payer participation: As indicated above, all Medicaid MCOs will be required to adopt the same APM. Alignment on the same quality and utilization measures is intended to reduce administrative complexity for Hubs and participating providers, while aligning incentives across Medicaid populations. The State will collaborate with commercial payers and Medicare Advantage (MA) plans operating in rural Missouri, with greatest effort to engage with those payers comprising greater than 5 percent rural market presence as well as those serving dual eligibles. The State will also explore policy options for commercial payer participation. Commercial payers (including MA plans) that participate voluntarily may exercise discretion over metrics, targets, and performance payment levels; however, the State will endeavor to achieve consistency and parity among participating payers, in order to: (1) reduce administrative complexity for Hubs and participating providers, (2) mitigate “free rider effects”; and (3) ensure that the efforts of lower-density payers are amplified by the efforts of other payers.

D. Payer engagement and technical assistance: The State will engage meaningfully with participating payers to arrive at a model design that can be operationalized efficiently and consistently. Deliverables of this collaborative effort will include: (1) an overview of potential APMs for use with participating payers and providers; (2) detailed business rules for data, analytics, and reporting including details for attribution methodology, clinical and business inclusions/exclusions, and risk adjustment where

applicable; (3) an analytic prototype as well as baseline performance for Medicaid patients, drawing upon T-MSIS, Missouri's Medicaid Data Warehouse/Lake, or other claims/encounter data from Medicaid MCOs. Hubs and providers will receive insights from baseline performance as part of the initial phase, enabling providers to collaborate with payers to identify opportunities.

The State will determine whether performance analytics and reporting for Medicaid members will be executed by each MCO independently, with oversight from the State, or centrally on an aggregated basis, subject to quality assurance by the MCOs. Commercial and MA plans will be encouraged to adopt reporting consistent with Medicaid to minimize administrative complexity for Hubs and their providers.

E. Provider technical assistance: During the program period, RHTP funds will provide TA to help Hubs and participating providers succeed under the APM. Support will focus on both financial and clinical improvement efforts that strengthen care coordination and operational performance. Funds will be used in two ways: (1) to support the RHTO in the development of clinical playbooks, best practices, and implementation guides, working with partners to establish processes needed to meet APM goals, and (2) to support RCNs in providing hands-on technical assistance to Hubs and associated providers. This will include support with implementing new care models and workflows, coordinating the delivery of the multiple service types to Hub participants, training teams on new data and reporting tools, and adapting workforce to sustain the new practices. TA personnel will assist RCNs and Hubs to identify opportunities for unaffiliated providers to join, expanding the APM and Value-Based Payment (VBP) network. In addition to supporting network growth, TA teams will help providers to engage payers,

improve coding and documentation, analyze clinical quality data, implement quality-improvement initiatives, and adopt technology upgrades as needed.

Missouri's experience with ToRCH, as well as literature, suggests that this TA is critical to the development of a sustainable APM/VBP program[23]. Assistance with financial reporting is important for sustaining multi-year payment arrangements by establishing trust and transparency between payers and providers[24]. Further, research has shown that upfront investment and guidance for rural programs is critically needed due to their smaller and less capital-intensive nature[25].

F. Technology Enablement: Given the role of technology in building sustainable systems of care, local Hubs and their providers will have requirements from the State to meet specific capability and process standards as a condition for participating in APMs for Medicaid and other payers. These requirements will include reporting on key quality and performance data, adopting defined access standards, and implementing essential technologies. Funding and financial incentives will be available to support the initial investments to meet these standards. Additional investments in bidirectional data sharing, and the creation of a comprehensive data warehouse/lake integrating claims, Electronic Health Record (EHR) and non-clinical risk factor data is also necessary. This would build on the functioning statewide population health platform connecting nearly all FQHCs and several hospitals with real-time data to inform healthcare decisions. All data and interoperability needs, outside of analytics and reporting, will fall under the Digital Backbone sub-initiatives (Section 3.3.2: Key activities).

3.2.3 Implementation plan and timeline

Stage	Timing	Milestone[26]

Stage 0 – Project Planning	Q1-Q3 2026	**Cross-cutting:** Governance team established **A.** Current rural MO APMs and adoption inventoried; program goals solicited from local stakeholders **B.** Quality and utilization measures selected; provider Medicaid performance baseline complete (as well as other populations pending payer participation); attainment/improvement targets established; performance payment schedules established based on imputed cost of care savings; quality, utilization, and cost of care reporting for Medicaid (aggregate or standardized across MCOs) are standardized **C.** Commitments from commercial and Medicare Advantage payers to participate on similar terms are formalized
Stage 1 – Project Plan Created & Initial Work Begun	Q2-Q4 2026	**B.** Baseline reporting provided to Hubs, including details by hospital and primary care practice **C.** Hubs enrolled for APM Medicaid participation (and commercial and Medicare Advantage plans, as applicable) **D, E.** TA clinical insights and playbooks developed; front-line change management program developed
Stage 2 – Implementation underway	2027	**A.** Additional clinical insights provided as foundation for improvement efforts **B.** Performance period under APM initiated for participating payers and Hubs; period reporting on performance for quality, utilization, cost of care initiated; Performance payments administered following conclusion of annual performance period **C, D, E.** RCNs leveraged to support TA and scale model to more payers, providers; clinical implementation and change management playbooks rolled out **E.** TA for Hubs and participating providers initiated to review clinical insights and improvement
Stage 3 – Halfway to Goals	2028-2030	**B.** Hub reach expanded, if all were not ready to participate in prior year **C.** APM expanded to additional commercial and Medicare Advantage payers, as applicable
Stage 4 – Deliverables Finalized	2028-2030	**A.** Payment model refined, including changes to quality/utilization measures, targets, incentive schedules **B.** Performance improvements in quality, utilization, cost of care evaluated; analytics and reporting for performance, clinical insights refined **D, E.** TA for clinical improvement efforts refined
Stage 5 – Full Implementation	2031	**A.** Next-generation model of APMs defined for post-RHTP, tailored for sustainability to local context **D, E.** Decision made on how continued support for APMs will be incorporated in the State agency

3.2.4 Governance and project management structure

Missouri DSS will serve as the lead agency. Governance structure and coordination with stakeholders will mirror those outlined in the Regional Coordinating Networks and Hub Activation initiative (Section 3.1.4).

Entity	Roles and Responsibility

State	• Lead design and oversight of APM rollout via DSS • Convene payers and associations to develop multi-payer APM models • Set performance targets and incentive payment structures • Provide technical assistance through the RHTO • Monitor ROI and performance of provider arrangements statewide
Network (RCN)	• Support design and regional implementation of APMs • Aggregate regional outcomes to inform shared savings distribution • Coordinate payer-provider learning collaboratives • Manage regional performance dashboards
Hub	• Provide input to design of APM care models, align hub-level programming with APM measures (e.g., ED reduction) • Convene local providers to identify shared improvement goals and savings distribution • Document outcomes to qualify for value-based payments • Report data to regional networks and State for validation
Providers / Community Partners	• Adopt value-based workflows, documentation, and reporting standards • Participate in technical assistance and readiness training • Implement clinical protocols aligned to APM measures • Reinforce patient engagement, prevention, and chronic disease management

Staffing Plan: The RHTO and team overseeing this initiative are included and described in Section 3.1.4. The State will engage external partners to support incentive model design, performance pool analytics, and provider TA.

3.2.5 Metrics and Evaluation Plan

Performance Measures and Outcomes, [C: county-level measurement]			
Outcome metrics	**Baseline**	**Target in Y5**	**How initiatives achieve the outcome**
% of rural Missourians with Hub APM available through payer	0%	≥50%	*Reflects payer adoption of APMs, measured in rural market density*
% of rural Missourians attributed to Hub APM	0%	≥50%	*Product of payer and Hub adoption of new Hub APM model*
ED visits per 1,000 for populations attributable to Hub APM [C]	Baseline in Y1	≥10% reduction from baseline	*Improved efficiency as proxy for cost of care savings*
Inpatient admits per 1,000 for populations attributable to Hub APM [C]	Baseline in Y1	≥5% reduction from baseline	*Improved efficiency as proxy for cost of care savings*
% of Hubs showing improvement in at least half of core quality metrics [C]	0%	≥60% by Y5	*Measurable improvement in quality of care*
% of Hubs achieving APM performance payments in excess of operating costs [C]	0%	≥50% by Y5	*Measure of overall RHTP program sustainability*

All APM participation and performance metrics will roll up from Hubs to RCNs, and then to the RHTO for statewide aggregation and review. Metrics will be reported annually to track progress, guide model updates, and inform performance payments, although the State may require more frequent reporting and implement real-time dashboards or other data systems where feasible.

Program Evaluation Plans

Once APMs are launched, RCNs will evaluate Hub performance based on State-developed standards for APM adoption, participation, and distribution of performance payments. The State will assess results and engage participating entities in identifying future improvements.

3.2.6 Sustainability Plan

Long-term sustainability will be achieved by embedding APMs into Medicaid and continuously refining them using performance data. Following the initial State investment, APMs will become self-sustaining by aligning financial incentives with measurable improvements in access, quality, and cost.

