Centers for Medicare & Medicaid Services (CMS)
Center for Medicaid and CHIP Services

Rural Health Transformation Program – State of Oklahoma

Project Narrative

REQUIREMENT	APPLICANT RESPONSE
FUNDING OPPORTUNITY TITLE	Rural Health Transformation Program – State of Oklahoma
FUNDING OPPORTUNITY NUMBER	CMS-RHT-26-001
ASSISTANCE LISTING	93.798
FUNDING AGENCY	Centers for Medicare & Medicaid Services (CMS) – Center for Medicaid and CHIP Services
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SUBMITTING AGENCY	Oklahoma State Department of Health 123 Robert S. Kerr Ave Oklahoma City, OK 73102
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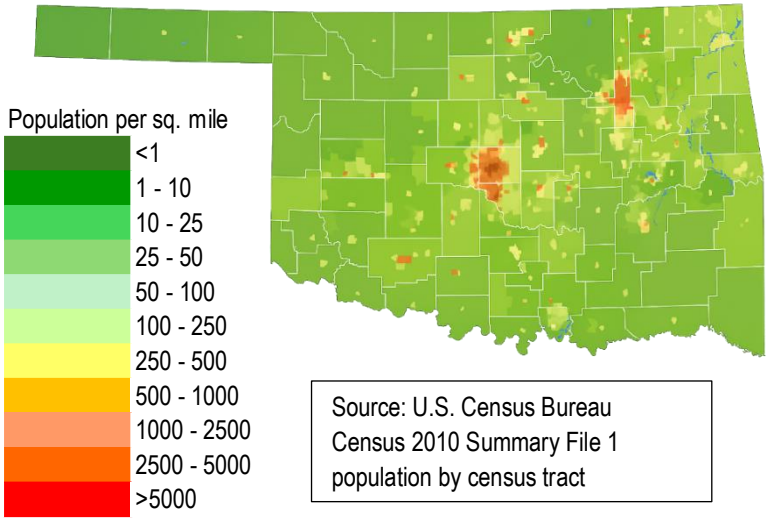
Project Narrative – Oklahoma Rural Health Transformation Program

1. Rural Health Needs and Target Population

Overview of Rural Health Landscape: Oklahoma's rural health ecosystem mirrors the population – few in number, but resilient and determined. This section underscores why a coordinated and well-funded strategy under the Rural Health Transformation (RHT) Program is essential to securing improved health outcomes for rural residents.



Oklahoma's geographic dispersion magnifies the access barriers and limits economic opportunities, creating conditions where rural residents face higher disease burden and diminished healthcare access compared to urban areas and national benchmarks.

Definition of Rural: For purposes of this application, *rural* refers to areas and populations located outside U.S. Census Bureau–defined urbanized areas and outside metropolitan statistical areas, consistent with definitions used by the Health Resources and Services Administration (HRSA). The Oklahoma Office of Rural Health identifies 59 of the State's 77 counties as rural under this classification, aligning with HRSA rural eligibility designations. These areas are characterized by low population density (50 persons per square mile or fewer) and limited healthcare infrastructure. Collectively, Oklahoma's rural regions represent approximately 40% of the State's population of 1.58 million residents, and its 59 rural counties cover approximately 88% of the State's total land area.

Oklahoma's geographic dispersion magnifies access barriers and limits economic opportunities, creating conditions where rural residents face higher disease burden and diminished healthcare access compared to urban areas and national benchmarks. Lived experience across the different rural regions of Oklahoma highlights how access and opportunities are constrained by the State's truly rural nature, such as:

Miles between neighbors: In more remote pockets, a "neighbor" might be two to five miles away, sometimes across fields or past windbreaks. This is especially true in Northwest Oklahoma and the Panhandle where healthcare facilities can be located hours apart. Specialty care is located even further away, often requiring overnight trips to Oklahoma City.

Sparse infrastructure: Many roads are unpaved, some postal routes are long and delivery services infrequent, and cell service is inconsistent. For example, the Bugtussle community in southeastern Oklahoma faces this challenge acutely; limited broadband and unreliable cellular coverage restrict access to both in-person and telehealth services.

Long travel times for essentials: To reach groceries, gasoline, schools, or health care, rural Oklahomans often drive 20, 30, or even 50 miles each way. This challenge is particularly evident in southern Oklahoma, where a single bridge over Lake Texoma connects the region to the rest of the State. When the bridge is closed or flooding occurs, residents and Emergency Medical Services (EMS) must take significantly longer detours to reach care providers. In these sparsely populated areas, healthcare facilities are as limited as the population itself—yet they remain resilient and deeply committed to serving their communities. Continued support is needed to sustain high-quality care and improve health outcomes for rural Oklahomans.

Oklahoma's rural health needs can be identified across four key dimensions: demographics and socioeconomic conditions, health outcomes, healthcare access, and financial health of rural facilities. Across all four, data reveal a consistent pattern — rural Oklahomans face deeper disparities and weaker

system reliability than nearly any other population in the nation. Compared to the U.S. average, they are more likely to live in poverty, less likely to have insurance, less likely to have completed higher education, and more likely to face food insecurity and economic hardship. These social determinants translate directly into health risk and service gaps that perpetuate poor health outcomes. Yet Oklahoma has a strong foundation for change through innovation. The State's Tribal, State, and community systems, established telehealth network foundations, and its engaged rural health stakeholders position Oklahoma to take full advantage of the RHT Program to advance sustainable access, preventive care, and data-driven delivery models. A coordinated and well-funded strategy under the RHT Program will drive lasting improvements in health outcomes for rural residents.

Rural Demographics and Socioeconomic Data: Ranked the 14th most rural state in the U.S., Oklahoma has 1,579,235 rural residents — nearly 40% of the population — a share that exceeds the national median of 14% (Dobis, 2025; Sanders, 2025; U.S. Department of Agriculture, 2025). Geographical differences are mirrored in Oklahoma's rural economy, where income levels and workforce shortages amplify health disparities. Oklahoma's overall median family income is $66k, about $17k below the U.S. average (U.S. Census Bureau, 2025). Nonmetro Oklahoma shows an even starker gap at $29k below U.S. median household income, placing rural Oklahoma's median income among the bottom of *all* states (U.S. Census Bureau, 2024). Urban and rural unemployment in Oklahoma tracks closely with national ranges of 3%-4%, with rural Oklahomans unemployed at the high bound of that range (*Oklahoma Employment Report*, 2025). Most employed rural Oklahomans work in agriculture, extraction, and natural resources - jobs that are declining and being replaced by lower-paying transportation jobs (Wilkerson, 2022). Notably, 15% of Oklahomans live in poverty. Lower income is closely tied to lower levels of education attainment (Healthy People 2030, 2025), another area where the State lags the national average: 26% of urban and 16% of rural Oklahomans hold a bachelor's degree or higher, compared with a national 37% (Federal Reserve

Economic Data [FRED], 2023). Oklahoma's health coverage is similarly below average with a rural uninsurance rate of 11% that exceeds that of 47 other states (America's Health Rankings [AHR], 2023; Oklahoma Health Care Authority [OHCA], 2024). These social determinants relate to higher rates of morbidity and shorter life expectancy (*Healthy People 2030*, n.d.). Furthermore, Oklahoma has unique aspects further magnifying the health gap between rural Oklahoma and both its urban areas and national benchmarks, including Oklahoma's large Indigenous population (16%) (U.S. Census Bureau, 2025) with overlapping jurisdictional health systems, frontier-level isolation across 35% of land area and 7% of the population, and fragile provider ecosystem (Dobis, 2025).

Health Outcomes Overview: Health outcomes are notably poor among Oklahoma's rural population. Oklahoma's low ranking for overall health (47th) in the nation is evident in the State's high rates of chronic conditions and poor access to and use of preventive healthcare services (AHR, 2024). Heart disease has a staggering rate of 250 deaths per 100k people compared to the national average of 162, which could be attributed to high rates of obesity and diabetes. In rural Oklahoma, 41% of adults are obese and 14% have diabetes. Compared to the national average, obesity in rural Oklahoma occurs at 1.2x and diabetes death at 1.4x. Cancer in rural Oklahoma also exceeds national average, with colon cancer occurring at 1.2x national rates. Similarly, rural Oklahoma sees suicide at 1.6x national average (CDC, 2025), a statistic exacerbated by limited access to behavioral health.

Oklahoma's child and maternal health outcomes are also poor, ranking 44th overall in the U.S. (CDC, 2025). Oklahoma's counties with the highest rates of infant mortality are all rural, with the leading cause of infant mortality (23%) being preterm births and low birth weight (Oklahoma State Department of Health [OSDH], 2025). These are indicators of poor maternal health, including behavioral health challenges and limited access to routine monitoring and screening (Behrman et al., 2007; Dagostini, 2025). These maternal

health gaps start early, as only 70% of rural mothers receive first trimester prenatal care, 6% below national rates (CDC, 2025).

Within these broader trends, Indigenous populations face even more severe disparities. For example, maternal morbidity among Indigenous women in Oklahoma is 2x higher than white women, Indigenous infant mortality is 33% higher than the State average (Heck et al., 2021), and Indigenous people in Oklahoma experience diabetes (15.1%) at a higher rate vs. the State average and rural populations as a whole (United Health Foundation, 2023).

Healthcare Access and Infrastructure: Poor health outcomes in Oklahoma can be attributed to geographical barriers to healthcare access. With Oklahoma ranking at the bottom nationally in healthcare access and affordability (48th) and primary care physician (PCP) supply (43rd), barriers to care are even more acute for rural residents (Radley et al., 2025). In rural areas, there are 88 hospitals (39 of which are critical access and only 4 of which are emergency), 143 rural health clinics, 201 Federally Qualified Health Centers (FQHCs), 82 Certified Community Behavioral Health Clinics (CCBHCs), and 17[1] opioid treatment facilities (CMS, 2025). Oklahoma's critical and rural access hospitals (CAH) count is low compared to peer states Texas and Kansas, both of which have over 80 (RHIHub, n.d.). Oklahoma is also significantly lower than peer state rural health clinic count (KS: 183, TX: 376) (National Association of Rural Health Clinics, 2025). Further, the number of hospitals and behavioral health facilities are lower than those of urban Oklahoma, despite serving a much larger land area with a comparable population base. In addition to facilities, healthcare professionals are also scarce. Nationally, there are 75 PCPs for every 100,000 people. Rural Oklahomans have fewer than half of that with 35 PCPs per 100k people. A similar pattern is repeated across specialties, with the most acute deficits being OB/GYN generalists (2 for every 100k rural Oklahomans vs. 13 nationally), psychiatrists (1 in Oklahoma vs. 12 nationally), and child psychologists (0.3

[1] DMH Certification Data indicates 17, different from 10 listed by CMS

in Oklahoma vs 10 nationally) (Gooch, 2023). This low access to specialty care results in an overtaxed emergency system, where already-strained EMS assets are required to fill the access gap for urgent specialty care in rural communities (Oklahoma Rural EMS Providers, personal communication, 2025). Contributing to this provider shortage are rural Oklahoma's significant challenges in workforce recruitment, including lower wages, fewer housing options, and access barriers for existing rural residents seeking healthcare education.

Even where rural health facilities are available, getting to them proves a challenge for Oklahomans. Of Oklahoma's 77 counties, 75 are designated Healthcare Professional Shortage Areas (Cicero Institute, 2025). On average, rural Oklahomans travel 80 minutes to obtain comprehensive trauma care vs. 30 minutes for urban residents (OHA, 2025). Only 13% of rural Oklahomans live within 30 miles of a trauma center, with the remaining traveling an average of 81 miles (CMS, 2025; HRSA, 2024; U.S. Census Bureau, 2021). These distances strain EMS, as communities can go hours without available providers when ambulances travel long distances to bring patients to hospitals. Transportation to care is an additional challenge, as only 1% of Oklahoma's land area is covered by public transit, with nearly all being located in urban areas. For rural Oklahomans without reliable personal vehicles capable of long-distance travel, opportunities to access care are limited. The bottom line remains — access to proper care for rural Oklahomans often depends on how far they can drive, who is available to provide services, and whether the system can reach them in time.

Rural Facility Financial Health: Funding, or lack thereof, for healthcare facilities and providers is the leading obstacle to better health care in rural Oklahoma. Existing healthcare facilities and providers in rural Oklahoma struggle with low financial stability and sustainability. Oklahoma's CAHs reported the weakest performance of all peer states (Texas, Arkansas, Kansas), with median operating margins of -16% and total margins of -5%, and 79% of them were rated as medium/higher risk (OHA, 2025). Indeed, Oklahoma has

lost many rural hospitals since 2015 due to financial reasons (CHQPR, 2025). Compounding these structural financial concerns, Oklahoma's hospitals face unique population risks. The high uninsured rate in Oklahoma threatens the long-term vitality of rural hospitals, costing Oklahoma hospitals more than $663 million in uncompensated care annually. (OHA, 2021). The median uncompensated care ratio in Oklahoma is 5.37%, almost double the national average of 2.84%. Despite these financial risks, only 27 rural hospitals receive Medicaid Disproportionate Share Hospital (DSH) payments (OSDH, 2025a), leaving many facilities without monetary support. Financial resilience is crucial to maintaining quality care, especially in rural facilities where patient volumes are low and operational costs remain high. Across CAHs, Oklahoma sees 9,700 staffed beds, 395,592 total discharges, and 1,894,177 total patient days annually. Each full-time provider, including physicians, Nurse Practitioners, Physician's Assistants, and Certified Nurse Midwives, serves on average 277 patients per year, driven by significant barriers to care. Together, these patterns create a fragile system characterized by limited economies of scale and constrained financial flexibility.

Target Populations and Geographic Area: An infusion of funding will directly strengthen Oklahoma's rural health care system by bridging funding gaps across a wide range of rural communities and provider types in the State's 59 rural counties, as defined by the Oklahoma Office of Rural Health and consistent with HRSA rural designations—a large portion of Oklahoma that stands to benefit from the RHT Program. Maternal, elderly, Tribal populations, and those experiencing chronic conditions are among those who will benefit the most. For example, maternal and child populations will directly benefit from increased access. Over half of Oklahoma's 77 counties have no hospital or birth center with obstetrics (OB) services, one of the worst rates in the U.S. (Anderson, 2024). Oklahoma's population in need of long-term care, including elderly Oklahomans, will also stand to benefit. Rural Oklahomans require long-term care at higher rates than their urban counterparts and face greater barriers to obtaining it, making expanded access especially impactful. A third population that RHT Program funds in Oklahoma will target are those in need of care for

chronic conditions including obesity, diabetes, behavioral health conditions, and related comorbidities. Rural Oklahomans with these common conditions are frequently unable to get care, resulting in higher costs to a strained rural health care system. Across each of these populations, increased funding for the rural healthcare ecosystem will have a transformational impact on healthcare quality, access, and outcomes, creating a healthier future for Oklahomans.

Case for Change: Across every indicator—demographic, clinical, access, and financial—rural Oklahomans experience deeper and more persistent disparities than their urban peers. The data reveals a system that is overextended, under-resourced, and at risk of further decline without coordinated investment. Yet the State's existing networks of Tribal, State, and community partners, combined with expanding telehealth capacity and strong rural engagement, provide a foundation for change. The RHT Program offers the means to build on these strengths, stabilize the rural health infrastructure, and realign care toward prevention, coordination, and long-term sustainability.

2. Rural Health Transformation Plan: Goals and Strategies

Vision for RHT: Oklahoma envisions a future where every community—no matter how small or remote—has access to high-quality, locally grounded care that is connected through technology, supported by regional collaboration, and sustained by a strong rural workforce. In this future, data flows securely across systems, helping providers make timely, informed decisions. Rural healthcare will be financially stable, powered by innovation, and resilient for generations to come.

Oklahoma's high rurality, combined with poor health outcomes, limited access, and fragile facility funding, makes the State an ideal candidate for RHT support. Rural communities face intertwined challenges that affect access, quality, and sustainability of care. Persistent workforce shortages—particularly among nurses, OB/GYNs, and specialty providers—restrict service availability. Residents often travel long distances across underdeveloped transportation networks to reach care, while low patient volumes and

aging infrastructure strain provider viability. Together, these barriers contribute to high rates of unmanaged chronic disease and underscore the urgent need for transformation through the RHT Program.