Hubs will evolve into local engines of transformation, providing technical assistance and acting as intermediaries between payers and providers. As the model matures, payers will take on greater responsibility for onboarding and supporting new providers, reducing the need for ongoing state support. The State will also leverage Missouri Health Plus—an established network representing most FQHCs and many CCBHCs—that already manages multi-payer value-based contracts across Medicaid, Medicare, and Medicare Advantage. This network can provide the training, data infrastructure, and technical support needed to help providers thrive in value-based arrangements.

Over time, Medicaid and its MCOs are expected to sustain the model based on demonstrated value and cost savings. Hubs will generate sufficient surplus through APM participation to cover operating costs and share net savings with providers and community-based organizations. Most technology investments are one-time, upfront costs that will not require continued state funding.

3.3 ToRCH Care: Digital Backbone

Digital Backbone			
Main Strategic Goal(s):	Tech innovation, Sustainable Access, Innovative Care	**Use(s) of Funds:**	C, D, F, K
Technical Score Factors:	**Primary:** B.1 F.1, F.2, F.3 **Supporting**: C.1	**Estimated Funding:**	$364M
Impacted Counties:	104 counties defined[3]		
Key stakeholders	DSS, DMH, DHSS, MORHPC, MHA, MBHC, MPCA, Missouri Pharmacy Association (MPA), FQHCs, CCBHCs, hospitals, CAHs, RHCs, EMS Agencies, LPHAs, EHR vendors, technology vendors, system integrators, and LHCs.		

3.3.1 Initiative overview

Missouri's rural health systems are rich in data but are fragmented across multiple, disconnected electronic platforms. This initiative provides a unified workflow and information-governance layer that connects legacy and modern systems without forcing wholesale EHR replacement. Missouri will launch a Rural Health Data Collaborative that integrates HL7-compliant data from all provider access points such as hospitals, primary care providers, pharmacies, and digital tools into statewide systems to ensure data-driven decision making, continuity of care and improved health quality and outcomes. This initiative positions ToRCH Care as a national model for rural health digital transformation and the use of advanced technology for innovation, efficiency, and scale. By enabling secure, standards-based exchange of health data, hospitals, clinics,

behavioral health centers, pharmacies, and public health partners are connected into a single, trusted data ecosystem. For patients, this equates to seamless, personalized, and coordinated care experience. For providers, this will lead to reduced documentation burden, improved efficiency, and faster access to insights that improve safety and outcomes. For the State, digital backbone is established to sustain APMs, population health management, and access to services across rural Missouri.

3.3.2 Key activities

A. Baseline Digital Readiness and Interoperability Assessment

We will conduct a comprehensive rural assessment, aligned with Healthcare Information Management Systems Society (HIMSS) Electronic Medical Record Adoption Model (EMRAM), and Office of the National Coordination for Health Information Technology (ONC) Certification, to evaluate each provider's readiness across interoperability, cybersecurity, workforce, and analytics. The assessment will consider factors such as EHR maturity, gaps between inpatient and outpatient settings, and rural independent status, among other criteria to classify facilities into tiers of readiness[27].

B. EHR Modernization and Deployment Support:

EHR Modern-ization	• Prioritize EHR interoperability updates required to support data sharing AI enablement, and APMs, and develop tailored modernization plans that strategically allocate funding and technical assistance based on Hub or provider needs to ensure efficient allocation of funds • Provide funding for EHR licenses, upgrade costs and interfaces with external agencies aligned with program goals as needed • Provide technical assistance to support EHR upgrades
Deployment to Shared Model	• Support procurement of shared Fast Healthcare Interoperability Resources (FHIR) enabled EHR platforms for rural providers with a documented interoperability gap • Integrate shared workflow modules to standardize patient data capture and enable cross-provider continuity of care • Develop data-sharing agreements and participation standards that streamline onboarding, define ownership and stewardship of data, and protect privacy while maximizing analytic and operational value

	• Align the shared EHR deployment with future rural payment models, including value based and population health programs to ensure the technology foundation supports ongoing transformation and sustainability

C. **Interoperability and Reporting:** To maintain progress and momentum while building out the technology foundation, Missouri will leverage existing infrastructure including the Hospital Industry Data Institute (HIDI), CLIVE Data Warehouse, and MPCA Analytics and transitioning to a more seamless statewide platform to drive interoperability and reporting through phases of data aggregation and standardization, secure data pipelines and care coordination, federated interoperability and governance framework[28].

D. **Frontline Community-Based Access Interoperability:** This initiative establishes the interoperability capabilities to support a network of community access points using HL7 FHIR R4+ and USCDI-aligned documentation and exchange standards[29].

E. **Remote Patient Monitoring (RPM) Integration:** Many rural providers rely on stand-alone RPM platforms outside clinical workflows, limiting the use of continuous patient data and the value it brings for care planning and risk management. To address this, Missouri will integrate RPM data directly into rural EHRs, providing technical support, standardized APIs, and integration toolkits for vital signs, glucose levels, and medication adherence, following HL7 FHIR R4 standards for interoperability and federal compliance. Providers will also receive guidance on workflow redesign, clinician training, and data validation to make RPM insights actionable and reliable. This approach reduces provider burden, strengthens continuity of care, and lays the foundation for scalable APMs and population-health models across rural Missouri.

F. **Social Care Referral Platform Integration:** The State will invest in deploying a Social Care Referral Platform to connect healthcare providers, community-based organizations, and social service agencies, enabling streamlined screening, electronic referrals, and outcome tracking for services such as food, housing, transportation, and behavioral health. Integration with existing EHR systems will be prioritized using HL7 FHIR R4+ and USCDI v3 standards, ensuring referrals and care coordination activities work seamlessly within clinical workflows.

G. **Data and AI Governance**: The overall goal of data governance will be to support security, privacy, quality and lineage. AI governance will build on data governance and other processes to design and deploy trustworthy AI[30].

H. **Adoption and Change Management Support:** To support comprehensive adoption and change management, we will equip rural providers, staff, and leadership with targeted training, workflow redesign, and ongoing technical assistance to successfully implement, use, and sustain new interoperability and analytics capabilities. We will work with Hubs to integrate workflow governance, information stewardship, and interoperability to ensure they confidently understand consent, data-sharing, and privacy compliance.

3.3.3 Implementation plan and timeline

Stage	Timing	Milestones
Stage 0 – Project Planning	Q4 2025	• State Digital Governance Board established and operational • Assessment tools, procurement framework, and governance charter finalized
Stage 1 – Project Plan Created & Initial Work Begun	Q1–Q2 2026	• Statewide digital maturity and readiness assessment completed • Initial data aggregation and standardization across systems initiated • Data and AI governance framework developed and approved. • Interoperability policy on consent, audit, and access finalized

Stage 2 – Implementation underway	Q3–Q4 2026	• Tiered EHR modernization plans finalized for participating providers • Shared procurements and vendor contracts executed (including EHR, Social Care Referral Platform) • Initial interoperability dashboards deployed • Governance onboarding toolkit distributed to RCNs
Stage 3 – Halfway to Goals	Q1 2027 – Q4 2028	• EHR upgrades and FHIR interfaces implemented across providers • Cloud platform hybrid architecture established • Readiness testing completed for all regional participants • Automated endpoint validation activated statewide • Social Care Referral Platform integrated with modernized EHRs
Stage 4 – Deliverables Finalized	2029 – 2030	• Real-time dashboards and predictive analytics deployed statewide • Agentic monitoring dashboards launched for endpoint health and USCDI conformance • Hub and regional analytic performance reporting initiated
Stage 5 – Full Implementation	2030	• Rural Health Data Trust (see below in 3.3.6) established and transitioned to shared-service model

3.3.4 Governance and project management structure

Entity	Roles and Responsibility
State	• Set statewide interoperability, cybersecurity, and data governance and AI governance standards for ongoing alignment to the latest policy requirements • Oversee the Rural Health Data Collaborative and hybrid cloud implementation • Provide guidance on acceptable vendors for data, technology and AI platforms • Manage compliance with HL7 FHIR R4+ / USCDI v3 and metadata management • Monitor performance metrics and sustain the State Digital Governance Board • Develop data-sharing agreements and participation standards
Network (RCN)	• Coordinate EHR modernization and data exchange across regional partners • Validate FHIR endpoint readiness and data quality • Provide technical assistance, cybersecurity support, and readiness reporting to the State
Hub	• Onboard local providers (e.g., hospitals, RHCs, EMS, pharmacies, LPHAs) • Implement shared workflow-governance tools for consent, audit, and referral tracking • Deploy vendor contract for data, technology and AI platforms • Deliver local training and report data-quality metrics to RCNs • Review data for continuous improvement, and identify and escalate shared challenges to the RCNs
Providers / Community Partners	• Maintain compliant EHR connections and data-sharing agreements • Exchange standardized USCDI v3 and health-related social needs data • Participate in governance training and quality-improvement reporting

Staffing Plan: RHTO and team providing oversight on this initiative included and described in Section 3.1. External partners will be contracted to support.