RHT Program Core Strategies and Statutory Alignment: To realize this vision, Oklahoma's RHT Program is organized into six interrelated initiatives that together address the key barriers to access, quality, and sustainability in rural health care. Each initiative aligns with the State's strategic pillars and directly supports the required elements outlined in 42 U.S.C. 1397ee(h)(2)(A)(i)—including access, outcomes, technology, partnerships, workforce, data-driven solutions, financial solvency, and identification of the causes of rural hospital closures. The following RHT Program Concept Alignment Matrix presents these six initiatives, showing their descriptions, alignment with CMS strategic goals, and correspondence to statutory requirements.

RHT Program Concept Alignment Matrix			
Initiative	**Description**	**Strategic goals alignment**	**RHT Program Statute Requirements**
Innovating the care model	Oklahoma will expand access to care, bridging challenges presented by geography and provider distribution, by bringing necessary care to rural residents and bringing rural residents to care. This initiative will improve access to care connections and provision of care, while enhancing core enablers to care, such as tele-connection for specialty care, expanded transport, and expanded community care.	Make rural America healthy again, Tech innovation	**Improving access:** Expands telehealth and transportation networks to rural residents **Improving outcomes:** Reduces care delays, improves maternal, chronic, and acute outcomes through timely access to specialty and emergency care **Technology use:** Deploys tele-consults, remote monitoring devices, and technology-enabled workflows **Partnerships:** Partners with hospitals with clinics for coordinated specialty access **Workforce:** Trains community paramedics and doulas to extend provider capacity **Data-driven solutions:** Uses digital reporting tools and shared data on service use and outcomes **Financial solvency strategies:** Technology cooperative allows PCPs and Behavioral Health (BH) providers to benefit from joint purchasing agreements for needed tools remote patient monitoring (RPM), telehealth, AI-enabled clinical documentation **Cause identification:** Addresses geographic isolation, lack of specialty access, and outdated healthcare technologies that limit care availability in rural communities
Moving upstream	Oklahoma will address preventable chronic conditions through proactive, community-driven prevention, and management programs. This	Make rural America healthy again, Innovative care	**Improving access:** Expands access to chronic disease prevention, wellness hubs, and remote monitoring for rural residents **Improving outcomes:** Reduces preventable hospitalizations and complications from chronic conditions

RHT Program Concept Alignment Matrix			
Initiative	**Description**	**Strategic goals alignment**	**RHT Program Statute Requirements**
	includes a chronic disease management program supported by consumer-facing technology, remote monitoring, and AI-enabled analytics, as well as community-led population health networks organized through wellness hubs that connect residents and local health departments to determine social determinants of health.		**Technology use:** Leverages RPM, AI-based screening, and consumer-facing digital platforms, demonstrating ROI for path to sustainable funding **Partnerships:** Establishes community-led hubs linking Community-Based Organizations, public health, and local health departments via centralized platforms **Workforce:** Builds capacity of and recruits Community Health Workers (CHWs) in hospital settings **Data-driven solutions:** Develops analytics for chronic disease tracking and community-level outcomes **Financial solvency strategies:** Transitions successful pilots into billable models that reduce total cost of care **Cause identification:** Tackles root causes of preventable chronic disease through early intervention, wellness promotion, and social determinant screening
Facilitating regional collaboration	Oklahoma will strengthen regional coordination across hospitals, clinics, EMS, and community organizations through new multicounty regional collaboratives that share data and operational resources. This includes a shared platform for data reporting, right sizing, and an EMS communications and logistics network for real-time dispatch and education. Collectively, these networks will improve efficiency, expand local service capacity, and reduce duplication of effort.	Sustainable access, Innovative care	**Improving access:** Expands multicounty service networks and shared EMS coordination **Improving outcomes:** Improves patient outcomes through regional specialty access and coordinated emergency response **Technology use:** Employs shared platforms for data reporting and communication **Partnerships:** Creates formal regional collaboratives and multicounty governance models **Workforce:** Supports leadership and cross-training within partner networks **Data-driven solutions:** Aggregates regional data to guide resource allocation and population health efforts **Financial solvency strategies:** Promotes cost sharing and operational efficiencies that reduce duplication and stabilize finance **Cause identification:** Addresses fragmentation of rural care systems and financial instability caused by operating in isolation
Shifting to value	Oklahoma will establish financial assistance and transition programs that stabilize rural health facilities and incentivize adoption of value-based payment models. This initiative addresses the root causes of rural hospital instability—low patient volume, payer mix, uncompensated care—by supporting both short-term solvency and long-term reform.	Sustainable access, Innovative Care	**Improving access:** Maintains rural access by stabilizing facilities through incentive and value-based programs **Improving outcomes:** Rewards improved quality and reduced avoidable utilization **Technology use:** Uses data systems to monitor quality metrics and payment performance **Partnerships:** Coordinates across providers, payors, and Accountable Care Organization (ACOs) for integrated value-based care **Workforce:** Offers provider support Technical Assistance on value-based and risk-sharing arrangements **Data-driven solutions:** Tracks outcomes, costs, and performance through standardized data reporting **Financial solvency strategies:** Transitions facilities to sustainable value-based payment models and strengthens financial solvency

RHT Program Concept Alignment Matrix			
Initiative	**Description**	**Strategic goals alignment**	**RHT Program Statute Requirements**
			Cause identification: Addresses low patient volumes, high uncompensated care, and dependence on fee-for-service payments that drive closures
Growing next generation rural talent	To build a sustainable workforce pipeline, Oklahoma will expand rural residency programs and rotations, establish provider incentive programs for rural service commitment, and launch "Grow Your Own" initiatives targeting high school and community-college students. Training opportunities will include certification and upskilling for existing rural clinicians, particularly advanced practice providers. These actions will reduce care deserts, shorten wait times, and ensure long-term rural retention.	Workforce development	**Improving access:** Expands access through new rural residencies, relocation incentives, and local training pipelines **Improving outcomes:** Improves health outcomes by addressing provider shortages and expanding service reach **Technology use:** Uses virtual learning and tele-education for training and supervision **Partnerships:** Aligns educational institutions, hospitals, and communities in "Grow Your Own" programs **Workforce:** Expands and retains the rural clinical workforce through expanded rural residencies and relocation incentives **Data-driven solutions:** Tracks workforce distribution and retention using State data dashboards **Financial solvency strategies:** Strengthens provider stability by reducing staffing gaps and reliance on costly locum coverage **Cause identification:** Addresses rural workforce shortages, lack of specialty providers, and outmigration of clinicians
Building health data utility	Oklahoma will create a connected rural health data ecosystem by expanding electronic health record (EHR) reach and capabilities, improving interoperability through Health Information Exchange (HIE) enhancement, and developing integrated analytics, and cybersecurity infrastructure. These upgrades will enable real-time information exchange between rural and urban providers, reduce duplicative testing, and support data-driven quality improvement and decision making statewide.	Tech innovation	**Improving access:** Enables seamless patient data exchange across urban and rural settings, improving care continuity **Improving outcomes:** Reduces duplicative tests and delays, leading to better diagnostic accuracy and follow-up **Technology use:** Expands EHR reach, HIE interoperability, and cybersecurity readiness statewide **Partnerships:** Connects providers, health systems, and State agencies through shared data platforms **Workforce:** Supports training on health IT use for rural clinicians and staff **Data-driven solutions:** Builds integrated analytics to support outcome measurement and quality improvement **Financial solvency strategies:** Improves efficiency and billing accuracy through unified digital infrastructure **Cause identification:** Closes data gaps, enabling informed decisions that improve efficiency, quality, and financial health in rural systems

Program Key Performance Objectives: By the end of the five-year RHT Program (FY 2026-FY 2030), Oklahoma will achieve measurable improvements in access, outcomes, technology use, partnerships, workforce, data-driven solutions, financial solvency strategies, and cause identification.

Key performance objectives include:

- **Access:** Expand number of rural residents treated via telehealth and number of trained community paramedics and doulas in rural counties, while increasing preventive visit completion rates in communities with coordinated transportation by 20%.
- **Outcomes:** Achieve a measurable reduction in preventable hospitalizations and emergency department visits year over year.
- **Technology use and data-driven solutions:** Connect 75% of rural providers to EHR system, reduce duplicate testing rates by at least 15% through HIE interoperability, and reduce provider documentation time by 20% through the Technology Cooperative.
- **Partnerships and financial solvency:** Establish a statewide Clinically Integrated Network (CIN) and centralized EMS platform, achieving 20% administrative savings and faster emergency response times.
- **Workforce:** Launch six new rural residencies, recruit 30 rural providers (including 10 in behavioral health), and train at least 60 community paramedics and 30 doulas annually.
- **By FY2031, all initiatives will operate on sustainable funding models**—through billable services, payer reimbursement, cost sharing, or braided public and private funding—ensuring long-term access, stronger outcomes, and a more resilient rural healthcare system for Oklahoma.
- **Strategic Pillars and Alignment with CMS Goals** Oklahoma's RHT organizes initiatives into six strategic pillars that reflect our rural communities' core needs and align with the five CMS stated strategic goals as shown in the following table.

Oklahoma RHT Program Alignment with CMS Five Strategic Goals			
Oklahoma RHT Strategic Pillar		**CMS Five Strategic Goals Met**	
Innovating the Care Model	Deploy care delivery models that expand preventive, primary, and specialty care to rural residents through expanded care teams, telehealth, and transportation supports.	**Goal 1** Make Rural America Healthy Again **Goal 5** Tech Innovation	Improve access and outcomes; modernize delivery through technology and new payment models.
Moving Upstream	Invest in prevention and management of chronic conditions and wellness initiatives, including expanded connections to care, consumer-facing technology, and chronic disease prevention and management.	**Goal 1** Make Rural America Healthy Again **Goal 4** Innovative Care **Goal 5** Tech Innovation	Promote preventive healthcare and address root causes of disease; integrate innovative models and technology.
Facilitating Regional Collaboration	Invest in a statewide rural regionalization plan, including prioritizing shifts in care models, development of a rural-based Clinically Integrated Network (CIN), and centralized EMS capabilities.	**Goal 2** Sustainable Access **Goal 4** Innovative Care	Strengthen provider infrastructure and enhance local and regional partnerships.
Shifting to Value	Enable value-based payment paths for primary care and behavioral health through practice enablement and clinical extension pilots and expand Program of All-Inclusive Care for the Elderly (PACE) for dual-eligibles.	**Goal 2** Sustainable Access **Goal 4** Innovative Care	Improve outcomes and financial sustainability through value-based care models.
Growing the Next Generation of Rural Talent	Build recruiting pipelines through 'Grow Your Own' programs and incentives for rural practice.	**Goal 3** Workforce Development	Expand and retain a highly skilled rural healthcare workforce.
Building Health Data Utility	Expand access to, use of, and uses for the State HIE through investment in base technology (EHR, interoperability, and analytics).	**Goal 5** Tech Innovation	Ensure efficient, data-driven care delivery through technology innovation.

Legislative or Regulatory Action

Oklahoma recognizes that sustainable RHT requires enabling policy and regulatory change. Under the RHT Program, the State will advance targeted legislative and regulatory actions to improve access, strengthen the workforce, and promote financial sustainability. The tables below summarize current

policies, planned actions, and timelines aligned with Notice of Funding Opportunity (NOFO) technical score factors to achieve measurable improvements by 2027–2028.

Oklahoma RHT Legislative and Regulatory Action Commitments				
Technical score factor	**Current state**	**Future policy commitments**	**Timeline to achieve future policy**	**Impact of future policy**
B.2 – Health and Lifestyle	No policy currently reinstating the Presidential Fitness Test. However, HB 1938 / HB 1493 (passed House; pending Senate Education Committee) require districts to conduct annual fitness assessments beginning SY 2025–26 and to require physical activity into school.	Oklahoma will pursue legislation reinstating the Presidential Fitness Test aligned with Executive Order 14327	Legislation reinstating the Presidential Fitness Test will be passed by **December 31, 2028**. Related fitness and activity legislation is currently advancing.	Reinstating the Presidential Fitness Test promotes early, lifelong engagement in physical activity, especially in rural communities. Embedding health and fitness education in schools supports prevention of obesity, diabetes, and cardiovascular disease.
B.3 – Supplemental Nutrition Assistance Program (SNAP) Waivers	Oklahoma has an approved USDA SNAP Food Restriction Waiver restricting the purchase of soft drinks and candy with SNAP benefits, effective January 1, 2026.	N/A	N/A	N/A
B.4 – Nutrition Continuing Medical Education (CME)	Oklahoma has no requirements.	Oklahoma will pursue legislative change by the implementation deadline	Legislation requiring nutrition-related CME will be passed by **December 31, 2028.**	Requiring and enforcing nutrition-related CME in Oklahoma could significantly improve rural health outcomes by equipping primary care providers with tools to identify and manage nutrition-related conditions. This improves access by expanding nutrition care within existing clinics, enhances quality by promoting consistent, guideline-based treatment for chronic diseases like diabetes and hypertension, and lowers costs by preventing complications, which can lead to increased health care utilization, including hospital admissions, and reducing medication dependence.
C.3 – Certificate of Need (CON)	Long-term care facilities are the only category still requiring a CON. HB 2330 (effective May 6, 2024) repealed the Psychiatric and Chemical Dependency Facility CON Act. Current Cicero Institute CON score is 20/100 and expected to improve to 5/100.	N/A	N/A	N/A
D.2 – Licensure Compacts	Licensure Compact is fully enacted in Oklahoma.	N/A	N/A	N/A
D.3 – Scope of Practice	**PA:** HB 2584 (effective Aug 28, 2025) removes practice-agreement requirements	N/A	N/A	N/A

Oklahoma RHT Legislative and Regulatory Action Commitments				
Technical score factor	**Current state**	**Future policy commitments**	**Timeline to achieve future policy**	**Impact of future policy**
	for PAs with >6,240 hours; SB 1915 (2020) allows direct pay; PA representation on Medical Board. **NP:** HB 2298 (effective Nov 1, 2025) grants independent prescriptive authority after 6,240 hours; under Oklahoma Board of Nursing **Pharmacy:** SB 398 (effective 2021) allows pharmacists to administer any FDA approved or authorized immunization "without a patient-specific prescription, standing order, or similar arrangement."			
E.3 – Short-Term, Limited-Duration Insurance (STLDI)	Oklahoma allows STLDI plans with a maximum initial contract term of 12 months and a total coverage period of 36 months — less restrictive than federal limits of 3 and 4 months respectively	N/A	N/A	N/A
F.1 – Remote Care Services	Oklahoma complies with 4 of 5 policy measures: Live Video, Store and Forward, RPM, Telehealth License/Registration Process.	N/A	N/A	N/A

Legislative or Regulatory Action Sources				
Factor	**Policy / Legislative Source**	**Citation / Description**	**Attachment or Link to Statue**	**Status / Notes**
B.2 – Health and Lifestyle	HB 1938 and HB 1493	Enacted 2025	**HB 1938:** https://www.oklegislature.gov/cf_pdf/2025-26%20ENGR/hB/HB1938%20ENGR.PDF **HB 1493:** https://www.oklegislature.gov/cf_pdf/2025-26%20ENGR/hB/HB1493%20ENGR.PDF	Legislative actions supporting statewide physical activity initiatives
B.3 – SNAP Waivers	SNAP Waiver Policy	Current State Policy Document	**SNAP Waiver Policy:** https://www.fns.usda.gov/snap/	Administrative policy maintaining existing waiver program

Legislative or Regulatory Action Sources				
Factor	**Policy / Legislative Source**	**Citation / Description**	**Attachment or Link to Statue**	**Status / Notes**
			waivers/foodrestriction/oklahoma	
B.4 – Nutrition CME Requirements	N/A	N/A – No existing policy; commitment to change	**None**	Legislative action commitment
C.3 – Certificate of Need	HB 2330	Enacted 2024	**HB 2330:** https://www.oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/protective-health/hrds/health-facility-systems/HB2330%20ENR.pdf	Modernizes facility planning requirements for rural areas
D.2 – Licensure Compacts	Interstate Medical Licensure Compact	59 O.S. § 493.7 (Enacted 2019)	**59 O.S. § 493.7:** https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=486080	IMLC Member State serving as SPL
	Nurse Licensure Compact	59 O.S. § 567.21 (Enacted 2016)	**59 O.S. § 567.21** https://url.us.m.mimecastprotect.com/s/5wgKC0R94vtglgQQXc3uJu9EI5T	NLC Member State
	EMS Compact	63 O.S. § 1-2550 et seq. (Enacted 2023)	**63 O.S. § 1-2550 et seq.** https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=494684	EMS Compact Member State
	Psychology Interjurisdictional Compact	59 O.S. § 1377 et seq. (Enacted 2019)	**59 O.S. § 1377 et seq.** https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=485534	PSYPACT Participating State
	Physician Assistant Licensure Compact	59 O.S. § 545.1 et seq. (Enacted 2024)	59 O.S. § 545.1 et seq.	PA Compact Member State