3.3.5 Metrics and Evaluation Plan

Performance Measures and Outcomes, [C: county-level measurement]			
Outcome metrics	**Baseline**	**Target**	**How initiatives achieve the outcome**
% of rural facilities with live, certified HL7 FHIR R4 endpoints [C]	TBD	≥ 60 % by FY 2028	*Directly measures statewide interoperability progress driven by EHR modernization, FHIR-enabled data exchange, and hybrid cloud deployment. This will be reported at the Hub level.*
% of required USCDI elements captured/exchanged	TBD	≥ 60 % by FY 2029	*Reflects completeness of standardized clinical and social data exchange achieved through modernization of EHR systems, and shared workflow modules. Supported by ongoing governance through the Hubs.*
% of facilities using shared governance modules	TBD	≥ 60 % by FY 2030	*Indicates extent of implementation of shared consent, audit, and access-control frameworks across facilities (to reinforce interoperability)*
Avg time from encounter → HIE availability	TBD	≤ 24 h by FY 2030	*Measures efficiency of real-time data transfer enabled by hybrid cloud and FHIR API connections.*
% of facilities meeting HHS Cyber Goals / HITRUST certification	TBD	≥ 60 % by FY 2030	*Demonstrates adherence to State cybersecurity and HITRUST-aligned performance goals.*

Program Evaluation Plans

Metrics will be collected through automated validation and reporting tools integrated within the EHRs and hybrid cloud infrastructure. Hubs will submit quarterly performance reports to their RCNs who will aggregate and analyze data for submission to the State.

Evaluation	Description
Hub-Level Monitoring	Each Hub will track adoption of EHR interoperability standards, workflow-governance tools, and social care referral integration
RCN Review	RCNs will assess regional progress on digital readiness, data quality, and provider participation, highlighting sites requiring targeted technical assistance
State Oversight	The RHTO will conduct statewide assessments on data completeness, latency, and alignment with interoperability and cybersecurity benchmarks. The State will partner with a Missouri-based academic institution to evaluate program outcomes, focusing on cost efficiency, care coordination, and health outcome improvements.

3.3.6 Sustainability Plan

By 2031, Missouri will transition the Digital Backbone into a Rural Health Data Trust, a shared-service model that brings interoperability, workflow governance, and analytics infrastructure under long-term state stewardship. This approach will ensure durability

without future EHR replacement cycles and maintain system performance, cybersecurity, and effective data use well beyond the RHTP funding period. The model will be sustained through a tiered access structure that allows Hubs and providers to pay affordable annual fees for data services and analytics tools. Operationally, several key features will support long-term sustainability:

Key Features	Descriptions
Agentic Stewardship	AI-assisted data stewards continuously monitor USCDI conformance and cyber compliance.
Ongoing Training	The State partners with universities to offer certifications in rural informatics and data governance.
Public Health Integration	DHSS incorporates the hybrid cloud into routine surveillance and policy analytics.
Workflow and Information Governance Continuity	The shared-service model maintains consent, audit, and access-control standards, allowing rural providers to sustain interoperability compliance independent of their local system vendor.

3.4 ToRCH Care: Rural Health Workforce Programs

Initiative Overview			
Main Strategic Goal(s):	Workforce Development	**Use(s) of Funds:**	A, D, E, H
Technical Score Factors:	**Primary:** C.2, D.1 **Supporting:** B.1, C.1	**Estimated Funding:**	$115M
Impacted Counties:	104 counties defined for RHTP		
Key stakeholders	Missouri DSS, DHSS, Department of Higher Education & Workforce Development (DHEWD), Department of Elementary and Secondary Education (DESE), DMH, MPCA, MHA, FQHCs, LPHAs, Missouri Community College Association (MCCA), rural providers, educational institutions, and Children's Trust Fund		

3.4.1 Initiative overview

Rural Missouri faces persistent workforce shortages; every rural county in Missouri has a Health Professional Shortage Designation (HPSD) and dental care shortage[31]. Furthermore, 42 percent of counties are maternity care deserts[32]. Behavioral health vacancies exceed 30 percent in rural Missouri[33]. Over 270 medical students leave the state each year for out-of-state clinical clerkships[34]. By 2026, Missouri will have a shortage of 2157 physicians[35].

To address these challenges, Missouri will launch the Rural Health Workforce Program (Workforce Initiative), a statewide initiative to build a coordinated system connecting recruitment, education, training, employment, and retention in rural healthcare. The initiative will focus on building a robust pipeline of healthcare professionals. This design was shaped through extensive engagement with key stakeholders, including deans from all seven medical schools, rural hospital leaders, nursing program directors, and state policy experts who collectively identified critical training gaps and workforce priorities.

3.4.2 Key activities

A. Early Healthcare Workforce Pathways: Rural Missourians have limited access to healthcare training programs, undermining the ability of rural communities to build their own local workforce. This sub-initiative will expand healthcare-focused Career and Technical Education (CTE) programs in rural high schools and post-secondary sites, creating defined routes from classrooms to healthcare careers. Working with partners such as the Alliance for Healthcare Education in Southwest Missouri, the state will launch new CTE sites and provide support for staff and materials. Through dual enrollment, students will take both high school and healthcare courses, allowing them to earn academic credits and, in some cases, professional certifications before graduation.

Certifications and training programs will align with rural needs, including Certified Nursing Assistant, Behavioral Health Support Worker, Community Health Worker, Emergency Medical Technician, Behavioral Health Technician, Dental Hygienists, and Pharmacy Technician. Missouri has developed a framework for healthcare career laddering, and will begin supporting rural students to pursue dual credits through college-level courses; for instance, obtaining Licensed Practical Nurse or Registered Nurse credentials.

B. Maternal Health Workforce Expansion: Rural Missouri suffers a critical shortage of maternal care providers, leaving many communities without consistent perinatal care, which contributes to low birth weight, infant mortality, and maternal mortality. The Maternal Health Workforce Expansion sub-initiative will develop a connected workforce of trusted clinical and community providers to improve access, continuity of care, and positive outcomes for mothers and babies by focusing on the following:

- **Certified Nurse Midwives (CNM):** Missouri currently has zero in-state training for CNMs, despite a dearth of rural maternity care. The State will establish its first CNM program with an accredited nursing school. The program will use rural clinical training sites and offer awards for graduates who commit to serve in rural areas, creating an in-state pathway for maternal-care providers.
- **Doulas:** Doulas remain scarce in rural areas, despite strong evidence for improved maternal-infant outcomes and recently established reimbursement by Missouri HealthNet. The State will support training and certification for doulas to support rural women through pregnancy, birth, and recovery.

- **Perinatal Home Visitors:** Missouri will expand training for perinatal home visitors to provide evidence-based prenatal and postpartum support. These providers offer cost-effective education, care coordination, timely interventions, and connections to local health and social resources.

C. Medical School Clerkship Expansion: Hundreds of students leave the State each year to complete their 3rd- and 4th-year clerkships at out-of-state, mostly urban hospitals. Because physicians tend to remain where they train, expanding in-state clerkship capacity is critical to reducing this rural brain drain. This initiative will help rural hospitals launch and sustain clinical training programs for medical students through funding for initial setup, faculty development, and coordination. Once established, these partnerships between rural medical schools and hospitals will be sustained through payments from the medical schools to the participating hospitals. Over time, these clerkships will strengthen rural care by increasing access to local physicians,

D. Coordinated Investment in EMS: Missouri's EMS network is fragmented, with 234 independently operated ambulance services that differ in size, funding, and governance, but share similar fiscal and personnel struggles. This structure limits efficiency, strains local budgets, and exacerbates workforce shortages, especially in rural regions facing long transport times and high call volumes. This sub-initiative will build a stronger, more unified EMS system by expanding workforce capacity, strengthening training infrastructure, and incentivizing regional collaboration. These reforms are expected to contribute to measurable improvements in rural emergency response time and preventable ED visits across practicing hubs.

- **Expand the EMS workforce** by offering training awards for EMS students, prioritizing rural rotations, and establishing pathways to retain graduates.
- **Develop regional training hubs** by building upon Missouri's Workforce Opportunity for Rural Communities (WORC) initiative and working in conjunction with the early healthcare workforce pathway programs. New satellite education sites will make EMS training accessible in underserved rural areas and create a consistent local pipeline of trained personnel to support regionalized systems.
- **Incentivize regional coordination** by providing planning and implementation grants for agencies that merge into regional systems. Optimized agencies will gain access to additional funding and equipment grants, creating a clear financial incentive to collaborate. These regional systems will reduce administrative costs, expand coverage, and improve reliability of emergency care across rural Missouri.

E. Workforce Retention and Enablers: Rural healthcare systems face persistent workforce instability stemming from burnout, understaffing, sparse and delayed access to experts for immediate clinical advice, administrative burden from antiquated systems, and limited access to childcare. This sub-initiative will fund practical, sustainable support that makes rural practice more accessible and rewarding. The state will provide support to the Hubs around funding and TA to help them design and implementation retention strategies tailored to local needs. These may include:

- **Childcare access** support through local planning, recruitment, and other efforts reduce barriers to workforce participation,
- **Housing support** such as shared-equity home loans[36] or short-term housing grants to help rural healthcare workers live near rural practice sites,

- **Awards for healthcare professionals** who commit to both serving in rural areas and teaching within their field of healthcare expertise for at least 5 years, and
- **Real-time clinical support access to perinatal or child psychiatrists** for continuous professional support through the Maternal Health Access Program (MHAP) and the Child Psychiatry Access Program (MO-CPAP), per Section 3.1.1. These efforts will be reinforced by teleconsultation, as well as data-exchange, and AI-driven analytics capabilities outlined in Section 3.3, ensuring rural clinicians remain connected to specialists and decision-support tools in real time.

3.4.3 Implementation plan and timeline

Stage	Timing	Milestone Across Activities (A-E)
Stage 0 – Project Planning	Q1 & Q2 2026	**Cross-Cutting:** Program governance established **A.** Local workforce data assessment completed to focus rural CTE and post-secondary pipeline efforts. **B.** NOFO for CNM, Doula, and Perinatal CHW programs developed. **C.** Framework for expanding medical clerkships developed. **D.** Framework for EMS system coordination, workforce training, and system support developed. **E.** Framework for regional workforce retention supports developed.
Stage 1 – Project Plan Created & Initial Work Begun	Q3 and Q4 2026	**A.** ▲*Contracts secured for launch of 10 rural CTE programs.* **B.** CNM program recipients secured, training modules for Doula and PCHW education and certification identified. **C.** Commitment secured from five hospital facilities committed to host medical clerkship rotations. **D.** Contract and partnerships established among EMS districts, hospitals, and local ahead of pilot launch. **E.** Childcare community planning groups set up in first 10 hubs.
Stage 2 – Implementation underway	2027	**A.** ▲*10 rural CTE and post-secondary sites launched* ***B.*** ▲*First Doula and PCHW cohorts certified* ***C.*** Five new hospitals committed to host medical clerkship rotations ***D.*** ▲*EMS regional pilot programs launched* **E.** 10 new childcare planning groups established
Stage 3 – Halfway to Goals	2028	**A.** ▲*10 additional rural CTE and post-secondary sites launched.* **B.** CNM program developed and student recruitment launched. **C.** Five additional hospitals committed to host medical clerkship rotations. **D.** EMS regional coordination expanded. **E.** 10 new childcare planning groups established. ▲***Operational milestone:*** *2000 rural healthcare workers supported by RHTP funded programs*

Stage 4 – Deliverables Finalized	2029	**Cross-Cutting:** • Full statewide implementation of all initiatives • Unified data, governance, and workforce coordination established • Integrated reporting system launched to track workforce growth and access improvements ***B.*** *▲First CNM class enrolled* **E.** Third childcare provider cohort expansion implemented
Stage 5 – Full Implementation	2030	**Cross-Cutting:** • Statewide delivery and monitoring sustained across all initiatives • Long-term funding and governance structures secured • Successful workforce models institutionalized statewide • Program performance metrics integrated into state reporting frameworks **B.** CNM program accreditation finalized, rural maternal-health workforce roles sustained **E.** Third childcare provider cohort expansion completed ***▲Operational milestone:*** *4000 rural healthcare workers supported by RHTP funded programs, 75 new clerkship positions established*

3.4.4 Governance and project management structure

Missouri DSS will serve as the lead agency. Governance structure and coordination with stakeholders will mirror those outlined in Section 3.1.4.

Entity	Roles and Responsibility
State	• Lead design and oversight of the Rural Health Workforce Pathways Initiative. • Coordinate program management through existing RHTO staff, including the Workforce Development Program Manager (see Section 3.1). • Set statewide performance targets, monitor progress, and ensure alignment across initiatives • Provide technical assistance and oversight through the RHTO Office • Evaluate statewide performance, ROI, and sustainability of workforce sub-initiatives
Network (RCN)	• Support regional implementation of training, recruitment, and retention activities • Aggregate regional data and outcomes to inform statewide workforce dashboards • Coordinate with Hubs and local providers to align workforce supports • Manage regional performance tracking and technical assistance to hubs
Hub	• Convene local providers to implement training and retention activities aligned with RHWP goals • Coordinate with educational partners (e.g., MCCA, osteopathic medical schools, and other academic institutions) to expand clinical training opportunities • Lead hub-level data reporting and share metrics with RCNs and RHTO for validation
Providers / Community Partners	• Deliver training, recruitment, and retention programs tailored to local workforce needs • Participate in technical assistance and readiness sessions led by RHTO or RCNs • Collect and report data on workforce participation and outcomes

	• Reinforce community partnerships supporting childcare, housing, and mentorship to improve retention

Staffing Plan: The RHTO and team overseeing this initiative are included and described in Section 3.1.4. External partners will be contracted to support Workforce Initiative implementation and provide technical assistance.

3.4.5 Metrics and Evaluation Plan

Performance Measures and Outcomes, [C: county-level measurement]			
Key Metrics	**Baseline**	**Target by Year 5**	**How initiatives achieve the outcome**
No. of rural healthcare workers supported through workforce programs	0	≥4000	*Relates to all RHWP initiatives by measuring collective progress in expanding the rural healthcare workforce pipeline through coordinated training, clinical education, and placement efforts*
% completion rate of workforce initiative programs	0	≥80%	*Measures program effectiveness and quality of instruction in moving participants through training to successful completion and employment*
% of Regional Networks with access to at least 1 active workforce training program/site	0%	100% coverage	*Reflects integration of RHWP training programs within the community hub & regional networks*
Number of successful EMS network optimized resulting in sustained shared operations each year [C]	0	8	*Reflects system-level improvement, duplication reduction, and broadening access to EMS achieved through regional EMS coordination and optimization*
1-year retention rates for CTE Program graduates	0%	≥75% retention	*Measures how coordinated pathways and placement support result in long-term provider stability in rural practice*
% admin cost saved from EMS network optimization	0%	10-25% reduction for consolidated EMS providers	*Quantifies how regional system optimization improves efficiency, sustainability, and reinvestment capacity across rural networks*

Program Evaluation Plans

The RHTO will collect and report data for the Workforce Initiative annually. Program evaluations will be aligned to key outcomes and implementation timelines to measure

progress and impact. Feedback from Hubs and RCNs will also guide adjustments to enhance program effectiveness and ensure alignment with community needs.

3.4.6 Sustainability Plan

Missouri's sustainability approach builds upon existing systems to ensure successful continuation beyond the grant period. Programs will transition to one or more of the following models:

Model	Descriptions
Regional optimization of EMS systems	Optimization of systems will generate cost savings, improve operational efficiency, and strengthen the long-term sustainability of rural EMS providers.
Employer- and APM-Based	Retention and enabler programs will continue through employer contributions and integration into value-based APMs.
One-Time Investments	Early healthcare workforce programs as well as training for doulas, CNM, perinatal home visitors, and EMS will be a single investment to establish a workforce pipeline for healthy APMs implementation. Targeted awards for healthcare professionals and medical school clerkships will foster future generations of workforce.

Integrating lessons from this program into ongoing policy

Lessons from this initiative, including early rural engagement, education-to-employment pipelines, and multi-lane team-based care, will be embedded into Missouri's workforce frameworks and policy processes. Recruiting and training students from rural areas has proven to increase the likelihood that they return to serve their home communities, making local talent development a continuing focus of state workforce strategy. The ToRCH Care framework will reinforce these efforts by linking workforce planning to real-time local needs, ensuring that training programs and care delivery evolve together.

3.5 ToRCH Care: Provider Transformation

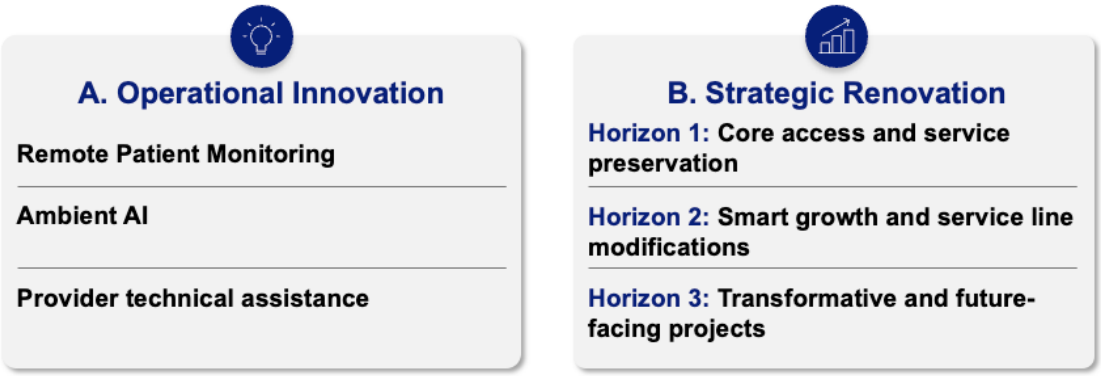
Provider Transformation			
Main Strategic Goal(s):	MRAHA; Sustainable access; Innovative care; Tech innovation	**Use(s) of Funds:**	A, C, D, F, G, H, I, J, K

Technical Score Factors:	**Primary:** B.1, F.1, F.3 **Supporting**: C.1	**Estimated Funding:**	$252M
Impacted Counties:	104 counties defined for RHTP		
Key stakeholders	Department of Social Services (DSS), Department of Health and Senior Services (DHSS), Office of Rural Health and Primary Care (ORHPC), Missouri Hospital Association (MHA), Missouri Behavioral Health Council (MBHC), Missouri Primary Care Association (MPCA), FQHCs, CCBHCs, hospitals, CAHs, RHCs, LPHAs, RCN and Community Hubs / CBOs		

3.5.1 Initiative overview

ToRCH Care's Provider Transformation Initiative will strengthen the physical, technological, and operational backbone of rural healthcare through two complementary pathways. The first focuses on operational innovation, equipping rural providers with modern tools and systems to improve care quality, coordination, and efficiency. The second focuses on strategic facility modernization, ensuring that rural hospitals and clinics remain stable, structurally sound, and capable of sustaining access to essential services. A needs assessment of rural Missouri conducted in 2024 identified limited service offerings and inadequate funding as major barriers to improving patient care[37]. This initiative addresses those challenges by funding operational innovations that reduce administrative burden, strengthen provider retention, promote shared resources and projects with economies of scale, and invests in infrastructure that optimizes rural service lines.