Legislative or Regulatory Action Sources				
Factor	**Policy / Legislative Source**	**Citation / Description**	**Attachment or Link to Statue**	**Status / Notes**
			https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=538586	
D.3 – Scope of Practice	SB 398, HB 2584, HB 2298	Enacted 2024 – 2025 Sessions	**SB 398 attached** **HB 2584:** https://www.oklegislature.gov/cf_pdf/2025-26%20ENR/hB/HB2584%20ENR.PDF **HB 2298:** https://www.oklegislature.gov/cf_pdf/2025-26%20ENR/hB/HB2298%20ENR.PDF	Legislative actions expanding practice authority for select professions
E.3 – Short-Term, Limited-Duration Insurance	36 O.S. § 4419 (OSCN 2025)	Codified State Law	**36 O.S. § 4419** https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=485745	Current statute governing short-term health plans
F.1 – Remote Care Services	Telehealth Policy	Current State Policy Document	**Attached**	Defines telehealth standards and provider eligibility for rural care

Required State Data Submissions		
Data	**Description / Content**	**Format**
A.2 – Certified Community Behavioral Health Clinics (CCBHCs) **Attached as "A.2 2025 CCBHC Data Submission"**	Most current list (as of Sept 1, 2025) including every active site and address. **Note:** All of Oklahoma's CCBHC sites were under demonstration as of Sept 1, 2025, so are marked "Y" per form instructions. However, the demonstration ended for Oklahoma on Sept 30, 2025, so as of application submission, none of Oklahoma's sites are under demonstration. Community Based Structured Crisis Centers (CBSCCs), CCBHC satellite sites, were also included in final list.	PDF
A.7 – Medicaid Disproportionate Share Hospital (DSH) Payments **Attached as "A.7 2025 DSH Allocation"**	Most recent State plan rate year report.	PDF

E.2 – Individuals dually eligible for Medicare and Medicaid	• Medicare-Medicaid dual enrollees include both full-and-partial-duals (Medicare Monthly Enrollment Data) • Integrated plan enrollment: At least one integrated plan exists (e.g., PACE) today with individuals enrolled with • Two identified primary contacts regarding dually eligible individuals: David Ward (david.ward@okhca.org) and Kristen Booth (kristen.booth@okhca.org) of OHCA	N/A
F.2 – Data Infrastructure Attached as "F.2 TMSIS Portal Communication"	Oklahoma believes that the fix communicated to CMS in Sept. 2025 (see Attachment, "F.2 TMSIS Portal Communication), will solve expenditure issue 598 and has solved high priority issues 507 and 542. Oklahoma is actively working to solve open critical issue 602.	PDF

Oklahoma's RHT Program fulfills all statutory elements outlined in 42 U.S.C. 1397ee(h)(2)(A)(i) and fully aligns with CMS's five strategic goals. Each of the six strategic pillars contributes to improving access and outcomes, expanding technology use, strengthening partnerships, developing the workforce, advancing data-driven solutions, and promoting financial stability. Together, these initiatives form a unified, data-driven, and sustainable framework designed to transform rural health care across Oklahoma—ensuring equitable access, resilient systems, and improvements in the health and well-being of rural residents.

3. Proposed Initiative and Use of Funds

Oklahoma's six proposed initiatives translate the State's RHT Program into targeted, measurable actions. Each initiative aligns with the CMS strategic goals and statutory elements in 42 U.S.C. 1397ee(h)(2)(A)(i)—advancing access to care, technology adoption, workforce development, financial stability, and regional collaboration. The following section details each initiative's objectives, use of funds, key stakeholders, expected outcomes, and estimated funding. Approximately $65M over 5 years will be spent on cross-initiative fund uses. All estimates are based on the CMS recommendation to build toward approximately $200M annual budget, and OSDH is prepared to scale the funding allocation in alignment with the total award amount.

INITIATIVE 1: Innovating Care Models

Description

This initiative will increase access to primary and specialty care in rural communities through expansion of digital solutions, transportation support, and expansion of the non-physician workforce.

Fund use: Telestroke Expansion
Stroke treatment is highly time sensitive. Rural hospitals in Oklahoma often lack onsite neurologists and rapid access to stroke specialists. Establishing a statewide telestroke network ensures that rural patients receive expert diagnosis and treatment within critical time windows. This fund use will enable real-time neurological consultations, improve transfer coordination, and increase the number of acute stroke-ready facilities across rural Oklahoma.

Use of Funds
- Acute stroke-ready certification and initial licensing fees for rural hospitals
- Training and technical assistance to hospital staff on stroke protocols, telestroke workflow integration, and use of telehealth platforms
- Vendor and connectivity costs to ensure system reliability and integration with existing telehealth infrastructure
- Staffing costs to coordinate telestroke connection to rural hospitals
- Program monitoring and reporting on utilization, quality, and cost savings

The path toward sustainability is that all services are reimbursable. Setting up telehealth involves high upfront equipment and software costs, but ongoing maintenance costs are low compared to revenues, ensuring financial sustainability past the funding period.

This fund use is administered by OSDH.
Fund use: MFM Telehealth Expansion
High-risk pregnant women in rural Oklahoma face long travel times and limited access to Maternal–Fetal Medicine (MFM) specialists, nearly all of whom are located in Oklahoma City. This initiative will expand the reach of MFM specialists through a tele-MFM network connecting rural hospitals, clinics, and county health departments. By equipping rural sites with connected ultrasound technology and telehealth capacity, patients can receive specialty consultations, imaging review, and care coordination locally. This fund use will improve maternal outcomes and reduce transfers and complications

Funds will be used for:
- Purchase and deployment of telehealth and ultrasound equipment at rural sites
- Training / upskilling local sonographers, nurses, and coordinators to support tele-MFM workflows
- Integration with EHR systems for secure imaging and data sharing
- Technical assistance and IT support for connectivity, maintenance, and troubleshooting
- Care coordination staffing, including ultra sonographers, case managers, and perinatal navigators
- Program monitoring to track utilization, access, and maternal health outcomes.

The path to sustainability is that MFM services are billable; the State will also ensure that telehealth policies are in place to allow provider uptake.
This fund use is administered by OSDH.

Fund use: Remote Patient Monitoring (RPM): Maternal
Studies show that RPM for conditions like hypertension during pregnancy can reduce readmissions and improve chronic disease management during pregnancy. Currently, Oklahoma covers continuous glucose monitoring, but not blood pressure cuffs. Oklahoma has multiple high-risk OB programs overseen by OHCA (Medicaid) that could benefit from targeted RPM programs with blood pressure cuffs including the High-Risk Obstetrical Care Management (HROB), TMAH Model, and other State center of excellence models, including the MFM expansion model which will be built as part of the RHT Program.

The funds will be used for:
- Purchase and distribution of connected blood pressure cuffs for high-risk OB patients
- Integration of remote monitoring data into EHR systems for MFM providers and rural OB/GYNs
- Technical assistance, IT support, and staffing to manage monitoring programs
- Provider and patient education for remote hypertension management
- Program monitoring on maternal health outcomes and scalability of RPM models

Funding will be used to expand pilots for maternal health RPM. The path to sustainability is to incorporate as a billable service through Medicaid and other payers given strengthened demonstrated effectiveness.

This fund use is administered by OHCA.

Fund use: Transportation Expansion
Oklahoma is one of the most rural states in the country, so residents often need to travel up to 50 miles. This distance is exacerbated by variable weather, geography including steep hills, and limited thoroughfares including one region connected to the state by a single bridge. The high transit burden is unaffordable and inaccessible for many residents, leading to escalation of chronic or treatable conditions into expensive acute traditions. This fund use applies funds to extend current pilots in Southwest Oklahoma to the rest of the State on a regional model, closing the transit affordability and availability gaps.

The funds will be used for:
- Licensing, hosting, and deployment of a low-bandwidth ride dispatch and scheduling platform connecting clinics, drivers, and patients
- Recruitment and initial compensation for regional mobility navigators and mileage / secondary reimbursement for the volunteer driver programs
- Regional coordination and interagency agreements for shared governance, reporting, and data dashboards
- Partial vehicle purchase funding for rural transportation agencies
- Initial hardware, licensing, and implementation for low-bandwidth dispatch platform that can integrate volunteer drivers, track mileage, schedule rides across agencies, and track driver / ride metrics

The path toward sustainability is for pilots to demonstrate value and support for shift to braided funding that integrates streams including Medicaid, Federal Transit Administration (FTA) Sections 5310 and 5311, the U.S. Department of Veterans Affairs (VA), Tribal transit, hospital operations, workforce boards, and philanthropy.
This fund use is administered by Oklahoma Association of Regional Councils (OARC).

Fund use: Expanding care:
Oklahoma, like many states, struggles to attract physicians to rural areas, which limits access for rural residents. By enhancing the clinical capability of non-physician professionals, rural Oklahoma will be able to better meet patient needs, reduce wait times, and sustain access to preventive and primary care close to home.

Community Paramedicine
The funds will be used for:
- Establishment of training programs for community paramedics
- Technical assistance and curriculum development, including educational materials
- Funding for vehicle and supply purchases for community paramedicine teams
- Creation of an uncompensated care fund to reimburse community paramedicine services until payer coverage is established
- Program monitoring and support for inclusion of services into Medicaid and commercial reimbursement models

Doulas
The funds will be used for:
- Establishment of training programs for doulas
- Technical assistance and curriculum development, including educational materials
- Creation of an uncompensated care fund to reimburse doula services not currently reimbursed today
- Program monitoring and support for inclusion of services into Medicaid and commercial reimbursement models

The path toward sustainability is to continue training through private funding (e.g., additional Masonic Foundation grants). Additionally, demonstrated value will put community paramedicine and doulas on the path toward becoming a billable service through expanded care coverage.
This fund use is administered by OSDH.

Fund use: Behavioral Health Integration in Primary Care
Oklahoma was one of the first states to convert all Community Mental Health Centers (CMHC) into CCBHCs and has made significant progress in ensuring Substance Use Disorder (SUD) treatment is an emphasis of BH treatment across the State. However, significant gaps persist, specifically around inpatient SUD treatment, integrated BH and SUD treatment in primary care settings, and SUD treatment during pregnancy. Currently Oklahoma only has 10 Opioid Treatment Providers in the State.

The funds will be used for:

- Convening of existing BH and PCP providers interested in upskilling or recruiting PCP providers to prescribe Medication Assisted Treatment (MAT) in a PCP setting and / or setting up a comprehensive hub and spoke MAT model
- Program design, procurement development, and program selection
- Provider training / recruitment
- [Optional for hub and spoke] telehealth connectivity for hub and spoke providers, PCP provider training, and wraparound care staff for hub and spokes

In an effort to promote team-based integrated care, this fund use will expand access to MAT at the primary care clinical level. Because MAT is billable through most payers, after startup funding, this fund is use is self-sustaining.
This fund use is administered by OSDH.

Fund use: Technology Cooperative for PCPs and BH providers
Many independent rural primary care and behavioral health providers in Oklahoma lack the bargaining power or technical resources to afford modern digital tools such as RPM, telemedicine platforms, or AI-assisted clinical documentation. This fund use will establish a statewide technology cooperative that leverages group purchasing to provide lower-cost access to these tools, along with shared implementation and technical support.

Funds will be used for:
- Establishment of technology cooperative: governance, membership structure, and eligibility criteria for rural primary care and behavioral health providers.
- Stand up of group purchasing contracts for approved RPM devices, telehealth platforms, and AI-enabled clinical documentation tools.
- Initial implementation costs for small and rural clinics, including licensing fees, user setup, and connectivity support.
- Statewide training and helpdesk support for installation, configuration, and workflow integration of new technologies.
- Program monitoring to collect utilization, satisfaction, and performance data to assess savings, adoption rates, and improved clinical efficiency

The path to sustainability is that providers will pay applicable dues to maintain membership offset by cost benefits gained through purchasing negotiation.
This fund use is administered by OSDH.

Fund use: School-Based Health Services with Focus on Behavioral Health
Currently Oklahoma schools are only able to bill Medicaid for students on Individualized Education Programs. Additionally, Oklahoma received a CMS grant to pilot and develop school services for $2.5 M over three years. Building on this initial momentum, Oklahoma is currently working on a State Plan Amendment (SPA) for expanding school-based services for submission to CMS. Schools are an ideal location for integrated services for youth and families, but setting up Medicaid billing, hiring providers, and developing clinical flows requires a significant amount of upfront resources that rural schools may not be able to front. This fund use will help provide initial funding and technical assistance for schools interested in providing Medicaid services.

Funds will be used for:
- Technical assistance for developing administrative functions like Medicaid billing
- Initial recruitment costs for some of the needed clinical staff like: nurses, schools, counselors, physical therapists, clinical resources may be shared
- Platforms and tech needed to track and bill services

This will be a limited time investment as schools will be up and running with Medicaid billable services and will become self-sustaining after stand up investment.
This fund use is administered by Oklahoma State Department of Education (OSDE)

Main strategic goal: Make Rural America Healthy Again, Tech innovation			
Use of funds	A, B, C, D, E, F, G, H, I, K	**Technical score factors**	B1, B2, C1, F1, F2, F3
Key stakeholders: Rural hospitals, FQHCs, Rural Health Clinics, Community-Based Clinics, County Health Departments, and local public health agencies, EMS agencies, Career and Technical Education partners, payers, academic medical centers, community-based organizations, philanthropic foundations			

Outcomes
- # of hospitals connected w/ telestroke equipment
- # of hospitals accredited as telestroke ready

- # of stroke incidents addressed via telehealth
- Increase in # of people to whom thrombolysis medication was administered to appropriately
- Monitor door to needle time for thrombolysis and door in door out times
- # of "spoke" clinics providing telehealth MFM visits
- # of patients seen via telehealth, # of visits
- Patient and provider satisfaction for MFM expansion
- Reduction in the # of in-person trips enrolled patients take to see an MFM specialist
- # of appropriate birth plans with needed supports matching risk of delivery
- Reduced negative outcomes: infant and maternal mortality and morbidity, low birth weight
- Number of participants for RPM: maternal health
- Increase in preventive care visit completions in coordinated communities by 20%
- Decreased canceled ride percentage in coordinated communities
- Driver retention across regions to be at least 75%
- Tracking of number of appointments which would have been missed without transportation
- Increased number of counties with community paramedics
- Number of people treated via community paramedicine, number of home visits, etc.
- Decline in rate of ED utilization in counties with community paramedics
- Number of Doulas trained to practice in rural counties
- Number of Doulas registered as Medicaid providers

Impacted counties: All rural counties: See Appendix for Federal Information Processing Standards (FIPS) codes

Estimated funding required:
Estimated funding for this initiative is ~$150M over 5 years

Initiative 2: Moving Upstream

Description
Oklahoma ranks 47th nationally in overall health (AHR, 2024) with chronic disease driving much of this burden. Rural Oklahomans experience colon cancer in 1.2x national rates, obesity at 1.2x national rates, diabetes death at 1.4x national rates, and smoke at 1.6x national rates (with rural males using smokeless tobacco at 3x national rates) (OSDH, 2022). This initiative focuses on how the State can empower individuals and their communities to build toward a healthier Oklahoma through access to innovative, consumer-focused technologies grounded in local community assets. This initiative will support (1) underlying community connection technology infrastructure to support resource connection within local communities, (2) piloting, and scaling as warranted, chronic disease management programs and consumer-facing technology for chronic disease and behavioral health prevention and management, (3) expansion of community-based wellness initiatives including Community Health Worker (CHW) expansion, wellness hub development and Presidential Fitness Test reinstatement, and school-based services and (4) expanding lung cancer screening to attrit one of the leading causes of chronic disease in Oklahoma.

Fund use: Closed-Loop Community Care Platform
Closed-loop community care platforms support connections to community-based resources for food, housing, utilities, behavioral health, and transportation needs. These platforms help providers, care coordinators, and community partners track referrals, outcomes and health-related social needs in real time and serve as shared infrastructure backbone to support the other elements of the initiative above. Oklahoma has implemented a closed-loop community care platform covering 4,800 distinct programs (incl. medical care, utilities, food support, etc.). The platform has completed 125K referrals since going live in May of 2024. This initiative will extend the use of the platform to local health departments and rural providers who are not yet connected.

The funds will be used for:
- Extension of platform licenses to 39 CAH, 4 rural emergency hospitals, and 68 county health departments
- Startup costs associated with connecting new organizations into platform
- Collection and aggregation of data from the platform to inform needs and resources in the community

The platform will transition to sustainability through State Medicaid administrative claiming and participating payer (and as needed, organization) subscriptions.
This fund use will be administered by OHCA.

Fund use: Chronic Disease Management Programs

While Oklahoma experiences challenges from chronic disease, the rich community environment of Oklahoma has supported success of community-responsive chronic disease programs in State. Oklahoma has seen success combating chronic disease by rolling out high-touch, evidence-based programs like Special Diabetes Program for Indians (SDPI) which has halved rates of end-stage renal disease and diabetic eye disease in 35 states including Oklahoma. The Chickasaw Nation has been lauded as a uniquely effective SDPI implementor. Homegrown interventions like the Total Wellness Program (TWP), a county health driven obesity program, has driven consistent results in target weight reduction (5% of bodyweight) and improved lipid panels. This initiative will build upon these successes by providing funding for evidence-based, community-focused chronic disease management programs. The State will provide strict guidelines on participant profiles, target geographies, and evidence-based program standards to ensure impactful use of funds.

The funds will be used for:
- Establishing a NOFO for competitive applications by community-led health and wellness programs for deployment of chronic disease management programs
- Awarding funds to select programs offering developed plans to address chronic disease in their community over a 2-2.5 year period
- Entities will use funds for startup costs for expanding chronic disease management programs including program design, staffing, equipment, education, participant recruitment, technical assistance, and maintenance

Other considerations:
- The State will provide strict guardrails for funded organizations, requiring identification of a chronic condition with >1x national average impact on rural Oklahoma, alignment with evidence-based programs and treatments, selection, measurement, and report of achievable outcomes, and prioritizing programs that innovate model delivery (e.g., that use consumer-facing tech)
- At a minimum, funded organizations will be required to set goals and track outcomes for retention, chronic condition improvement, and a reduction in complications from disease progression. Funded organizations may set additional metrics but will be required to track any set metrics
- This fund use incorporates Category J funds and is part of the capped 20% total

The programs will transition to sustainability by demonstrating Return on Investment (ROI) through a reduction in high-cost complications and follow-on treatment. Proven ROI chronic management programs will transition to payer supported models.
This fund use will be administered by OSDH

Fund use: Consumer-Facing Technology for Chronic Disease Prevention and Management and Behavioral Health
This initiative will pilot emerging technologies across consumer-facing prevention and management apps to support individuals in managing their own health journey, with particular focus on supporting maternal health, behavioral health, and the aging population (dual-eligibles). Consumer-facing prevention platforms directly engage individuals (and their caregivers) through app-based conversational AI assistants that provide coaching, reminders and education on daily habits like physical activity, proper nutrition, mental wellness practices, and care plan adherence, while also thoughtfully linking to clinical care teams. Aligned with CMS Health Technology Ecosystem criteria, these apps use personalized experiences and gamification, including incentives to drive engagement.

The funds will be used for:
- Convening stakeholders, including rural residents with chronic conditions, to further understand needs, and advise on potential consumer-facing technology to pilot
- Procurement of consumer-facing technologies by the State on behalf of payers, providers and community-based organizations
- Development of pilots including selection of partners to support rollout with member / patient base
- Awards for consumer participation in prevention and wellness programs
- Measurement of pilot success
- Further rollout of successful technologies

Other considerations:
- The State will play critical convener and assessor role in the process. Alongside an advisory council of rural residents, technologists, providers, payers, and experts in rural health, the State will align on proposed applications, geographies, and stakeholder partners to run pilots. The State will then fund the selected application vendors to initiate pilots and collect and share results.

The path to sustainability will be by demonstrating utility and ROI to be able to claim Medicaid and other payer billability for ROI-proven tech tools.
This fund use will be administered by OSDH.

Fund use: CHW Expansion into Hospitals

Peer states have shown significant impact by embedding CHWs in more settings – specifically hospital emergency rooms and community clinics – to support diversion from acute care settings and avoidance of more costly-spend. Arkansas experienced a 23.8% decrease in annual Medicaid spending reduction from a deployment of CHWs to connect individuals with long-term care needs with Medicaid home and community-based services. Similarly, Texas experienced an up to 15% decrease in ED visits among multivisit patients after embedding CHWs in emergency departments. Oklahoma has conducted limited pilots with CHWs embedded in local health departments to support care navigation and connection to resources, including behavioral health services, housing, and nutrition supports. These programs have demonstrated early success in increasing engagement with the health system and access to supportive services. However, these programs have not been expanded outside the limited setting of local health departments. This initiative will expand the use of CHWs in rural communities to further demonstrate effectiveness and expand coverage of CHWs across payer types. The ROI to expanded CHW use has been proven in other states; this initiative will demonstrate CHW utility in Oklahoma.

The funds will be used for:
- Recruiting and training CHWs from rural communities for deployment in local hospitals (incl. travel)
- Hiring and compensation of 30 additional CHWs to be deployed in hospitals across rural Oklahoma

Other considerations:
- Administrator will work with hospital partners to develop usage report for CHWs, ensure monitoring and reporting, and build sustainability model
- CHWs must be deployed to hospitals where each can support a full caseload to support effective outcome demonstration
- Administrator will set full caseload based on support intensity and setting

The programs will transition to sustainability through payer coverage for hospital-based CHWs.
This fund use will be administered by OHCA.

Fund use: Community-Led Wellness Hubs: Microgrants
Many of Oklahoma's rural communities are limited in their ability to acquire lasting healthcare assets that would dramatically improve healthcare. Many of these communities report demand for health needs including diagnostic tools or exercise and fitness equipment but cannot afford the initial capital outlay. This initiative will provide an opportunity for local health departments in Oklahoma's 59 rural counties to address localized needs to support upstream prevention activities. This program would be novel in Oklahoma but has some recent precedent to demonstrate efficacy. A grant used for community gardens in Wyoming showed significant increases in fruit/vegetable access (Hume, et. al., 2022). This fund use will allow local health departments to use their high community knowledge to address onetime community health needs and close identified health gaps barred only by lack of funds.

The funds will be used for:
- Establishing a NOFO against a pool of money for competitive applications by local health departments in Oklahoma's 59 rural counties
- Funds will be allocated for onetime purchases of up to $50K to address a demonstrated unmet wellness demand in the local department's community
- Funds will be used for single capital expenditures including technical equipment, minor renovations, supplies, or diagnostics

Other considerations:
- Only grants requesting items otherwise allowable through RHT will be considered. Grantees must demonstrate unmet demand by quantitatively showing health access or outcome impact from not having access to wellness infrastructure
- As a condition of grant funding grantees must agree to absorb all ongoing maintenance for acquired assets. Grantees must also agree to track and report improvements in health outcomes and/or access attributable to wellness infrastructure
- Grantees will be allowed to apply more than once but only once per year

This program will be sustainable as onetime microgrants for communities to invest in lasting wellness infrastructure.
This fund use will be administered by OSDH.

Fund use: Lung Cancer Screening
Oklahoma continues to experience disproportionately high rates of smoking and lung cancer, with new lung cancer cases occurring at 63.7 per 100,000 residents, compared to the national rate of 53.6. Rural communities in particular face barriers to early detection, treatment, and tobacco cessation services. Oklahoma has one of the lowest rates of lung cancer screening in the U.S. at 9% contributing to a higher-than-average lung cancer occurrence and morbidity rate. This initiative will expand comprehensive lung cancer

screening programs in rural areas to improve early diagnosis, connect patients to cessation support, and strengthen the long-term sustainability of screening services statewide. By expanding screening access this initiative will help decrease lung cancer's outsize impact on rural Oklahoma.

Funds will be used for:
- Embedding Lung Screening Program Directors (Advanced Practice Providers, PAs, or NPs) in 11 rural or regional health systems to establish and lead evidence-based lung cancer screening programs integrated with tobacco cessation.
- Development of billing and reimbursement systems to ensure long-term financial sustainability for screening services.
- Statewide program manager to coordinate implementation, evaluation, and dissemination of best practices.
- Technical assistance and data support for quality tracking, early detection rates, and program performance.

This program will be sustainable as onetime purchases of vehicles and equipment to expand mobile screening access. Screening will be sustainable long-term as a billable service through Medicaid and other payers.
This fund use will be administered by OSDH.

Presidential Fitness preparation funding
Although Oklahoma currently requires physical fitness testing for students in grades 4 and above, the State has an opportunity to strengthen its commitment to youth health by reinstating the Presidential Fitness Test as a statewide wellness benchmark and providing support to teachers and students to achieve success. This fund use will expand fitness and wellness programming in rural schools by providing equipment for schools, an interactive cardio- and walking-focused app for students, and professional development for physical education teachers, ensuring that every student—regardless of geography—has access to quality physical education and the resources needed to build lifelong healthy habits.

Funds will be used for:
- Reimbursement for physical education equipment for rural schools that have not previously received OSDE or Tobacco Settlement Endowment Trust (TSET) wellness funding. Priority will go to exercise equipment that supports the metrics evaluated in the Presidential Fitness Test
- Professional development and virtual training opportunities for physical education teachers to prepare students for the updated test and strengthen overall school-based fitness instruction
- Program development and primary application development to develop a cardio- and walking-focused fitness application for students
- Statewide program manager to oversee reimbursements, partnerships, and outcome reporting.

This program will be sustainable as onetime funding for app development and for supporting physical education departments within schools with the supplies and programmatic support needed to prepare students for and conduct the Presidential Fitness Test. Ongoing application maintenance can be sustained through Oklahoma TSET funding or fitness technology partnerships.
This fund use will be administered by OSDE.

fMain strategic goal Make Rural America Healthy Again, Innovative care, Technology Innovation			
Use of funds	A, C, D, F, G, H, J, K	**Technical score factors**	B1, B2, C1, D1, F1, F2, F3
Key stakeholders: Rural hospitals, Critical Access Hospitals, Rural Emergency Hospitals, Indian Health Services (IHS) hospitals, Clinics, Community-Based Organizations, Rural Schools, Payers, OHCA, OSDH, SDE			

Outcomes
- Percent of closed-loop referrals
- Number of Community-Based Organization (CBOs) included in community referral platform
- Active use of closed-loop referral system (at least once per quarter) by CAH and rural emergency hospitals
- Participant retention across all chronic care program sites
- Reductions in complications from disease progression
- Improvement in symptoms following entrance into chronic care program
- Population percent with primary care engagement at least once per year attributable to RMP
- Care coordination contact increase per month per user from RPM
- Percent of actionable alerts from RPM triggering provider or CHW intervention
- Decrease in ED readmissions among multivisit patients with CHW contact vs. those without
- Use (as factor of caseload determined by support intensity / setting) of hospital CHWs
- Increase in community use of assets acquired with microgrant
- Increase in health-related behaviors tied to new microgrant asset (e.g., new track surfacing increases walking/running)
- Community satisfaction with new platform/RPM tool/asset

- Student uptake of cardio- and walking-focused fitness application
Impacted counties: All rural counties: See Appendix for Federal Information Processing Standards (FIPS) codes
Estimated funding required Estimated funding for this initiative is ~$95M over the five years.

INITIATIVE 3: Facilitating Regional Collaboration

Description
A core goal of Oklahoma's RHT is to support access to high-quality health care services in a sustainable way through strategic regionalization of services. This includes right sizing and efficiently allocating services across the State, fostering collaboration across elements of the health care and supportive ecosystem, and gaining scale through shared purchasing and services. This initiative includes creation of a statewide Rural Regional Reorientation Plan, development of a rural-focused CIN, and build out of regional EMS capabilities.

Fund use: Rural-focused CIN
Oklahoma's rural hospitals and associated outpatient clinics face structural barriers to delivering care sustainably driven by greater fixed costs, higher recruiting and staffing costs, and lower negotiating power with payers and suppliers. These hospitals also miss out on advanced technologies and participation in value-based arrangements. In the face of these obstacles, rural hospitals remain resilient to meet the needs of their patients. This initiative builds joint resiliency for rural hospitals through stand up of a rural-focused CIN under a new non-profit owned by the member hospitals. This model maintains local control while providing members access to shared administrative supports, technical assistance, staffing, and technology (e.g., AI tools, EHR upgrades) and to scale to engage in new care models and value-based care. Additionally, the CIN will build upon the Rural Regional Reorientation Plan as input to a central referral management system for the CIN.

The funds will be used for:
- Establishment of the collaborative including the organizational framework, governance model, and membership composition
- Development of a needs assessment and priority use cases for the collaborative
- Investment in the stand up of the use cases, included, but not limited to, shared administrative supports (e.g., group purchasing, shared services, payer relations), shared clinical supports (e.g., telemedicine, shared specialty staffing pool), and governance support (e.g., leadership and board training)
- Enabling technology infrastructure including IT systems, software, and configuration support for population health management, referral management, and care coordination
- Technical assistance for members including legal, regulatory, clinical advisory, and data aggregation support

The collaborative will be self-sustaining beyond the life of the grant through enablement of alternative payment arrangements with payers and as needed membership fees that will be offset by improvements in financials from member benefits (e.g., improved efficiency, improved supply costs given group purchasing).
This fund use is administered by OSDH.

Fund use: Rural Regional Reorientation Plan
Oklahoma has seen 7 rural hospitals shutter in the last 10 years, with 30% at immediate risk of closure (CHQPR, 2023). At the same time, rural residents have difficulty accessing the care they need with long wait times and long travel times for services. Through the RHT Program, Oklahoma has an opportunity to build toward a reoriented system of care for rural residents: one that focuses on delivering the right services at the right time in the right modality in a sustainable way. To support that vision, Oklahoma will facilitate development of a Rural Regional Reorientation Plan, bringing rural hospitals and ecosystem partners (outpatient providers, long-term care, payers) together to align on the future system of care grounded in the needs of rural communities and oriented toward improved access to upstream prevention and primary care. The effort will be convened by OSDH in conjunction with sister health agencies, OHCA, ODMHSAS, and Department of Human Services. The first phase of the effort will include robust data gathering on current state utilization, cost, and quality and engagement with rural hospitals on challenges and opportunities. Rural hospitals will then drive development of regional strategies including rightsizing of service lines and improved connections across services, supported by analysis on impact of changes on access and outcomes. Finally, the State will incorporate regional plans into single statewide plan accompanied by funding to support implementation of the regional plans.

The funds will be used for:

- Technical assistance to support plan development including data and analytics, stakeholder engagement, financial analysis, and legal, regulatory, and financing advisory support
- Technology infrastructure to support collection of baseline data and monitoring data
- Funding to participating hospitals for plan development and implementation, including provider incentives to right size facilities and infrastructure funds to support development of new services

The plan will be developed through onetime funding and sustained through resulting initiatives.
This fund use is administered by OSDH

Fund use: EMS collaboration
Oklahoma's EMS resources are fragmented and limited across the State; limited coordination and long transit times result in EMS use for non-emergencies occupies up to 50% of community EM resources at any given time. Central coordination would allow for pooled resources and more effective communication across EMS providers to ensure highest use of the assets.

The funds will be used for:
- Procurement of a single platform including software licensing fees and provision of needed technical equipment for EMS providers
- Technical assistance to support implementation across Oklahoma EMS providers
- Stand up of central program support including recruiting, training, and equipment

The model will be funded beyond course of the program through the Oklahoma Trauma Fund which supports access to trauma services across the State.
This fund use is administered by OSDH.