3.5.2 Key activities



A. Operational Innovation

- **Remote patient monitoring (RPM) presents a critical opportunity to connect rural patients and providers in real time,** enabling care to reach patient when needed and helping providers proactively manage conditions. With RPM, providers caring for maternity patients can monitor high-risk pregnancy blood pressure and weight, gestational diabetes and maternal metabolism, and postpartum symptoms for maternal wellness and recovery. Providers caring for chronic disease patients can monitor blood glucose, blood pressure, weight, and other key health indicators. Provider capability will be supported by the Digital Backbone Remote Patient Monitoring Integration sub-initiative (Section 3.3.2). The State will support three major components where barriers prevent adoption:

RPM support	
Component	**State support mechanisms**
1. Patient education and engagement	• Develop and deploy patient-friendly education materials to increase digital literacy and self-management skills • Fund local RPM demonstration labs at select Hubs where patients can test devices, learn to interpret results, and understand how data is shared with their care team • Provide training to families to encourage engagement and adherence to care plans
2. Provider enablement and workflow integration	• Offer technical assistance and direct grants to rural providers for equipment purchase, data integration, and workflow redesign • Train providers and care coordinators to shift from reactive monitoring to proactive management using live dashboards and risk stratification tools

	• Integrate RPM alerts and reporting into EHRs via the Digital Health Backbone, enabling automated documentation and follow-up
3. Demo rollout units	• Establish regional demonstration sites to develop RPM models, evaluate outcomes, and disseminate best practices statewide • Share results and training through the regional learning collaboratives and statewide Hub convenings to accelerate adoption and consistency

- **Ambient AI streamlines administrative tasks, reduces clinician workload and burnout risk,** and allows providers to focus more on patient care. The State will gradually fund licensing and implementation support for providers demonstrating readiness and potential for high impact through a cost-sharing model. Integrated with EHRs, Ambient AI will automate documentation, provide real-time recommendations, and support clinicians throughout the care workflow. Health systems have reported nearly a 75 percent reduction in burnout and a 10 percent increase in patient encounters after adoption[38]. Key deployment activities include readiness assessment, workflow transformation, and change-management support from RCNs and Hubs. The Digital Backbone initiative's EHR and data-governance efforts will support this work (Section 3.3.2).
- **TA will offer hands-on training and resources** to help clinicians and staff strengthen skills, improve workflows, and adopt new RPM and Ambient AI technologies. The State will connect providers with experts to troubleshoot challenges, share best practices, and build confidence in modern care methods. All TA for these technologies and the APM will be centralized under the Provider Transformation initiative to ensure flexibility and shared learning. TA professionals will collaborate closely with experts from the Digital Backbone Adoption and Change Management Support sub-initiative (Section 3.3.2).

B. Strategic Renovations

Strategic renovation investments will help rural providers stabilize essential services and patient safety while building toward sustainable growth. Funding will follow a data-driven framework, such as the Hospital Stress Index (a detailed framework measuring rural hospital's Average Days Cash on Hand, Debt Coverage Ratio, Average Age of Plant, etc.) to target resources where they have the greatest impact on stability and outcomes. Investments will align to three horizons: facilities needing critical support to maintain access, those ready to reconfigure services, and those positioned for transformation.

- **Horizon 1 – Core access and service preservation:** Address safety and infrastructure risks to protect access, support patient and provider well-being, and strengthen sustainability in key rural facilities. Nearly 60 percent of rural Missouri hospitals report that infrastructure upgrades are among their most urgent needs to maintain financial stability and operational continuity, with average margins of just 0.4 percent (Section 1.0). These needs stem from ongoing financial strain. Horizon 1 investments will prevent and address infrastructure failures that could immediately jeopardize rural access to care.
- **Horizon 2 – Smart growth and service line modification:** Renovate underused facilities to meet the needs of local rural populations and ensure services are delivered safely and sustainably. Some rural patients currently travel nearly 50 miles for laparoscopic procedures and 70 miles for critical heart condition diagnostics[39]—almost three times farther than non-rural patients for comparable care (Section 1.0). These investments will "right-size" care access by converting underused space into high-demand service lines. Service-line changes will be guided by a network-level

assessment of regional demand for services that impose the greatest travel burden on rural residents. Missouri will specifically address the issue of obstetric deserts to improve maternal health and lower Missouri's low-birth-weight rate.

Regional Coordinating Networks' role in solving for rural OB deserts	
Action	**Purpose**
Map out a regional system of care	• Plan to meet needs at different levels of risk • Develop region-specific emergency response and transfer/transport protocols for hospitals with low-intervention birth units
Boost access to preventive and educational services	• Increase the share of low-risk births (e.g., normal weight) • Utilize workforce trained under Initiative 3.4 (Workforce), such as perinatal home visitors, doulas, behavioral health counselors
Convert existing hospital spaces to low-intervention birthing units	• Use available Horizon 2 funds as warranted and assessed by clinical sites, to be part of a regional network response • Deploy models of care that leverage Advanced Practice Registered Nurses trained under Initiative 3.4 (Workforce) and Family Practice providers with OB training, to staff and support low-intervention birthing units
Plan for sustainability by addressing malpractice costs and the value generated through a risk-based system of care	• Fund OB service line start-up costs at the regional network level, when participating hospitals use recommended care models developed by the regional network • Lower future malpractice rates and support development of a value-based funding stream through Medicaid MCOs' existing incentives on birth outcomes to sustain each region's system of care

- **Horizon 3 – Transformative and future-facing projects:** Reimagine Missouri's rural care infrastructure to drive innovation, training, and new capabilities to expand how providers serve their specific communities, including beyond clinical services. These projects may include multiple partners such as other providers, local public agencies, and community-based organizations that can rapidly bring existing expertise to bear**Error! Bookmark not defined.**. Examples of projects include addressing barriers to least-restrictive care settings transitions, renovating unused areas to provide social services, creation of a telehealth center, or a training lab, and duals-specific programming. For instance, the Healthcare Home program, a partnership between behavioral health centers and hospitals that provides integrated whole-

person care at FQHCs, has already achieved 55 percent fewer avoidable ED visits and 67 percent fewer avoidable hospitalizations since 2011.

- **Eligibility and matching:** Facility investments will be evaluated on their impacts to facility stability[40], care access[41], and RHTP service priorities[42]. State funds will require provider matching to boost facility incentive towards success, except for extreme cases where a waiver would be applied.

Eligibility criteria		
Project category	**Eligibility**	**Example investments**
Horizon 1 – Core access and service preservation	• Facilities are in the bottom half of financial strength per the Hospital Stress Index[43] (or equivalent measure for non-hospital providers) OR • Facilities in counties with severely limited alternative access	• Infrastructure investments necessary to preserve or restore access to care will vary by provider
Horizon 2 – Smart growth and service line modification	• Preference given to organizations that did not receive Horizon 1 funding • Must support 2 or more ongoing services aligned with program goals, at least 1 of which enables new offerings for that organization or organization's community	• Emergency Department and diagnostic improvements (e.g., co-locating CT scanners) • Inpatient and Primary Care • OB/GYN operating room modernization to reduce maternal complications • Behavioral health services (e.g., Youth Crisis Centers)[44] • New outpatient specialty or surgical services (infusion, oncology, dialysis, orthopedics) • Telehealth services, including tele-specialty and outreach programs for high-cost chronic conditions • Community wellness, nutrition, and prevention services
Horizon 3 – Transformative and future-facing projects	• Preference given to organizations demonstrating that their current facilities and systems are advanced enough to support innovation and shared technology centers • Regional Networks will assess proposals based on care access and RHTP service priorities	• Repurposing underutilized space e.g., simulation labs and workforce training centers, shared data command centers • Creating multi-partner projects for innovation e.g., telehealth coordination spaces to connect providers and community partners / resources

Match and waiver policies		
Project Type	**Default Match**	**Waiver policies**

Horizon 1	State: 90% Local: 10%	Complete waiver of local matching obligation is available upon review of finances and stress of hospital, if facility finances and community need are especially dire
Horizon 2	State: 75% Local: 25%	Partial waiver possible for projects serving multi-county populations or addressing statewide service line priority gaps.
Horizon 3	State: 75% Local: 25%	Generally expected to include local or philanthropic match. Partial waiver only if project serves as regional demonstration of clinical/community partnership, transformation of patient care, or directly addressing critically-needed social health services (e.g., postnatal welcome center for foster children with no home).

3.5.3 Implementation plan and timeline

Stage	Timing	Milestone
Stage 0 – Project Planning	Q1-Q3 2026	**Cross-cutting** • Governance team established • Charter complete with investment criteria and fund requirements **A.** RFP issued for RPM grants, RPM Support Center begins buildout, Ambient AI readiness assessment complete, annual funds disbursed for initial license rollout **B.** RFP issued for Horizons 1-2; funds distributed for approx. 10 Horizon 1 Projects, 3 Horizon 2 projects
Stage 1 – Project Plan Created & Initial Work Begun	Q2 2026-2027	**Cross-cutting** • Impact metrics aggregated by State • Investment criteria adjusted based on 2026 outcomes **A.** RPM grant recipients determined; RPM Support Center operational with Specialists; annual Ambient AI license funds disbursed **B.** RFP issued for Horizon 3; aggregate funds distributed for additional Horizon 1 projects, 8 more Horizon 2 projects; unspent 2026 funds reallocated; 2026 early projects completed with capacity improvement and ROI collected
Stage 2 – Implementation underway	2028	**Cross-cutting:** • Impact metrics aggregated by State • Investment criteria adjusted **A.** All initial RPM; RPM Support Center begins demo labs, evaluation and reporting, vendor training; annual Ambient AI license funds disbursed, Ambient AI deployed in at least 20 Hubs **B.** Remaining Horizon 1 projects approved; majority of Horizon 2 projects approved and funded; Horizon 3 projects identified and prioritized 2027 projects completed with capacity improvement and ROI collected
Stage 3 – Halfway to Goals	2029	**Cross-cutting:** • Impact metrics aggregated by State • Investment criteria adjusted **A.** RPM program is fully scaled; annual Ambient AI license funds disbursed **B.** Over half of Horizon 2 projects underway and over half of Horizon 3 projects funding approved; unspent 2028 funds reallocated; 2028 projects completed with capacity improvement and ROI collected

Stage 4 – Deliverables Finalized	2030	**Cross-cutting:** Impact metrics aggregated by State **A.** Annual Ambient AI license funds disbursed and deployed at all 30 Hubs **B.** All funds allocated for Horizon 2-3 projects, 2029 funds reallocated. Over 80% of projects with completion milestones
Stage 5 – Full Implementation	2031	**Cross-cutting:** Initiative outcomes aggregated and distributed to RCNs for strategic planning **A.** RPM support consolidated to Specialists offering remote support; ambient AI costs evaluated for continued investment **B.** Unspent 2030 funds reallocated and overall impact evaluated

3.5.4 Governance and project management structure

Missouri DSS will serve as the lead agency. Governance structure and coordination with stakeholders will mirror those outlined in the Regional Networks and Hub Activation initiative (Section 3.1.4).

Entity	Roles and Responsibility
State	• Administer funding for facility modernization and operational innovation • Prioritize capital allocations in year 1 • Approve Horizons 1-3 projects and oversee compliance with match/waiver policy • Track ROI, safety, and service expansion outcomes • Coordinate operational innovation implementation statewide
Network (RCN)	• Review and score provider proposals based on need and impact starting year 2 • Manage allocation of capital funds within the region • Provide shared technical assistance on implementation • Aggregate outcomes and sustainability data
Hub	• Identify facility and service line needs aligned with hub priorities • Support provider adoption of AI and RPM technologies • Facilitate peer learning and user feedback on innovation use • Report local impact metrics to RCN
Providers / Community Partners	• Implement facility renovation and innovation projects • Train staff on new technologies and workflows • Ensure compliance with reporting and quality standards • Collect pre- and post-investment outcomes

The State will allocate funding directly to providers until RCNs are stood up with capacity to prioritize investments for regions, subject to State approval. Upon approval, funding will be allocated by associated RCNs. RCN will balance investments between independent, system-affiliated, and non-hospital providers (FQHCs, behavioral health, LPHAs) to strengthen the full care continuum.

Staffing Plan: The RHTO and team overseeing this initiative are included and described in Section 3.1.4. External partners will be contracted to support RPM rollout and provide technical assistance.

3.5.5 Metrics and Evaluation Plan

Performance Measures and Outcomes, [C: county-level measurement]			
Outcome metrics	**Baseline**	**Target in Y5**	**How initiatives achieve the outcome**
Service access restored or preserved	Baseline in Y1	≥ 80% approved projects operational	*Improves access for rural communities*
# of rural providers offering RPM coverage [C]	Baseline in Y1	≥10% increase from baseline	*Improves chronic care management and reduces acute utilization.*
Rural clinical hours worked supported by ambient AI [C]	Baseline in Y1	≥30-50% increase from baseline	*Improves chronic care management and reduces acute utilization.*
# of service line modifications and transformative projects through ToRCH Care [C]	0	≥30	*Improves access and innovation*

All metrics will be reported annually to RCNs and the RHTO to track progress and inform updates to investment and grant criteria. The MHA, MPCA, and associated providers receiving funding will provide financial stress data on key measures (e.g., Hospital Stress Index, Days of Cash on Hand), Hubs will report RPM and Ambient AI adoption, and the RHTO will track safety, access, and service-line investments requiring approval. More frequent reporting may be required as data integration and real-time dashboards come online, particularly for software-driven metrics such as rural clinical hours supported by Ambient AI.

Program Evaluation Plans

Each RCN will be expected to provide:

- Pre- and post-investment reporting on facility safety, access, and utilization
- Annual metrics for sustainability (margin improvement, service-line utilization)

- Hub- and RCN-level transparency dashboards to track regional progress

Over time, RCNs will assess return on investment not just by financial performance but by population health outcomes such as reduced avoidable transfers, improved chronic disease management, and maternal health outcomes.

3.5.6 Sustainability Plan

Most strategic renovations and operational innovations are one-time investments. After the initial funding, new service lines will be sustained through revenue from care delivery, while operational improvements will be assessed for their impact on cost reduction and long-term sustainability. Together, these sub-initiatives streamline workflows, strengthen system connectivity, and modernize infrastructure to reduce provider time spent on documentation, administration, and compliance. Beyond time and cost savings, these efforts aim to enhance both patient and provider experience, encouraging high-quality clinicians to remain in rural facilities and giving patients confidence to seek care locally. Most operational innovation costs will occur upfront for system purchases, training, change management, and integration with existing technology to ensure adoption.

Integrating lessons from this program into ongoing policy

The Provider Transformation initiative will identify which operational and infrastructure investments most effectively strengthen provider capacity and long-term sustainability. Evaluation of RPM and Ambient AI adoption, along with technical assistance deployment, will generate best practices to guide future state direction. Missouri Medicaid already reimburses providers for RPM services, creating a foundation for broader adoption and continued innovation (APPENDIX 1: State Policy Actions and

Commitments). Learnings from this initiative could identify which RPM models and technologies most effectively improve patient outcomes and reduce avoidable utilization, bringing updated covered services, reimbursement methodologies, and eligibility criteria.

4.0 IMPLEMENTATION

Housed within DSS, the RHTO will guide the overall effort and serve as the central governing and coordinating body for the statewide network. The team will provide strategic leadership, design major initiatives, and develop best practices to support implementation across all RCNs and Hubs. The RHTO will also oversee performance measurement, analytics, compliance, and annual CMS reviews, collecting and validating data and sharing results through standardized dashboards to track progress and drive continuous improvement. See initiative-specific implementation plans for detailed timelines, activities, and responsible partners.

5.0 STAKEHOLDER ENGAGEMENT

Missouri's approach to stakeholder engagement is grounded in transparency and accountability to the communities most affected by rural health transformation. The State has engaged a broad coalition of providers, associations, agencies, and rural residents in developing this application, and will continue that engagement throughout program implementation to ensure the RHTP remains responsive to local realities.

Stakeholder Engagement to Date: Weeks before the Notification of Funding Opportunity was released, Missouri convened a statewide Rural Health Workgroup to co-design the RHTP framework. This group included leadership and members from:

- MHA, MPCA, MBHC, MPA, Missouri Rural Health Association

- DHSS (including the Office of Rural Health and Primary Care), DMH, MO HealthNet Division (Medicaid), and the Governor's Office
- LPHAs, Critical Access Hospitals, FQHCs, RHCs, EMS agencies, and CBOs

Missouri held biweekly workgroup sessions, several all-day in-person meetings, and small-group provider discussions to gather input on the draft proposal, data priorities, workforce needs, and funding design. To ensure broad participation, the State also opened a 34-day public comment period, receiving 228 written comments from providers, community leaders, and residents across rural Missouri. Letters of support and a full list of stakeholder participants are included in *Supporting Documents.*

Missouri has no federally-recognized tribes and one Urban Indian Organization. Missouri DSS and Missouri's single qualifying entity, Heart of America Indian Center, d/b/a Kansas City Indian Center (KCIC), have established a process for notification of proposed changes to Missouri's Medicaid and CHIP program for state plan amendments, state plan waivers, and for demonstration project proposals. Because KCIC does not provide programming in rural communities, they were not engaged in Missouri's RHT proposal. KCIC will, however, be engaged for any state plan amendment requests, any waiver requests, or any demonstration project proposals resulting from the RHT proposal prior to submission to CMS.

Ongoing Stakeholder Engagement Framework: Missouri will maintain a formal stakeholder engagement framework throughout the cooperative agreement to ensure continuous feedback and shared ownership. Engagement will occur across three levels:

Level	Stakeholder Engagement
State	The RHTO will lead ongoing stakeholder coordination and lead a statewide stakeholder advisory council will review progress, align policies, and coordinate resources. The RHTO will convene **advisory sessions** with broader stakeholders to review data trends, funding priorities, and policy issues. A standing agenda item on ToRCH Care will be included in quarterly public **Medicaid Oversight Committee meetings**. Missouri will also maintain an online avenue for anyone to share ideas or concerns directly with the State.
Regional	Each RCN will convene regional forums bringing together Hub and provider stakeholders to share performance data, identify regional needs, and shape TA priorities. The RCN will serve as technical and engagement anchors, ensuring consistent communication across networks and alignment with statewide standards.
Local	Each Hub's Board will represent participating hospitals, FQHCs, behavioral health providers and other healthcare providers and CBOs. When available, Boards will create opportunity for patient or consumer representatives feedback. Boards will review data dashboards, set improvement priorities.