Other considerations:
- OSDH will be the administrator for the initiatives and will run a process to select contractors to support technical assistance and program delivery of the initiatives
- Funding for provider payments and infrastructure will comply with caps outlined in the NOFO

Main strategic goal Sustainable access, Innovative care

Use of funds	B, D, E, F, G, H, I, J, K	**Technical score factors**	B1, C1, C2, E1, E2, F1, F2

Key stakeholders: Rural Public Provider Supplemental Payment System (PPSS) Hospitals, Critical Access Hospitals, Rural Emergency Hospitals, IHS hospitals and clinics, FQHCs, CCBHCs, CMHCs, Independent practices, EMS providers, Community-Based Organizations, Payers, OHCA, OSDH, ODMHSAS

Outcomes
- **Financial stability index:** % of rural hospitals operating with improved margins post-implementation (State and county level)
- **Network participation rate:** # of rural hospitals and clinics participating in the CIN / total eligible (State-level)
- **Shared service savings rate:** % savings realized in administrative costs among participating facilities (State-level)
- **Value-based care participation:** % of member hospitals participating in at least one value-based or alternative payment model (State-level)
- **EMS system coverage ratio:** % of Oklahoma rural counties connected to central EMS coordination platform (State and county level)
- **Patient care timeliness:** Increase in patients receiving care within medical standard timelines (State and county level)
- **EMS reduction in admin time:** Reduction in administrative time for reports vs. non-users (State-level)

Impacted counties All rural counties: See Appendix for Federal Information Processing Standards (FIPS) codes

Estimated funding required
Estimated funding for this initiative is ~$420M over the five years

INITIATIVE 4: Shifting to Value

Description
This initiative will support primary care, behavioral health, hospital, and providers serving dual-eligibles in building a path to value-based care, specifically:
- Bolster value-based care (VBC) practice enablement programs to support primary care and behavioral health providers in building clinical practices aligned with value
- Pilot digital-enabled, value-based PCP clinical extension models

- Fund PACE expansion, a proven value-based model for dual populations

Fund use: Value-Based Care Practice Enablement Support
Oklahoma has strong foundations for supporting primary care movement to value-based arrangements including over 1,000 practices enrolled as patient-centered medical homes and over 500 practices participating in Health Access Networks which support practice training and support in complex care management and quality management (OHCA Provider FastFacts 2025). Beyond the support on clinical practice transformation, these practices would also benefit from business practice transformation. In this initiative, Oklahoma will provide capacity building funds to primary care practices to support business practice transformation including infrastructure to support risk stratification and performance tracking, technical assistance for payment model redesign, contract development and payer negotiation, and development of governance structure to support model.

The funds will be used for:
- Stand up of the program including identifying priority providers for engagement (targeting ~150-200 practices in rural areas across the State)
- Technology infrastructure and data and analytics support
- Technical assistance for payment model redesign, contract development and payer negotiation

This funding is meant to get practices through the transition to new payment models which will be self-sustaining through shared savings, Per member per month (PMPM)pr payments and/or full capitation arrangements.
fund use is administered by OHCA.

Fund use: PACE Expansion
PACE is a nationally recognized best practice ACO model focused on the dual-eligible population. By integrating Medicare and Medicaid financing, PACE offers comprehensive, team-based care that enables seniors to remain in their homes and communities, improving quality of life, and reducing need for higher-cost institutional care. Oklahoma has three PACE programs serving 800 members statewide with one rural-based option (Cherokee Elder Care) as starting point for how PACE translates in rural areas. With this foundation, Oklahoma would like to further expand PACE in rural areas; this initiative will fund the startup of 3-6 additional rural PACE centers, helping extend integrated, VBC to thousands of additional dual-eligible seniors.

The funding will be used for:
- Recruiting and selecting providers and locations targeting priority counties
- Startup funding (excluding major construction) for new rural PACE centers, including technical assistance, member recruitment, technology investment
- Telehealth and mobile clinic offerings to expand reach beyond physical PACE centers

Once at full utilization, the PACE centers will be self-sustaining through existing Medicare and Medicaid funding dollars.
This fund use is administered by OHCA.

Fund use: Value-Based Clinical Extension Models
Smaller primary care practices often lack the staffing capacity and time to conduct the required activities to be in full-risk models (e.g., closing care gaps, managing chronic conditions, escalating connection to specialists). Innovative models that marry in-person support and consumer-facing technology have been created to be clinical extensions (e.g., 'Primary Care as a Service', wraparound in-home support for dual populations) and support the move to risk. In conjunction with the practice enablement above, this initiative will allow practices to pilot these programs as part of a comprehensive model.

The funding will be used for:
- Piloting the clinical extension model in conjunction with managed care entities and targeted pilot practices
- Technology infrastructure and configuration with existing clinical and payment technology
- Technical assistance to support rollout of model
- Measurement of model success to support decision to further scale

Sustainability plan is that these extension models 'pay for themselves' and attract more commercial and government payers in Oklahoma to incorporate them into their models.
This fund use is administered by OHCA.

Main strategic goal Sustainable access, Innovative care

Use of funds	A, B, C, D, F, G, H, I, K	**Technical score factors**	B1, C1, E1, E2, F2, F3

Key stakeholders: Rural Health Clinic (RHCs), FQHCs, Independent practices, PACE providers, IHS/Tribal facilities, hospitals, clinicians, payers

Outcomes
- % of participating practices with signed VBC contracts (statewide)
- Average risk-adjusted total cost of care per attributed member (statewide)
- Improvement in % of patients achieving care-gap closure (statewide)
- Weighted improvement across standard quality metrics (statewide)
- Increase in PACE enrollment (statewide and county)
- Reduction in ED utilization vs. similar Medicaid members (statewide)
- Lower net Medicaid cost per dual enrollee (statewide)
- Caregiver survey before vs. after PACE enrollment (statewide and county)

Impacted counties: All rural counties: See Appendix for Federal Information Processing Standards (FIPS) codes

Estimated funding required
Estimated funding for this initiative is ~$100M over the five years with higher early year costs for set up and scaling down as value-based initiatives become self-sustaining.

INITIATIVE 5: Growing the Next Generation of Rural Talent

Description
This initiative will expand training capacity, attract providers to underserved areas, and create a pipeline from high school through professional healthcare practice.

Fund use: Rural Residencies
Rural Oklahoma faces some of the most significant healthcare workforce shortages in the nation, sitting well below the national average in ratio of healthcare workers to 100k residents across psychiatry (1 vs. 12), surgery (2 vs. 8), and Obstetrics and Gynecology (OBGYN) (2 vs. 13) providers, among others. Many rural communities have trouble attracting healthcare talent given the less robust infrastructure, smaller health networks and ecosystems, and more limited housing, employment, and educational opportunities for providers' families. Education in rural residencies has shown an increase in the likelihood for rural practice by almost 3x (Patterson et. al, 2023). This fund use seeks to increase the number of physicians choosing to practice in rural areas by providing robust opportunities for rural healthcare experience in residency.

The funds will be used for:
- Expanded rural residency programs for surgery, psychiatry, and OBGYN through partnerships with State medical schools and rural healthcare facilities
- Recruitment, curriculum design, accreditation, and faculty development
- Startup funding for rural hospitals or clinics to host residents, including stipends, housing support, and preceptor compensation
- Administrative coordination, evaluation, and accreditation activities to ensure long-term sustainability

The path toward sustainability includes a mix of private, provider cost sharing, and government funding for residencies.
This fund use is administrated by OSDH.

Fund use: Rural Relocation Incentives, Starting with Behavioral Health
Oklahoma currently has a severe shortage of behavioral health providers across rural counties, with only 1 psychiatrist and 0.3 child psychologists per 100k Oklahomans, compared to the national average of 12 psychiatrists and 10 child psychologists. As with physicians, many rural communities struggle to attract BH providers, and the State currently has no rural service incentives targeted toward BH. This initiative seeks to bring BH providers into rural areas of Oklahoma with a five-year commitment, giving providers time to establish their practices, fill their caseloads, and integrate themselves into the rural community, with the intention of encouraging providers to build their careers in rural Oklahoma. In addition, this initiative will identify additional provider types that are the biggest needs in rural Oklahoma communities and establish similar incentive programs.

The funds will be used for:
- Statewide needs assessment to identify high-need behavioral health professional types and geographic priority areas
- Five-year commitment stipends for behavioral health providers relocating to rural communities (psychiatrists, psychologists, social workers, counselors)

- Program expansion to include additional high-need provider types identified through the assessment
- Light-touch integration support for new providers—community orientation, practice onboarding, and networking with regional providers
- Program monitoring of placement retention, community satisfaction, and impact on access to behavioral health services.

The path to sustainability is to leverage existing Health Workforce Training Commission (HWTC) funding sources to continue incentives for target providers.
This fund use is administered by HWTC.

Fund use: "Grow Your Own" Programs Targeting High School Students
Oklahoma has a severe nursing shortage, ranking 46th in the nation (Nurse Journal, 2025) in RN-to-population ratio and 37th (Beckers Hospital Review, 2025) in overall nurse-to-population ratio (including Registered Nurses (RN) and practical nurses (PN)). Compounded by broader healthcare workforce shortages, Oklahoma stands to benefit greatly from an increased nursing workforce in rural areas. Additionally, healthcare practitioners who are originally from rural areas are often more likely to remain practicing in their communities, given family ties, familiarity, etc. Investing in educational opportunities for rural youth has the potential to impact the rural healthcare workforce for many years to come. Oklahoma does have existing programs in place to foster the healthcare workforce pipeline, like the Oklahoma Department of Career and Technology Education (CareerTech), a State agency that connects students with training opportunities that lead to rewarding careers in key Oklahoma careers, but there is opportunity to expand the programs more widely.

The funds will be used for:
- CareerTech partnerships with additional high schools to train rural students as PN and other entry-level healthcare providers
- Program funding for instructor salaries, student supplies, and National Council Licensure Examination (NCLEX) exam costs
- Program expansion into additional rural high schools and alignment with RN pathways
- Data reporting and tracking systems to monitor student enrollment, completion, and rural placement rates

The path toward sustainability is for CareerTech to absorb costs through education grants once student interest and demonstrated success is shown.
This fund use is administered by OSDH.

Main strategic goal: Workforce development			
Use of funds	F, G, K	**Technical score factors**	C1, F3
Key stakeholders: Career and Technical Education partners, academic medical centers, rural hospitals, rural health clinics, FQHCs, behavioral health providers, local workforce boards, private foundations, and philanthropic partners			
Outcomes - 6 additional rural residencies established for high-demand provider types - 10 behavioral health and 20 additional providers re-located to rural communities with demonstrated workforce need by FY2028 - Increased enrollment of high school students in Licensed Practical Nurse (LPN) training by FY2028 - Increased placement rate in nursing careers by FY2028 - Increased ratio of credentialed nurses to population in counties with HS LPN programs			
Impacted counties: Rural counties: See Appendix for Federal Information Processing Standards (FIPS) codes			
Estimated funding required: Estimated funding for this initiative is ~$70M over the 5 years.			

INITIATIVE 6: Building Health Data Utility

Description
This initiative builds a connected rural health data ecosystem enabled by an expanded underlying technology infrastructure, increased connectivity and utilization of the statewide HIE, and expanded use of data to support statewide planning, clinical decision making, and health care navigation for individuals.

Fund use: EHR Expansion
Connection to Oklahoma's HIE is limited by electronic health record system (EHR) uptake in rural Oklahoma. The long tail of smaller, independent rural providers that does not have EHRs today is estimated as ~10-20% of behavioral health providers and ~5-10% of primary care providers. Getting to universal coverage will support greater participation in the statewide data ecosystem.

This fund use closes the rural EHR connection gap by providing connections to a low-cost certified EHR technology (CEHRT) EHR for rural facilities without an EHR. OHCA via Oklahoma State Health Information Network Exchange (OKSHINE) will negotiate for a state-level group licensing for unconnected facilities and will subsidize EHR connection, equipment, and support in exchange for obligating HIE participation by subsidized facilities.

The funds will be used for:

- Onetime assessment to determine providers and clinics lacking EHR systems, those with EHRs that do not integrate with HIE, and low-cost CEHRT product(s) for EHR rate negotiation at state-level
- Low-cost EHR platform that meets federal interoperability standards for use by smaller, independent rural facilities
- Purchase and deployment of EHR hardware, connectivity, and software for unconnected rural providers
- Subsidizing EHR subscriptions on facility-size based model as incentive to routinely use EHR and connect to HIE
- Technical assistance for site-specific implementation, data migration, and staff training on new EHR
- Build peer-to-peer learning portal for EHR/HIE members

The path to sustainability is that after the onetime cost of EHR and HIE connection, providers will maintain ongoing subscription costs for their EHR. For providers electing the identified low-cost EHR, providers will absorb pooled maintenance costs. Providers will be incentivized to retain maintenance and licensing costs from proven ROI from HIE (esp. reduced duplicate testing) connection for which an EHR is necessary.
This fund use is administrated by OHCA (OKSHINE).

Fund use: Interoperability through HIE

HIE connection is low among some rural facilities in Oklahoma, especially RHCs. Although Oklahoma's HIE is high performing as a top-ten nationally in data density, it is not regularly used by rural clinics and providers. Up to 40% of substance abuse treatment centers and 46% of Oklahoma hospitals do not integrate with the HIE. RHCs are an even larger blind spot with up to 97% not connected (OKSHINE / MyHealth, 2025). The lack of cross-provider patient record access leads to an up to 20% duplicate diagnostic rate and multiday delays in obtaining patient data. Further, state and system-level decision makers are hampered by low rural HIE connectivity. Data on specific rural population health needs are fragmented and often collected through survey and direct interaction with providers and other care settings.

Oklahoma's HIE is seeking to expand its capability to include key data from particular care settings, including imaging and pharmacy. Uploading mental and behavioral health data is challenged by Oklahoma's opt-in requirement for those modalities (in contrast to the opt-out requirement for all other data types). Building a consumer-facing single consent portal for health data will help ease the difficulty in collecting behavioral health data by allowing for full health consent management at a single login. Ensuring exchange across modalities will allow providers, clinics, and state-level decision makers greater awareness of rural Oklahoma health needs. ROI will be realized through removing leading causes of duplication (especially imaging).

The funds will be used for:

- Connection fees and onboarding costs for rural providers joining Oklahoma's statewide HIE
- HIE and EHR Vendor costs/fees for rural providers joining Oklahoma's statewide HIE
- IT implementation, security credentialing, and change management for connected facilities
  Education campaigns and technical support to increase provider adoption and routine use of the HIE
- System upgrades to improve real-time data ingestion, testing, and compliance (including imaging, pharmacy, public health, and mortality feeds)
- Consumer-facing consent application for secure data sharing and behavioral health integration

The path to sustainability is that after the five-year grant period ensuring connection, support, and education to providers, ongoing HIE costs will be absorbed by providers through their HIE subscription. HIE subscribers will get access to upgrades on an elect-and-pay basis including built-in analytics capabilities and added reports from newly ingested data sources. Providers will realize ROI from the HIE from reduced administrative duplication and reduced delays in patient care from increased modality transfer.
This fund use is administered by OHCA (OKSHINE).

Fund use: Integrated Data and Analytics

Oklahoma's HIE has limited data dashboard capability. Including an advanced built-in analytics capability will enable state- and system- level real-time awareness of rural population health needs, market trends, care gaps, and outcomes. This will allow large-scale trend-tracking and aid resource targeting by determining data needs to Oklahoma that a more connected HIE can provide. This fund use identifies high-need analytics and dashboards with specific bearing in rural Oklahoma (e.g., smoking cessation, utilization across rural facility type) and establishes a data roadmap for added functionality and additional HIE integration for specific modalities.

The funds will be used for:

- Statewide "data roadmap" outlining new data streams, governance, and analytics capabilities
- Pilot data dashboard use cases (e.g., rural health outcomes, maternal health, chronic disease)
- Licensing and maintenance for analytics tools and dashboards
- Technical and data governance support to ensure HIPAA compliance, privacy, and transparency

The path toward sustainability is that after onetime costs the planning and roadmap, 90/10 matched Medicaid technology funds will be used to support rollout of new use cases. Long-term ROI to the state will be realized in reduced duplicate testing, 30-day readmissions, and improved care coordination, and preventive care.

This fund use is administered by OHCA (OKSHINE).