6.0 APPENDIX

APPENDIX 1: State Policy Actions and Commitments

Factors	Current policy	Commitment
B.2 Health and lifestyle	Requires schools to reestablish the Presidential Fitness Test	N/A
B.3 SNAP waivers	Waiver submitted to USDA and under review	USDA-approved waiver in effect
B.4 Nutrition Continuing Medical Education	No requirement	Requirement in place and enforced
C.3 Certificate of Need	45-79 score from the Cicero report for States with moderate CONs	***See below for nuance***
D.2 Licensure compacts		
• Physician	IMLC Member State serving as SPL (State of principal license)	N/A
• Nurse	NLC Member State	N/A
• EMS	Is a licensure compact member of the EMS Compact	N/A
• Psychology	PSYPACT participating	N/A
• Physician Assistant	No active legislation to become a PA Compact member	Legislation enacted to become a PA Compact member – State is a compact member
D.3 Scope of practice (NPs, PAs, pharmacists, hygienists)		
• PAs	Reduced scope of practice	
• NPs	Restricted scope of practice	

• Pharmacists	0-3 score from Cicero report for States with restricted authority	
• Dental hygienists	Semi-Restricted Scope of Practice (3-5 types tasks)	
E.3 Short-term limited duration insurance	STLDI plans are not restricted in the State beyond the latest federal guidance	N/A
F.1 Remote care services		
• Medicaid payment for > 1 form of live video	Reimbursed	N/A
• Medicaid payment for Store and Forward	Reimbursed	N/A
• Medicaid payment for RPM	Reimbursed	N/A
• In-state licensing requirement exception	Exceptions are in place	N/A
• Telehealth License/ Registration process	No process in place	Process in place

Physical Fitness and Youth Health: The Department of Elementary and Secondary Education (DESE) currently requires schools to conduct a physical fitness challenge assessing flexibility, strength, and aerobic capacity. Missouri supports reinstating the Presidential Fitness Test (EO 14327) and will align state regulations with federal standards by December 31, 2028. This alignment will reinforce early prevention of obesity and chronic disease among youth, improving long-term rural health outcomes.

Nutrition and SNAP Reform: Missouri's current SNAP policy follows federal purchasing rules. Under Executive Order 25-30, the Department of Social Services (DSS) has submitted a USDA waiver to restrict SNAP purchases of candy, desserts, soda, and fruit drinks with less than 50% juice. Pending approval, implementation is expected by October 1, 2026, with full execution by December 31, 2027. This reform will reduce sugar consumption and help address higher obesity and hypertension rates among rural Missourians.

Nutrition Training for Physicians: Missouri does not currently require nutrition education in physician continuing medical education (CME). Catalyzed by RHTP, the Missouri Board of Registration for the Healing Arts voted on October 31, 2025, to file regulations that require at least one CME hour in nutrition for physicians, with implementation initiated at the conclusion of the rule promulgation process. Missouri commits to full implementation by December 31, 2028.

Interstate Licensure Compacts: Missouri participates in multiple licensure compacts, including the Nurse Licensure Compact, EMS Compact, PSYPACT, and Interstate Medical Licensure Compact, which expand rural access by allowing providers to practice across state lines. The state commits to joining the Physician Assistant (PA) Compact, filing legislation in 2026, enacting it by 2027, and fully implementing it by December 31, 2027, to help address rural workforce shortages.

Telehealth Expansion: Missouri's current telehealth policy allows Medicaid reimbursement for live video, Store and Forward, and Remote Patient Monitoring, with limited licensure exemptions. The state will establish a telehealth-specific license or registration process, filing legislation in 2026 and implementing it by December 31, 2027, to create pathways for providers to serve rural areas.

Cicero Report Clarification: Missouri's Certificate of Need (CON) program covers medical inpatient, behavioral inpatient, imaging, and long-term care facilities. **Under the Cicero Institute's own methodology, Missouri should score a 45.** The Cicero report inaccurately claims that Missouri's CON includes medical outpatient services due to its reference to ambulatory surgical centers (ASCs), which are not within Missouri's CON scope. It also incorrectly asserts inclusion of behavioral outpatient services. A CON is

not required for behavioral outpatient care in licensed hospitals or freestanding centers. While Cicero correctly notes that Missouri's CON excludes day services, ancillary services, and other medical services, these mischaracterizations overstate Missouri's regulatory reach and understate its flexibility in expanding access to care. The AAPA classifies Missouri as a "Reduced Practice" state for Physician Assistants, and the AANP designates it as a "Restricted Practice" state for Nurse Practitioners. Cicero rates pharmacist authority as "restricted," though Missouri law grants pharmacists full authority to administer drugs. The OHWRC accurately recognizes Missouri's broad dental hygienist scope, including indirect administration of local anesthesia, direct Medicaid reimbursement, and authority to provide sealants and prophylaxis without prior examination. Missouri imposes no additional restrictions on Short-Term, Limited-Duration Insurance (STLDI) plans beyond federal guidance, reinforcing the state's commitment to regulatory flexibility and consumer choice.

Scope of Practice: Missouri will reassess our current scope of practice laws and regulations for Nurse Practitioners, Physician Assistants, Pharmacists, and Dental Hygienists. The state commits to using this evaluation to identify the optimal legislative and regulatory changes to increase the availability of services provided by these professionals in rural areas and enable them to reach rural Missourians who are struggling to access local care. Legislative and regulatory changes will be made by December 2027.

APPENDIX 2: Factor A.2: Current list of CCBHC

Missouri has 381 active sites of care associated with CCBHC entities. Please refer to *CCBHC List in Supporting Documents* for more details.

APPENDIX 3: Hospitals that received Medicaid DSH payment

Missouri has 85 hospitals that received Medicaid Disproportionate share Hospital (DHS) payments, 80 of which received non-IMD DSH payments.

End Notes

[1] U.S. Census Bureau 2021. https://www.census.gov/programs-surveys/popest/data/tables.html.
[2] U.S. Census Bureau 2021. https://www.census.gov/programs-surveys/popest/data/tables.html.
[3] 104 counties defined in MO RHTP addressable counties include 97 HRSA Federal Office of Rural Health Policy (FORHP) Rural counties, FIPS of counties below:

Rural FIPS (Fully FORHP Rural)										Urban FIPS (Not Fully FORHP Rural)
29001	29027	29057	29079	29105	29127	29149	29171	29197	29217	29003
29005	29029	29059	29081	29109	29129	29151	29173	29199	29219	29021
29007	29033	29061	29083	29111	29131	29153	29175	29201	29221	29031
29009	29035	29063	29085	29113	29133	29155	29177	29203	29223	29043
29011	29039	29065	29087	29115	29135	29157	29179	29205	29225	29097
29013	29041	29067	29089	29117	29137	29159	29181	29207	29227	29107
29015	29045	29069	29091	29119	29139	29161	29185	29209	29229	29145
29017	29049	29071	29093	29121	29141	29163	29186	29211		
29023	29053	29073	29101	29123	29143	29167	29187	29213		
29025	29055	29075	29103	29125	29147	29169	29195	29215		

[4] U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2022
[5] https://www.census.gov/about/policies/citation.html; data.hrsa.gov;
[6] See Supporting Document Map of Providers and Distance traveled for care

[7] HIDI Inpatient/Emergency Department/Outpatient for calendar years 2023-2024
[8] HIDI Inpatient/Emergency Department/Outpatient for calendar years 2023-2024
[9] https://www.mhanet.com/mhaimages/advocacy/missouri_hospital_closures.pdf
[10] To be refined with data in year 1
[11] Assumptions based on projected EMS CIH expansion to fund 7 programs across regions with 8000 encounters annually (Washington county pilot data in 2022), 7000 babies born in maternal care desserts * 10% encounters for MHAP; 3000 CAP encounters increase in awareness due to Hub participations
[12] Assumption based on meta studies showing a range of 10-40% reductions in hospitalizations/ED utilization adjusted based on empirical evidence of scaling interventions to broad population
[13] Total touchpoints to be baselined in year 1, current Rural FQHC PCP touchpoints are 1.2M for 230k patients in 2025 on current touchpoints from MCPA database. Program target assumes ~60k touchpoints from expanded hub access, 15k school-based clinics (assumes 1500 touchpoints p/site 10 initial sites); 25k integrated care access expansion increasing 40 touchpoints p/ 1k
[14] Baseline total rural ED visit (1.13M visits for 2.49M population) from MHA database, FY2025. Assumptions based on meta-analysis of MIH-CP program showing 10-40% reduction in ED visits adjusted based on empirical evidence of scaling interventions to broad population
[15] Assumption based on implementation of Missouri's Washington County MIH-CP program, NEJM Barbershop trial summaries, and Ochsner Digital Medicine case studies adjusted based on empirical evidence of scaling interventions to broad population
[16] Assumption based on meta-analysis of similar interventions implemented in Oregon CCOs model, Vermont Blueprint & diabetes and North Carolina CPESN programs adjusted based on empirical evidence of scaling interventions to broad population
[17] Assumption based on meta-analysis of perinatal and prenatal (paraprofessional CHW-style) home visiting programs implemented across states (NY, OH) and nationally for Medicaid beneficiaries adjusted based on empirical evidence of scaling interventions to broad population
[18] Assumption based on multi-state Medicaid study of OUD interventions from Medicaid Outcomes Distributed Research Network (MODRN) adjusted based on empirical evidence of scaling interventions to broad population
[19] Provider transformation horizon 1 funding to providers could precede Hub establishment in Year 1