Other considerations:

- Roadmap will need to identify data sources as well as any practical limitations to inclusion (e.g., PDMP is a federal database with limited two-way access)

Main strategic goal: Technology innovation

Use of funds	C, D, F, K	**Technical score factors**	C1, F1, F2

Key stakeholders: Rural hospitals, rural health clinics, FQHCs, academic and research partners, community-based clinics, behavioral health providers, data and technology vendors

Outcomes

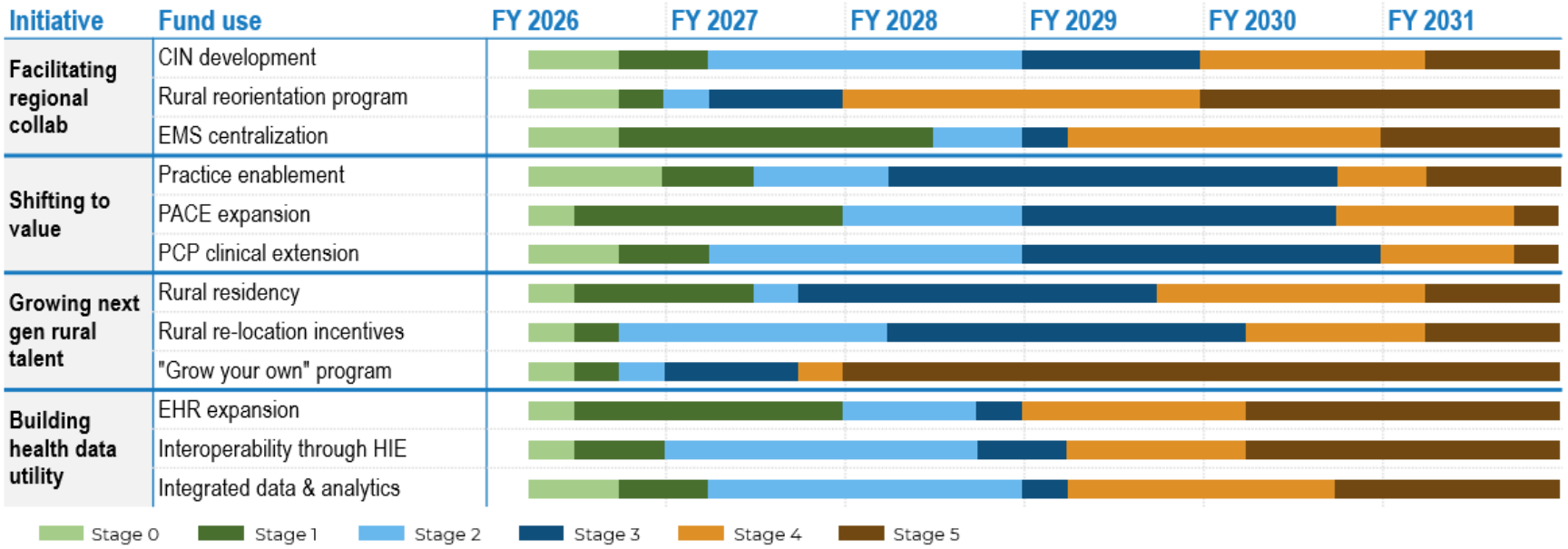
- Increased percent of rural providers / clinics connected to and using EHR by FY2028
- HIE penetration statewide by FY2028
- EHR / HIE statewide penetration by FY2028
- Percent of care settings among targeted modalities actively ingested and updated at least weekly by FY2029
- EHR / HIE
- HIE downtime by FY2030
- Reduction in unaddressed care gaps by FY2030
- Decrease in duplicate testing rates from 2025 by FY2030

Impacted counties: All counties: See Appendix for Federal Information Processing Standards (FIPS) codes

Estimated funding required:
Estimated funding for this initiative is ~$95M over 5 years.

4. Implementation Plan and Timeline

Initiative	Fund use	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
Innovating the care model	Telestroke expansion						
	MFM telehealth expansion						
	RPM: Maternal						
	Transportation expansion						
	Expanding care: Community Paramedicine						
	Expanding care: Doulas						
	BH integration in primary						
	Tech co-op for PCP & BH						
	School-based services						
Moving upstream	Chronic disease mgmt.						
	Community referral platform						
	Consumer-facing tech						
	CHW expansion						
	Wellness hub microgrants						
	Lung cancer screening						
	Presidential Fitness prep						



Oklahoma's RHT Program will be implemented in coordinated phases from FY 2026 through FY 2031, reflecting the five budget periods and the additional year to spend FY 2030 funding, as allowed in the RHT Program NOFO. Each initiative follows a structured timeline that includes project planning, launch, expansion, and evaluation milestones. This phased approach enables early demonstration of impact while supporting long-term sustainability. The following table outlines key activities and milestones by initiative, consistent with CMS's six implementation stages (0–5) and annual reporting requirements

Overview of activities in each stage

Oklahoma's RHT Program will follow a structured, phased approach from FY 2026 through FY 2031. Across fund uses, the key activities completed in each stage described in the RHT Program NOFO are consistent, with nuances based on individual project needs. Activities will include:

Stage	Key activities
Stage 0	**Convening of stakeholders** and onboarding of resources (if required) to administer the programs, **assessments** to determine target counties, facilities, and vendors, **development Request for Proposals (RFPs) and NOFOs** as needed for potential funding recipients, and **establishment governance models** for the fund uses
Stage 1	Initial program implementation begins, including **RFP / NOFO launch, selection of vendors / providers / funded entities,** and required **capability builds and equipment acquisitions** for initiative execution
Stage 2	Programs launch with identified funded entities, vendors, and partners, including **equipment / technology installation and setup, pilot and/or program launches**, and **plan refinements**
Stage 3	**Initial evaluation** occurs of pilots and first program participants, and **programs are refined as needed**. **Scaling across new geographies and participants** occurs for programs with plans to scale, and pathways to sustainability begin to be built (incorporating billable services, identifying philanthropic grants, etc.)
Stage 4	Programs **reach scale**, the administrator and funded entities (where applicable) continue to evaluate the program and **track outcomes for reporting**, and **sustainability plans are finalized or nearly finalized**
Stage 5	Programs are fully implemented and ongoing, and **outcomes aggregation occurs** for reporting. Transitions to sustainability plans begin, to be **completely transitioned by Q3 2031**, and any **onetime programs** (e.g., relocation incentives, infrastructure funding) **wrap up final disbursements and report on impacts**

Overarching governance

OSDH will serve as the lead agency for the RHT Program. OSDH will oversee all implementation activities, fiscal management, and reporting to CMS. The State's engagement framework for administration of the grant will include a State-led Steering Committee, OSDH program management office, OSDH-led working groups, and Advisory Councils (all described in more detail in the *Stakeholder Engagement* section of this application). OSDH has the statutory and regulatory authority to administer public health and healthcare transformation programs on behalf of the State of Oklahoma and will coordinate with relevant agencies and the Legislature on any additional legislative or regulatory actions needed to implement and sustain the RHT Program (all described in more detail in 'Legislative or Regulatory Action' in *Rural Health Transformation Plan: Goals and Strategies* section of this application). The OSDH has been designated by the Governor's Office as the AOR for the RHT Program. OSDH will serve as the lead agency and primary administrator for

most fund uses, with three additional State agencies and one association designated as sub-grantees responsible for specific program areas (listed below).

Initiative	Fund use	Administrator
Innovating the care model	Telestroke expansion	OSDH
	Maternal Fetal Medicine telemedicine expansion	OSDH
	RPM: Maternal	OHCA
	Transportation expansion	OARC
	Expanding care: Community Paramedicine	OSDH
	Expanding care: Doulas	OSDH
	BH integration in primary care	OSDH
	Technology cooperative for PCPs and BH providers	OSDH
	School-based service support	OSDE
Moving upstream	Chronic disease prevention and management program	OSDH
	Closed-loop community care platform	OHCA
	Consumer -facing tech, including BH	OSDH
	CHW expansion in hospitals	OHCA
	Wellness hubs: Microgrants	OSDH
	Lung cancer screening	OSDH
	Presidential Fitness preparation funding	OSDE
Facilitating regional collaboration	CIN development	OSDH
	Rural Regional Reorientation Plan	OSDH
	Centralized EMS	OSDH
Shifting to value	Practice enablement	OHCA
	PACE expansion	OHCA
	PCP clinical extension models	OHCA
Growing next gen rural talent	Rural residency	OSDH
	Rural relocation incentives	HWTC
	"Grow Your Own"	OSDH
Building health data utility	EHR expansion	OHCA
	HIE interoperability	OHCA
	Integrated data and analytics	OHCA

To manage the RHT Program, OSDH will dedicate 12 full-time and 2 part-time positions as described in the table below, all to be filled by December 31, 2025, prior to program launch. Across subrecipients State agencies, approximately six full-time equivalents (FTEs) will be dedicated to RHT activities before launch.

OSDH RHT Program Management Roles and Staffing Plan		
Role	**FTEs**	**Description**
Program Director	1	Provides overall oversight and direction of the RHT Program and serves as the primary liaison with CMS
Data Analyst	1	Manages data collection, integration, and reporting from all funded entities
Sr. Compliance Specialist	1	Ensures adherence to CMS requirements, cooperative agreement terms, and all State and federal regulations
Grants Mgmt. Specialists III	2	Support subaward administration and regulatory compliance across all initiatives

OSDH RHT Program Management Roles and Staffing Plan		
Role	**FTEs**	**Description**
Contracting and Acquisitions Agent II	1	Manages vendor procurement and contracting for initiatives and technical support
Communications Coordinator	0.5	Leads stakeholder engagement, external communications, and public awareness campaigns
Administrative Assistant	1	Provides administrative and scheduling support for program operations
Attorney	0.5	Provides legal oversight for contracting, compliance, and program governance
RHT Champions	N/A	Rural health representatives who will provide local implementation support and feedback (10 special duty assignments)
Project Manager – Population Health	1	Oversees data-driven initiatives addressing preventive health, health disparities, and social determinants of health (SDOH)
Project Manager – Health Systems	1	Leads system-level improvement projects focused on collaboration across the ecosystem of healthcare entities in Oklahoma
Project Analyst – Health Systems	1	Supports Project Manager – Health Systems in research, data analysis, and program oversight related to cross-system efforts
Project Manager – Tech	1	Provides support for technology-related projects, specifically focusing on coordination of the technology cooperative effort
Project Manager – Talent and Provider	1	Oversees talent-related efforts across workforce and upskilling activities, focusing on program oversight and partner support

OSDH will also engage external project management and technical assistance partners to support program execution. These partners will assist with governance framework development, project planning, infrastructure setup for monitoring, and ongoing grant administration. Their responsibilities will include facilitating annual reporting and statewide stakeholder engagement throughout the program's duration. This coordinated structure, led by the Program Director and Project Managers under the Chief of Staff to the Oklahoma Commissioner of Health, will provide integrated oversight across all initiatives and ensure timely progress toward implementation goals.

The following table summarizes key milestones by fund use category, reflecting Oklahoma's phased implementation approach and alignment with CMS reporting expectations.

Key Milestones by Fund Use		
Initiative	**Fund use**	**Key milestones**
Innovating the care model	Telestroke expansion	• Rural hospital subset is selected, clinical workflow planning, EHR configuration, and equipment purchasing is initiated (Q2 FY26) • Hospitals begin going online with telestroke capabilities via a phased rollout, evaluation begins (Q1 FY27)

Key Milestones by Fund Use		
Initiative	**Fund use**	**Key milestones**
		• Program is at full planned capacity (Q1 FY28) • Number of stroke-ready hospitals increases (Q1 FY30) • Program is self-sustaining, final evaluation (Q3 FY31)
	Maternal–Fetal Medicine telemedicine expansion	• Completion of clinical workflow development including hiring / allocation of admin staff, purchase of ultrasound equipment (Q4 FY26) • Completion of training and hiring of spoke clinical staff, EHR configuration complete (Q1 FY27) • Launch with initial telehealth visits in identified rural communities, start of initial evaluations (Q3 FY27) • Full scale operations across identified rural communities, refinement of workflows complete (Q1 FY29) • Model reaches sustainability via billed services (Q4 FY31)
	RPM: Maternal	• Convene high-risk pregnancy stakeholders for BP cuff RPM design, identify pilot programs for BP cuffs utilization, begin incorporating BP cuffs into program design (Q3 FY27) • Program planning including EHR template build out, clinical flow design, and piloting initial utilization, including initiating outcome collection (Q3 FY27) • BP cuff utilization (full scale launch 900 patients), data collection, patient and provider surveys, information is collected to make a Medicaid covered service (Q4 FY27- Q1 FY31) • Stakeholders are convened to begin insurance coverage plans and SPA drafting (Q3 FY31) • SPA is submitted to make Medicaid covered service (Q3 FY31)
	Transportation expansion	• Establish interagency working group (Q2 FY26) • Rollout final services in pilot Southwest region (Q3 FY26) • Launch volunteer program and recruitment (Q4 FY26) • Expand pilot to 2 additional regions; develop standard dashboards (Q3 FY27) • Complete launch statewide including coordination platform; transition toward centralized Oklahoma Department of Transportation (ODOT) management (Q3 FY28) • Finalize cross agency Memorandum of Understanding for funding, responsibilities, and operations (Q1 FY30) • Successful shift to braided funding model (Q3 FY31)
	Expanding care: Community paramedicine	• Launch first RHTP-funded Community Paramedicine cohorts (Q4 FY26) • Set up uncompensated care fund for treat-in-place and community paramedicine (Q1 FY27), dispersion begins (Q2 FY27, occurs semiannually thereafter) • Conduct annual reporting on providers trained (Q4 yearly) • Convene stakeholder groups for initiation of insurance coverage planning and SPA drafting (Q3 FY30) • Successful identification of funding sources for ongoing sustainability (Q2 FY31) • Submit SPA for coverage (Q2 FY31)
	Expanding care: Doulas	• Determine doula training programs which will be awarded funding (Q3 FY26) • Launch doula training programs (Q1 FY27) • Set up uncompensated care fund for doula visits for uninsured, commercial, and visits not covered by Medicaid (Q1 FY27), disbursement begins (Q2 FY27, occurs semiannually thereafter) • Initiate SPA drafting, limited stakeholder engagement, outreach to commercial payers (Q3 FY30) • Submit SPA for coverage (Q2 FY31)
	BH integration in primary care	• Convene existing BH and PCP providers for model design and draft NOFO (Q4 FY26)

Key Milestones by Fund Use		
Initiative	**Fund use**	**Key milestones**
		• Model is awarded, program design and telehealth enablement begins if relevant (Q2-Q4 FY27) • Service initiation (Q1 FY28) • Program is operating and reporting outcomes (Q4 28-Q1 FY31) • Program reaches sustainability (Q3 FY31)
	Technology cooperative for PCPs and BH providers	• Establish technology cooperative: selection of technology cooperative entity, governance, membership structure, eligibility criteria (Q3 FY26-Q1 FY27) • Identify priority technologies and needs assessment of rural primary and behavioral health providers (Q4 FY26) • Issue RFPs and negotiate group purchasing contract vendors for approved platforms; select implementation partner training and technical assistance (Q1 FY27) • Start launch of pilot with 25-30 PCPs / BH providers, and deploy initial RPM, telehealth tools, and AI-enabled documentation tools (Q4 FY27) • Evaluate pilot sites (Q4 FY28) • Expand cooperative membership to additional sites and continue data collection (Q3 FY28-Q2 FY29) • Measure impact on member financials (Q2 FY29) • Identify sustainable funding path post-RHT (Q2 FY30)
	School-based health services with focus on BH	• Program planning, meeting with schools, NOFO launch (Q3 FY26) • School awardee selection, beginning of technical assistance, and support in staffing recruitment (Q4 FY26-Q2 FY27) • Schools launch service provision on a rolling basis (Q3 FY27) • Initial subset of schools up and running w/ service provision (Q1 FY29) • School-based model is fully self-sustained (Q1 FY31)
Moving upstream	Chronic care prevention and management program	• Selection of programs and acquisition of required RPM (Q2 FY26) • Launch first three-program cohort sites (Q4 FY26) • Launch RPM enablement aspects of program (Q2 FY27) • Conduct 6 (Q2 FY27), 12 (Q4 FY27), 18 (Q2 FY28) mo. evaluations • Launch second set of two program sites (Q4 FY28) • Conduct 6 (Q2 FY29), 12 (Q4 FY29), 18 (Q2 FY30) mo. evaluations • Graduate first cohort (Q3 FY29) • Graduate second cohort (Q3 FY31) • Successful shift to payer model on demonstration of ROI (Q1 FY31)
	Closed-loop community care platform	• Identify staff for extension management and staffing (Q2 FY26) • Launch integration in rural communities (Q3 FY26) • Conduct 12 (Q3 27), 18-month evaluations (Q1 FY28) • Transition to steady-state network maintenance (Q3 FY31)
	Consumer-facing tech, including BH	• Convene stakeholders to determine needs and tech (Q2 FY26) • Procure tech and recruit providers (Q4 FY26) • Lauch initial pilots (Q2 FY27) • Expand successful tech statewide (Q1 FY30); convene payers to request coverage (Q2 FY30) • Develop pathway to sustainability through proven effective consumer-facing technology (Q1 FY31)
	CHW expansion in hospitals	• Identify priority hospitals and communities (Q2 FY26) • Deploy CHWs into hospitals (Q1 FY27) • Set up uncompensated care fund for CHW services (Q4 FY26), dispersion begins (Q1 FY27, occurs semiannually thereafter)

Key Milestones by Fund Use		
Initiative	**Fund use**	**Key milestones**
		• Convene stakeholder groups for initiation of insurance coverage planning and SPA drafting (Q3 FY30) • Submit SPA for coverage (Q1 FY31)
	Wellness hubs: Microgrants	• Release NOFO, including guidelines and contractual framework (Q3 FY26) • First set of grantees deploy funds (Q4 FY26) • Final grantee fund deployment (Q4 FY30) • Complete report demonstrating outcomes across communities (Q3 FY31)
	Lung cancer screening	• Convene health system stakeholders to identify program directors and health systems (Q2 FY26) • Placement of program directors in systems (Q4 FY26) • Establish billing process for lung cancer screenings (Q4 FY27) • Launch cancer screenings across health systems (Q4 FY27) • Conduct annual reporting on screenings and rates of early detection among diagnosed patients (Q3 each year following) to track efficacy
	Presidential Fitness preparation funding	• Convene education and health stakeholders to review updated Presidential Fitness requirements (Q2 FY26) • Launch program application for schools (Q3 FY26) • Accept first round of schools into program (Q4 FY26) • Launch pilot for the cardio / walking-focused app (Q1 FY27) • Report on pass rate on the Presidential Fitness Test following completion of the program (Q3 FY27, and annually for each round of participants) • Launch the app for use statewide (Q4 FY27)
Facilitating regional collab	CIN development	• Establish statewide governance structure and select technical assistance partners (Q2 FY26) • Incorporate non-profit entity and confirm founding members of the CIN (Q3 FY26) • Define priority use cases to implement (e.g., group purchasing, payer relations development) (Q4 FY26) • Select and implement core technology vendors to support CIN development (pop health, referral management) (Q1 FY27) • Establish value-based payment pilot with at least one payer partner (Q2 FY27) • Measure impact on member financials (Q1 FY29) • Identify sustainable funding path post-RHT (Q1 FY30)
	Rural Regional Reorientation Plan	• Establish statewide governance structure and select technical assistance partners (Q2 FY26) • Conduct comprehensive data gathering and complete baseline assessment (Q3 FY26) • Convene hospital stakeholders, draft regional reorientation plans, and assess impact on access, quality and outcomes (Q4 FY26) • Consolidate into single Rural Regional Reorientation Plan (Q1 FY27) • Award sub-grants to participating rural hospitals and regional partners for plan execution (Q1 FY27 – Q1 FY29) • Measure changes to access, outcomes and cost (Q1 FY28- Q1 FY31)
	EMS centralization	• OSDH EMS staffer in place for platform management and maintenance (Q1 FY27) • Lauch single-region platform and resource sharing pilot; pilot public safety system (Q3 FY28) • Launch full functionality throughout State incl. public safety functionality (Q3 FY29) • Transition to state licensure payment and IT support (Q1 FY31)

Key Milestones by Fund Use		
Initiative	**Fund use**	**Key milestones**
Shifting to value	Practice enablement	• Setting up program administration including procuring technical assistance vendor (Q2 FY26) • Establishment of ACOs and identification of ACO administrator (Q4 FY26) • Shared savings pilot underway (start of Q3 FY27) • Data collection from shared savings pilot (Q2 FY28) • Pilot ACOs move to downside risk model and additional providers begin shared savings phase (Q1 FY29) • All ACOs on downside risk model (Q4 FY30)
	PACE expansion	• PACE centers/locations are selected (Q3 FY26) • Initial PACE centers go live with CMS approval and begin caring for participants, evaluation begins (Q1 FY28) • PACE centers provide initial healthcare outcomes (Q4 FY30) • PACE centers reach target enrollment and sustainability (Q4 FY31)
	PCP clinical extension models	• Target healthcare system is selected, target vendor is selected, clinical process flow and EHR/ tech integration begins (Q3 FY26) • Initial cohort of patients goes live w/ wraparound model w/in chosen healthcare systems, evaluation begins (Q2 FY27) • Initial round of health outcomes evaluation (Q4 FY28) • Economic evaluation of model is complete (Q4 FY30) • Healthcare systems can sustain cost of wraparound program (Q4 FY31)
Growing next gen rural talent	Rural residency	• Curriculum finalized and accreditation granted for new residency spots (Q2 FY27) • First cohort of residents launched (Q4 FY27) • Cohort completes rural rotation (Q3 FY31)
	Rural relocation incentives	• Launch application for prospective providers (Q3 FY26) • Launch program, placing providers in rural communities with five-year commitments (Q4 FY26) • Conduct 12, 24, 36, 48, and 60-month reporting (Q4 each year) to ensure continued compliance
	"Grow Your Own"	• Launch first class of program at new schools (Q4 FY26) • First class of students graduate from the program (Q3 FY27) • Conduct annual reporting (Q4 of each year) to track placement of graduates into careers or further education • Successful identification of funding for ongoing sustainability (Q2 FY31)
Building health data utility	EHR expansion	• Identify low-cost Electronic Health Record (EHR) for each rural provider type, open request for connectivity (Q4 FY26) • Open connectivity request portal via OHCA, OSDH sites (Q4 FY27) • Launch subsidized connection efforts (Q1 FY28) • 66% of all rural providers on an EHR (Q4 FY28) • Transition to provider maintenance payment model (Q4 FY31)
	HIE interoperability	• Launch HIE connection subsidization efforts; begin building ingestion capabilities (Q3 26) • Launch ingestion pilot over 1 region (Q2 27) • Launch peer-to-peer portal (Q4 FY27) • Full HIE available across entire State (Q1 FY29) • Transition to provider maintenance payment model (Q4 FY31)
	Integrated data and analytics	• Select roadmap vendor (Q2 FY26) • Identify data platform and capability vendors (Q4 FY26) • Launch limited data pilot in one region (Q3 FY28) • Launch full data analytic capability (Q1 FY29)

Key Milestones by Fund Use		
Initiative	**Fund use**	**Key milestones**
		• Transition license payment to State (Q1 FY31)

5. Stakeholder Engagement

To develop Oklahoma's RHT Program and application, the State conducted comprehensive stakeholder engagement to reflect the diverse voices of rural Oklahoma. Input was gathered from hospitals, providers, community organizations, patients and patient advocacy groups, and Tribal Nations to ensure that priorities and implementation strategies are grounded in the lived experience of rural residents.

Stakeholders Consulted and Planned for Engagement

- **Request for Information (RFI):** Received more than 400 responses (including 200 providers, 17 payers, 16 patient advocacy orgs and associations, 20 government orgs, and 100 individuals) with input on rural health challenges and associated fund ideas for rural Oklahoma.
- **Regional community listening sessions:** Conducted listening sessions in four regions with over 150 attendees including local hospital leadership, healthcare providers, community service providers, patient advocacy organizations, and community members.
- **Association consultations:** Conducted consultations with Rural Health Association, Primary Care Association, and Hospital Association to understand member needs and opportunities for transformation.
- **Tribal consultation:** Conducted consultation with Tribal Nations and Indian Health Services (IHS) with over 60 attendees representing tribes across Oklahoma.
- **40+ individual targeted interviews:** Interviewed stakeholders including individual providers in rural areas, educational institutions, community-based organizations, and national experts.
- **State Steering Committee:** Convened State Steering Committee comprising the Department of Health, Office of Primary Care, and Office of Rural Health, Health Care Authority (Medicaid),

Department of Mental Health and Substance Abuse Services, Health Workforce Training Commission (HWTC), Department of Human Services, State Department of Education, the Office of the Governor, and a Legislative Liaison to align on Transformation Plan and application components.

- **Letters of support and legislative alignment:** The State requested letters of support to accompany Oklahoma's RHT Program application. These letters, included in "Other supporting materials", reflect a broad range of stakeholders from across the state—many of whom participated in earlier engagement efforts to provide input on challenges and system-level needs in rural health care. Signers include representatives from Tribal Nations, hospitals, clinics, public health organizations, EMS partners, academic institutions, community-based nonprofits, and rural leaders. Together, these letters underscore the widespread commitment to improving health outcomes in Oklahoma's rural communities and demonstrate both the urgency of the need and the unified momentum behind the State's vision for change.

Engagement Framework

Oklahoma's ongoing engagement framework makes sure that stakeholders remain actively involved throughout program implementation. The framework includes:

- **Steering Committee:** The program will be governed by a State-led Steering Committee aligned to the Steering Committee stood up for application development. This group will convene on a regular basis to share updates, confirm progress against the grant goals, and as needed make decisions about grant implementation. Topics include fund deployment, milestone tracking, and assessment of impact metrics.
- **Program management office:** OSDH, as the designated agency for the grant, will establish a program management office that will serve as the primary point of contact for the grant. This office

will coordinate stakeholder engagement activity throughout the process, including providing oversight of the administrators of the funding.

- **Working groups:** OSDH will convene working groups aligned to each of the initiatives within the grant. These workgroups will be comprised of relevant State staff and external partners (e.g., provider representatives, MCOs, academic institutions, community members, patient advocacy groups) to provide input and feedback to the implementation process. These structures will include representation from rural community members, providers, patients, and Tribal partners to ensure that governance and decision making reflect the populations served.
- **Advisory Councils:** The State will establish Advisory Council(s) composed of rural community members, patients, rural providers, associations, and Tribal partners and liaisons to advise on implementation activities and confirm that the RHT Program reflects the priorities and needs of the communities it serves. The State will also have 10 regional representatives from the State Department of Health to serve as 'RHT Champions,' coordinating with local communities to ensure RHT activities are pulled through and properly address the needs of the communities toward which the funding is directed.
- **Public engagement:** Lastly, the State will provide routine updates to the public through the website and targeted public engagement sessions on status of the implementation and program successes.

Oklahoma's stakeholder engagement strategy fosters sustained collaboration and accountability across agencies, providers, and rural communities. By maintaining open channels for input and feedback, the State will strengthen trust, align implementation with community priorities, and ensure that the RHT Program delivers meaningful, lasting improvements in access, quality, and outcomes for all rural Oklahomans.

6. Metrics and Evaluation Plan

Metrics Framework

Oklahoma is committed to evaluating the effectiveness of all RHT initiatives through a rigorous, evidence-based approach. This includes collaboration with CMS evaluators, ensuring that subrecipients and contractors meet defined evaluation responsibilities, and conducting independent assessments for initiatives with broad-reaching or systemic impact. Preliminary metrics have been identified at the fund-use level, with most fund uses assigned multiple measures. Where applicable, the table below outlines data collection cadence, baseline and target values, and geographic granularity for each metric.

As implementation progresses, Oklahoma will continue to refine its metrics in collaboration with CMS and independent evaluation partners to ensure that they provide the most meaningful insight into program performance. To evaluate the overall success of the RHT Program, the State will conduct independent evaluations for initiatives with broad system-level implications, such as facilitating regional collaboration and advancing VBC. Oklahoma plans to partner with State academic institutions to perform these evaluations and will fully cooperate with all CMS-led evaluation and monitoring activities.

Metrics utilized by multiple programs:

Currently, there is only one metric that is utilized across multiple initiatives. The ED preventable visits metric was identified for two fund uses because PACE centers and community paramedics are ideally situated to help manage patients and avoid unnecessary emergency department utilization. Community paramedicine allows for treatment in place at the time and triage at time of a 911 call and for longer term in-community monitoring of higher risk individuals, PACE centers provide fully integrated care and maintain small high-touch patient panels with increased access to primary and specialty care and wraparound supports. Both PACE and community paramedicine will be county-level interventions, but as counties have not yet been identified, it is unclear whether there will be true metric overlap. Upon determining new PACE

sites and community paramedicine pilot communities, if there is regional overlap between the initiatives, we will baseline the programs together and set greater reductions in ED utilization than we would otherwise expect from an independent program.

Shared Metrics Across Initiatives			
Metric	**Applicable program**	**Data Sources**	**Outcome commitment or rationale**
ED utilization preventable visits	Community Paramedics	Paramedic forms/ Program logs	As counties have not yet been determined for programs, it is uncertain whether this metric will be truly overlapping. If PACE & community paramedicine occur in overlapping counties, we will calculate a baseline & set targets that account for the effect of two programs running in the same county.
	PACE	PACE quality data	

Initiative-Specific Metrics

Each RHT initiative includes defined, measurable outcomes to track implementation progress and program impact. The following table, *Initiative-Specific Metrics,* is aligned to fund use categories, showing the cadence of data collection, county-level granularity, baselines or targets where available, and the responsible data sources and entities. These measures reflect Oklahoma's commitment to transparent, data-driven performance management, and continuous improvement throughout the RHT Program.

Initiative-Specific Metrics							
Initiative	**Fund use**	**Metrics**	**Cadence of collection**	**County (Y/N)**	**Baseline/Target**	**Data source**	**Metric collection resp.**
Innovating care models	Telestroke expansion	# of hospitals connected w/ telestroke equipment	Quarterly	Y	Yr:0 Yr 3: 30 hospitals	OU program tracking	OU
		# of hospitals accredited as telestroke ready	Annually	Y	To be baselined upon program implementation	OU program tracking	OU
		# of stroke incidents addressed via telehealth	Quarterly	Y	To be baselined upon program implementation	Hospital EHR	OU
		Increase in # of people to whom thrombolysis medication was administered to appropriately	Quarterly	Y	To be baselined upon program implementation	Hospital EHR	Providers/OU
		Monitor door to needle time for thrombolysis and door in door out times	Quarterly	Y	To be baselined upon program implementation	Hospital EHR & EMS	Providers/OU
	MFM telehealth expansion	# of "spoke" clinics providing telehealth MFM visits	Quarterly	Y	Y3:0 Y3: 3+ clinics	Program logs	Program admin
		# of patients seen via telehealth, # of visits	Quarterly	Y	N/A, no MFM visits are currently occurring via telehealth	Provider EHR	Program admin
		Patient & provider satisfaction w/ telehealth MFM visits	Quarterly	Y	Y1:0 Y3: At least 50%	Program surveys	Program admin
		Reduction in the # of in-person trips enrolled patients take to see an MFM specialist	Semi-annual	N/A	To be baselined upon program implementation	Program surveys & EHR data	Program admin
		# of appropriate birth plans w/ needed supports matching risk of delivery	Semi-annual	N/A	To be baselined upon program implementation	Program tracking	Program admin
		Reduced negative outcomes: infant & maternal mortality & morbidity, low birth weight	Semi-annual	N/A	To be baselined upon program implementation	EHR, HIE	Program admin, EHR

Initiative-Specific Metrics							
Initiative	**Fund use**	**Metrics**	**Cadence of collection**	**County (Y/N)**	**Baseline/Target**	**Data source**	**Metric collection resp.**
	RPM: Maternal	# of participants utilizing BP cuffs	Quarterly	Y	Y0:0 Y28: 900 patients	Program logs	OHCA
		% of participants with BP maintenance within normal range	Quarterly	Y	To be baselined upon program implementation	Provider EHR, program logs	Providers, OHCA
	Transportation expansion	Increase in preventive care visit completions in coordinated communities by 20%	Quarterly	Y	To be baselined upon program implementation	Providers, EHR/HIE, transpo platform (once live)	OARC
		Decreased canceled ride % in coordinated communities	Quarterly	Y	To be baselined upon program implementation	Driver survey, transpo platform (once live)	OARC
		Driver retention across regions to be at least 60%	Annual	N	To be baselined upon program implementation	Coordinating centers	OARC
		Tracking of # of appointments which would have been missed	Semi-Annual	Y	To be baselined upon program implementation	Passenger survey	OARC & OSDH
	Non-traditional workforce expansion: Community paramedicine	Increased # of trained community paramedics	Annual	Y	Y0: 40 counties Y1-5: 60+ each year	EMS data / provider, training placement surveys	OSU & OSDH
		# of people treated via community paramedicine, # of home visits	Quarterly	Y	To be baselined upon program implementation	EMS tracking via paramedic form/survey, Uncompensated care fund	OSU & OSDH
		Decline in rate of ED utilization in counties with community paramedics	Quarterly	Y	To be baselined upon program implementation	Programmatic survey	OSU & OSDH
	Non-traditional workforce expansion: Doulas	# of Doulas trained to practice in rural counties	Annual	Y	Y1: 0 (w/in this program) Y2-5: 30+ doulas trained each year	Reporting through training provider	Doula vendors & OSDH