[20]

Types of care or services that can be provided or coordinated by Hubs	
Women's Health	Screenings, reproductive care, prenatal care, home visitation programs, breastfeeding training, and remote monitoring of high-risk pregnancies
EPSDT Services	Early and Periodic Screening, Diagnostic, and Treatment for children under 21
Healthy Homes	Lead and asthma home visits to prevent poisoning and reduce ER visits
Senior Home-Based Services	CHW and Nurse-led clinical services for aging populations
Community, Primary Care, and Behavioral Health Services	Screenings and health education; peer recovery specialists, diversion staff, Narcan distribution, suicide prevention training, and mental health first aid, community referral programs.
Chronic Disease Management	Diabetes prevention, chronic disease self-management programs, senior fall prevention, cancer screenings, and ongoing monitoring
Lab Services	Access to State Public Health Laboratory and local partnerships (e.g., LPHAs w/ dedicated lab space)
Non-Emergency Medical Transportation	Providing safe, coordinated transportation for medical appointments, pharmacy visits, and community-based care

[21] Hub Core Measures:

Hub Core Measures	
Chronic Disease	**Behavioral Health**
1. Diabetes control (A1c< 9% among diabetics)	7. Rates of hospital utilization for BH diagnosis
2. Overall rates of uncontrolled hypertension (>130/80)	8. Depression remission rates (based on PHQ-9)
3. Obesity rates for adults (BMI>30)	9. Continuity of Pharmacotherapy for OUD
4. Obesity rates for children (> 95th percentile)	**General Health, Wellbeing, and Patient Experience**
Maternal/Infant Health	10. Healthy days at home
5. Severe Maternal Morbidity rates	11. Improvement in patients' self-sufficiency index
6. Low birth weight rates (<2500g)	12. People's Voice assessment of patient experience

[22] The MITRE Corporation (2017). Alternative Payment Model: APM Framework. https://hcp-lan.org/wp-content/uploads/2025/08/APM-Framework-White-Paper.pdf

[23] Pandey et al (2024). Value-based purchasing design and effect: a systematic review and analysis. https://pmc.ncbi.nlm.nih.gov/articles/PMC11026120/

[24] AHIP, AMA, NAACOS (2024). Creating a Sustainable Future for Value-Based Care. https://www.ama-assn.org/system/files/vbc-best-practices-playbook.pdf

[25] Smith et al (2020). How to Better Support Small Physician-led Accountable Care Organizations. https://healthpolicy.duke.edu/sites/default/files/2020-07/How%20to%20Better%20Support%20Small%20Physician-Led%20ACOs.pdf

[26] APM sub-initiative F. Technology Enablement is exclusively meant to provide the technology required to implement the other sub-initiatives (e.g., Incentive Model Design) and therefore does not have its own implementation plan or milestones

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1. Meets Baseline	2. Modernization Candidate	3. Requires Deployment to Shared Model
EHR meets interoperability and advanced technology readiness, including AI-enabled capabilities, and is ready for interoperability and advanced technologies	EHR requires version upgrades, integration work, or configuration changes to meet baseline readiness.	Facility lacks sufficient EHR access or requires full replacement; considered for a shared EHR model.

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Phase	Activities
Phase 1 – Data Aggregation and Standardization	Build upon existing data assets and infrastructure to harmonize data definitions, implement shared interoperability standards, and enable statewide aggregate reporting across Community Hubs and Regional Care Networks. We will deploy automated validation scripts for HL7 FHIR schema integrity, US Core Data for Interoperability (USCDI) consistency, and metadata mapping. The State will provide data science and technical support to ensure high-quality statewide reporting without PHI exchange. We will validate HL7 FHIR schema integrity, USCDI v3 element mapping, and workflow metadata alignment across partners.
Phase 2 – Secure Data Pipelines and Care Coordination	Develop secure data pipelines among MHA, MBHC, MPCA, and MPA to support patient care coordination and integration of key datasets. Local operator agents will automatically verify consent and audit metadata to ensure end-to-end governance integrity. Use HL7 FHIR Bulk Data APIs (Flat FHIR) and HITRUST-certified transfer methods to ensure secure, standardized, and efficient exchange of patient and population health data across systems. Deploy local operator agents to reconcile USCDI fields, verify workflow metadata, and automate error flagging. Continuous readiness assessments will identify and onboard additional rural facilities, expanding the shared data ecosystem and advancing statewide analytic maturity.
Phase 3 – Federated Interoperability and Governance Framework	Launch a State-managed Federated Interoperability and Governance Framework that merges data-exchange, workflow-governance, and cybersecurity oversight into a single hybrid-cloud architecture. This model minimizes data egress costs while allowing us to utilize industry-leading analytics and application technologies. Details of this approach include: • Hybrid Cloud Architecture • Cybersecurity and access control • Monitoring and sustainability • Cybersecurity and access control • Monitoring and sustainability

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HL7 FHIR and Gravity Project Alignment	Data System Expansion	QHIN Integration
Documentation templates will be standardized and entered in HL7 FHIR compliant database for interoperability across the network of frontline and traditional care providers. All documentation templates and encounter forms will conform to HL7 FHIR R4+ resources, USCDI elements, and additional value sets to ensure consistent, interoperability.	We will rapidly scale base functionality of existing systems—MPA's System for Pharmacy Health Encounter Reporting & Evaluation (SPHERE), with centralized data aggregation, normalization and analytics capabilities. SPHERE will be enhanced to support FHIR APIs, USCDI data mapping, and automated schema validation.	We will phase in the frontline community-based access network into Qualified Health Information Networks (QHINs) to achieve long-term interoperability. This includes governance onboarding and testing of HL7 FHIR API endpoints for reliable data exchange, and maintaining critical workflow metadata.

[30]

Data Governance	Establish a statewide data governance framework that defines policies, roles, and standards for data access, quality, privacy, metadata and lineage, and consent management, to support consistent, compliant, and trusted data sharing across all rural health partners. The Data Governance committee will include relevant state agencies and stakeholders. A minimum viable product (MVP) approach includes: 1) the initial governance structure to be piloted as part of implementation; 2) provide training on governance processes so that individuals can determine the appropriate steps to ensure data quality; 3) develop the requirements and review tool(s) to support data governance.
AI Governance	Establish rules for responsible AI use within the HL7 FHIR/USCDI data environment. Key activities include creating a model assessment framework, tracking algorithm provenance, and ensuring AI audit readiness. The AI governance program will focus on four areas: (1) developing Responsible AI principles and policies based on regulatory and best-practice requirements; (2) creating a risk management framework and process to review and manage the AI inventory; (3) defining governance structures, operating models, and roles and responsibilities; and (4) building awareness through a communications plan that informs workforce training.

[31] HRSA, Designated Health Professional Shortage Areas Quarterly Summary, Fourth Quarter FY 2025, Table 3, page 6 and RHI Hub Health Professional Shortage Areas: Dental care, by County, July 2025
[32] March of Dimes Report on MO, 2023
[33] Health Professional Shortages at HRSA Health Workforce (unpublished report)
[34] Two osteopathic medical schools in Missouri. Kansas City University reports ~168 students per year leave MO. Kirksville College of Medicine reports ~104 students per year leave MO, as of Oct 2025
[35] data.hrsa.gov, analyzed by DHSS Health Economist John Fieno, PhD
[36] For a comparable shared-equity financing structure, see Stanford University's *Mortgage Assistance Program (MAP) Loan* brochure (Faculty Staff Housing, March 2022), available at https://fsh.stanford.edu/sites/default/files/2022-03/MAP.pdf.
[37] Missouri Rural Health Association (2024). Listening to Rural Missouri: A Needs Assessment. https://mrhassociation.org/wp-content/uploads/2024/01/RUMO_NeedsAssess.pdf

[38] Mobi Health News (2025). Rush expands AI-driven documentation with Suki partnership. https://www.mobihealthnews.com/news/rush-expands-ai-driven-documentation-suki-partnership

[39] Non-rural patients travel approximately 15 miles for laparoscopic treatments and 9 miles for rubidium heart condition diagnoses

[40] Metrics to estimate financial stability include cash-adjusted operating margin (%, adjusted for depreciation), days cash on hand, current ratio, debt-to-equity ratio, financial support of broader health system / regional network, projected ROI / sustainability following grant

[41] Metrics to estimate care access include proximity to nearest facility, % of rural residents impacted, average age of plant / facility, regulatory or safety compliance issues

[42] Metrics to estimate RHTP service priorities include participation in Hub, alignment to RHTP target outcomes,

[43] Stress index measures for different provider types will initially be used to evaluate provider investment need due to availability and reasonable accuracy of the index. Initiative goal is to quickly generate new, more tailored indices more suitable for the RHTP and investment Horizons.

[44] MO hospitals requested payments for 5,288 unfunded days (IDD population) and 909 unfunded days (MI population) in State FY 25.