Initiative-Specific Metrics							
Initiative	**Fund use**	**Metrics**	**Cadence of collection**	**County (Y/N)**	**Baseline/Target**	**Data source**	**Metric collection resp.**
		# of Doulas registered as Medicaid providers	Annual	N	To be baselined upon program implementation	Medicaid provider data	Doula vendors & OSDH
	BH integration in primary care	# of Primary Care Practices providing MAT	Quarterly	Y	To be baselined upon program implementation	Program logs	Awarded providers
		% of individuals screened & screened positive for SUD & OUD	Quarterly	Y	To be baselined upon program implementation	Provider EHR	Awarded providers, OSDH
		Use of pharmacotherapy (MAT) for OUD	Quarterly	Y	To be baselined upon program implementation	Provider EHR	Awarded providers, OSDH
	Technology cooperative for PCPs and BH providers	% decrease in reported documentation time for participating providers	Annual	N	Baseline: N/A Y3-5: at least 20%	Provider survey	Administrator
	School-based health services with focus on BH	# of schools equipped & billing Medicaid services	Annual	Y	To be baselined upon program implementation	Program logs	Participating schools, OHCA
		Reporting of service types offered by schools & # of visits	Annual	Y	To be baselined upon program implementation	School reporting	Schools, OHCA
Upstream prevention	Chronic disease management programs	Participant retention across all sites	Quarterly	Y	Y2-5: at least 70%	Administrator data, EHR	Administrator, OKSHINE
		Reductions in complications from disease progression	Annual	Y	Y1-3:0 Y4-5: at least 5%	EHR, provider(s), survey	Administrator, OKSHINE
		Improvement in symptoms following entrance in program vs. non-enrollees	Annual	N	Y1-2:0 Y5: at least 10%	Patient, provider survey	Administrator
	Community referral platform	# of CBOs by county	Quarterly	Y	To be baselined upon program implementation	Portal, community support survey	OHCA

Initiative-Specific Metrics							
Initiative	**Fund use**	**Metrics**	**Cadence of collection**	**County (Y/N)**	**Baseline/Target**	**Data source**	**Metric collection resp.**
		% of closed-loop referrals	Quarterly	Y	To be baselined upon program implementation	Portal entry by referred org, HIE	OHCA
		User satisfaction rate for platform	Quarterly	N	Y4-5: at least 55%	Patient, provider survey	County health depts/OHCA
	Consumer-facing tech, including BH	Mental health disorder rates (as determined by validated BH screens like PHQ-9)	Annual	N	To be baselined upon program implementation	App data	App vendor, administrator
		Childhood overall mental health rates between app / non-app users	Annual	N	To be baselined upon program implementation	App data	App vendor, administrator
		Stickiness ((DAU/MAU: daily active users / monthly active users) x 100)	Monthly	N	Y2-5: 25%	Internal app data	App vendor, administration
		# of actionable alerts from tech triggering provider / CHW intervention	Quarterly	Y	Y1:0 Y2-5: 5-10% of readings with 1-3% requiring action	EHR, internal data	App vendor, administrator
	CHW expansion	Decrease in readmissions among multivisit patients	Annual	N	Y1-2:0 Y3-5: at least 10%	Partner hospital data / HIE	Partner hospitals
		Utilization (as factor of caseload determined by support intensity and setting)	Quarterly	N	Y1-2: 50% Y3-5: 100%	Partner hospital data	Partner hospitals
	Wellness hubs: Microgrants	Reports on the expenditures & projects from awarded county health departments	Once per project lifecycle	Y	Y1 of implementation: 0 >Y1 implementation: 25%	Community survey, asset use data	County health depts./OSDH
	Lung cancer screening	Early diagnosis rate (baselined defined by American Lung Association)	Annual	Y	Baseline: 23.4% statewide as of 2024 Target reduction to be identified at a county level from county baselines	Oklahoma Central Cancer Registry	OSDH

Initiative-Specific Metrics							
Initiative	**Fund use**	**Metrics**	**Cadence of collection**	**County (Y/N)**	**Baseline/Target**	**Data source**	**Metric collection resp.**
		Screenings in newly equipped health systems	Quarterly	Y	To be baselined upon program implementation	Reporting through providers	OSDH
	Support for school-based fitness programs	# of schools / physical education departments funded through the program	Annual	Y	Y1-5: 60 schools each year	Reporting through administrator / disbursements	OSDE
		Active users of the fitness application (as a portion of eligible students)	Annual	N	Y3: 50% of eligible students at participating schools	Application data tracking	OSDE
		Pass rate for students in program schools	Annual	Y	To be baselined upon program implementation	School reporting	OSDE
Facilitating regional collaboration	Regional reorientation	% of rural hospitals operating with improved margin	Annual	N	To be baselined upon program implementation	Financial reporting	OSDH
	CIN development	# of rural hospitals and clinics participating in CIN / # eligible	Annual	N	Baseline: N/A Y2: 20%, >Y3: 30%	Provider & state program logs	CIN
		% savings realized in administrative spend among participating facilities	Annual	N	Baseline: N/A Y2-5: 20%	Provider & state program logs	CIN
		% member hospitals participating in at least one value-based or alternative payment model	Annual	Y	Baseline: N/A Y3: 80%; >Y4: 100%	Provider logs	CIN
	Centralized EMS	Counties connected to central EMS by region	Semi-annual	Y	Y1-2:0 Y3-5: at least 3 new counties / region	EMS Platform data	Vendor, OSDH
		Increase in patients receiving care within medical standard timelines	Annual	N	Y4-5: at least 6% increase (absolute)	EMS Platform data, EHR, HIE	Vendor, OSDH, OKSHINE
		Reduction in administrative time for reports	Annual	N	Y5: at least 10%	Platform data, EHR, HIE, provider survey	Vendor

Initiative-Specific Metrics							
Initiative	**Fund use**	**Metrics**	**Cadence of collection**	**County (Y/N)**	**Baseline/Target**	**Data source**	**Metric collection resp.**
Shifting to value	Practice enablement	% of participating practices with signed VBC contracts	Annual	N	Y2: at least 25% >Y3: at least 50%	OHCA tracking	OHCA
		Improvement in rates of relevant CMS core set measures for preventive care	Annual	N	To be determined upon program implementation	OHCA tracking	OHCA
	PACE	# of participants enrolled	Quarterly	Y	Y1: ~800 participants Y4: 1400+ participants	PACE reporting	PACE centers/OHCA
		Reductions in ED utilization v similar Medicaid members by 15-20%	Quarterly	N	To be baselined upon program implementation	PACE reporting	PACE/OHCA
		Lower net Medicaid cost per dual enrollee by 10%	Quarterly	N	Y1: Participants on Medicaid Cap: $3,721. PMPM Y4: Increased # of participants transitioned to PACE cap: $3,349 *Note: rates may change overtime per state rulemaking*	PACE capitation rate, Medicaid capitation rate	OHCA
		Caregiver surveys before v after PACE enrollment (reported high stress among caregivers, improved ability to care for self)	Annual	N	To be baselined upon program implementation	Caregiver surveys	OHCA
	PCP clinical extension models	Average risk-adjusted total cost of care per attributed member	Annual	N	N/A	Provider reporting	OHCA
Growing next generation rural talent	Rural residency	# of available rural residency positions	Annual	N	Y2: 6 new programs established	Residency provider tracking	OSDH
	Rural relocation incentives	# of providers re-located to rural communities	Annual	Y	Y1: 10 Y2-5: 30 total	HWTC tracking	HWTC

Initiative-Specific Metrics							
Initiative	**Fund use**	**Metrics**	**Cadence of collection**	**County (Y/N)**	**Baseline/Target**	**Data source**	**Metric collection resp.**
	"Grow your own"	Enrollment in the High School LPN training	Annual	Y	Y2: 85% of available seats are filled Y3-5: 90% of available sets are filled	CareerTech reporting	OSDH
		Placement rate in careers or higher education (by high school / county)	Annual	Y	To be baselined upon program implementation	CareerTech reporting	OSDH
		Ratio of credentialed nurses to population in counties with new HS LPN programs	Annual	Y	To be baselined upon program implementation	NCSBN nurse registration statistics	OSDH
Building health data utility	EHR expansion	% of rural providers and clinics connected to a preferred EHR	Annual	Y	Y1-2:50% Y3-5: 75%	HIE / provider survey	OKSHINE
		Rural providers and clinics using EHR on day-to-day basis	Annual	Y	Y1-2: 33% Y3-5: 66%	Provider survey	OKSHINE
		State EHR satisfaction rating by connected providers / clinics	Annual	N	Y5: at least 55%	Provider survey	OKSHINE
	Interoperability through HIE	HIE RHC penetration (statewide)	Quarterly	N	Y1-3: baseline 3%; Y4-5: 50%	HIE	OKSHINE
		HIE downtime	Annual	N	Y4-5: no more than 5% /yr	HIE internal	OKSHINE
		HIE satisfaction rating by connected providers / clinics	Annual	N	Y5: at least 55%	Provider survey	OKSHINE
		Imaging, pharmacy, public health, and PDMP/death data available by county	Annual	Y	Y1-4:0 Y5: data available in 100% of counties	HIE, provider survey	OKSHINE
		Decrease in duplicate testing rates from 2025 by county	Annual	Y	Y1-4:20% absolute current rate Y5: at least 15% relative decrease	HIE, Medicare / Medicaid billing data	OKSHINE

Initiative-Specific Metrics							
Initiative	**Fund use**	**Metrics**	**Cadence of collection**	**County (Y/N)**	**Baseline/Target**	**Data source**	**Metric collection resp.**
	Integrated data & analytics	Participant self-report of analytic / dashboard use	Annual	N	Y5: at least 50%	Provider survey	OKSHINE
		Reduction in unaddressed care gaps by county	Annual	Y	Y1-4:0 Y5: at least 15%	CareGaps reporting	OKSHINE

Oklahoma will coordinate evaluation activities across OSDH, subrecipients, and CMS to maintain consistency in data reporting and analysis. The State will collaborate with academic partners to conduct independent evaluations of initiatives with broad or systemic impact, such as regional collaboration and VBC, and will fully participate in CMS-led monitoring and evaluation activities. This coordinated approach ensures that lessons learned inform ongoing program improvement and provide a foundation for sustainable rural health transformation.

7. Sustainability Plan

Oklahoma's RHT initiatives are built for lasting impact beyond the grant period by embedding successful models into State policy and reimbursement systems, strengthening partnerships, and aligning with long-term Medicaid and health priorities.

Sustainability by Initiative Type:

Initiatives and associated activities will be sustained beyond the five-year RHT Program period to ensure lasting change through one of five models:

- **Billable service:** For funding using establishing new services, OSDH and administrators will pursue reimbursement pathways and secure payer coverage, including development of State Plan Amendments (SPA) and collaboration with the Oklahoma Legislature to incorporate new models into the SoonerCare Medicaid State plan and other payer mechanisms to ensure long-term financial sustainability.
- **Provider assumed cost:** For fund uses improving provider efficiency and reducing operating costs, providers will assume ongoing costs after startup (e.g., regional collaboration membership dues). OSDH will assist providers in identifying savings and revenue strategies that enable continued participation without State or federal support.
- **Private funding:** Private and philanthropic partners will be engaged to sustain and scale selected fund uses. Examples include individuals self-funding career-advancing training and healthcare-

focused philanthropies investing in community or population health networks to complement public investments and extend program reach.

- **Government funding:** For fund uses aligned with or expanding existing publicly funded programs, recipients may pursue complementary federal, State, local grant, or appropriations opportunities to meet ongoing needs.
- **One-time payment:** Select fund uses will require onetime startup investments and will thereafter operate independently through established reimbursement, cost sharing, or revenue-generating mechanisms.

Sustainability by Initiative

Across each fund use, OSDH is committed to long-term sustainability through tailored combinations of these models to maintain program impact beyond the RHT funding period.

Sustainability by Initiative and Fund Use			
Initiative	**Fund use**	**Sustainability plan**	**Rationale**
Innovating the care model	Telestroke expansion	Billable service	Funding to cover startup equipment and software. Providers will assume minimal ongoing maintenance costs. Services will be billable through Medicaid and other payers, with sustainability strengthened by policies simplifying telehealth billing.
	Maternal–Fetal Medicine telemedicine expansion		
	RPM: Maternal	Billable service	Funding will expand maternal health RPM pilots; SPA will establish billing through Medicaid and other payers based on proven effectiveness.
	Transportation expansion	Government funding	Pilots will demonstrate value for braided funding that combines Medicaid, FTA 5310/5311, VA, tribal, hospital, workforce, and philanthropic sources.
	Expanding care: Community Paramedicine	Private entity funding; Billable service	Ongoing EMS training funded by philanthropic partners (e.g., Masonic Foundation). Providers receiving uncompensated care funds must track utilization, ED avoidance, visit duration, and services. Using these data, the State Medicaid agency will submit a SPA and engage payers on treat-in-place and community paramedicine coverage.
	Expanding care: Doulas	Private entity funding; Billable service	Doula training funded by individuals seeking certification, encouraged by growing rural demand. Providers receiving uncompensated care funds must track utilization and outcomes. Data will inform OHCA's SPA and payer engagement for expanded doula coverage.
	BH integration in primary care	Billable service	Funds equipment and training to expand MAT prescribers or extend services to PCP clinics. MAT is billable through most payers and self-sustaining after startup.

Sustainability by Initiative and Fund Use			
Initiative	**Fund use**	**Sustainability plan**	**Rationale**
	Technology cooperative for PCPs and BH providers	Provider assumed cost	Funding will cover initial costs to stand up the cooperative. Providers will pay applicable dues to maintain membership, offset by cost benefits gained through cost savings from purchasing negotiation.
	School-based service support	One-time payment	Services will be billable after SPA approval; funding is onetime startup payment to provide technical assistance and limited staff recruitment assistance.
Moving upstream	Chronic care prevention and management program	Billable service	Following funding for initial program startup, plan to leverage using proven ROI compared to current treatment protocols to advocate for Medicaid and other payer coverage expansion to new models.
	Closed-loop community care platform	One-payment: Provider assumed cost	Funding will be used to expand referral platform access to 39 CAH / 4 rural emergency hospitals and county health departments without current platforms; ongoing maintenance costs will continue to be assumed by providers and/or OHCA.
	Consumer -facing tech, including BH	Billable service	Funds pilots for consumer-facing tech to demonstrate ROI, with plans to transition to value-added benefits or service coverage for managed care entities and providers.
	CHW expansion in hospitals	Billable service	Funds CHW hospital pilots to demonstrate effectiveness and support payer coverage expansion. Hospitals receiving uncompensated care funds must track utilization and outcomes. Data will inform OHCA's SPA and payer engagement to broaden CHW service coverage.
	Wellness hubs: Microgrants	One-time payment	Funds onetime community microgrants for lasting wellness infrastructure; communities will absorb ongoing costs.
	Lung cancer screening	Billable service	Funds development of screening in rural health systems; services will be sustainable as billable through Medicaid and other payers.
	Presidential Fitness preparation funding	One-time payment; Private entity; Government funding;	Funds supplies and programming to help physical education departments prepare students for the Presidential Fitness Test. Ongoing application maintenance can be sustained through Oklahoma TSET funding or fitness technology partnerships.
Facilitating regional collaboration	CIN development	Provider assumed cost	Funds initial CIN setup. Ongoing dues paid through value-based care (VBC) arrangements between providers and payers. CIN sustainability is supported by VBC participation and savings from group purchasing.
	Rural Regional Reorientation Plan	One-time payment	Funds onetime grants and incentives, resulting in more efficient healthcare systems moving forward.
	Centralized EMS	Government funding	Funds initial buildout cost of centralized EMS system; ongoing licensing and maintenance cost covered by the State the current trauma fund.
Shifting to value	Practice enablement	Provider assumed cost	Funds primary care transition to downside risk model; sustained long-term through savings generated by the new approach
	PACE expansion	Billable service	Funds startup and initial costs for new PACE clinics; services become billable through Medicaid and other payers once operational.
	PCP clinical extension models	Billable service	Funds pilot of clinical model; payers and providers expected to adopt after proven effectiveness.
Growing next gen rural talent	Rural residency	Private entity; Government funding	Funds program startup and initial residents. Residency programs will pursue sustainable funding through State Graduate Medical Education (GME) appropriations, health system cost sharing, and philanthropic support after the RHT Program concludes.
	Rural relocation incentives	Government funding	Ongoing provider incentives can be incorporated into existing State budget for similar workforce opportunities.
	"Grow Your Own"	Private entity	Program funding may be integrated into the CareerTech budget and supported by education grants once established and with student interest.

Sustainability by Initiative and Fund Use			
Initiative	**Fund use**	**Sustainability plan**	**Rationale**
Building health data utility	EHR expansion	Provider assumed cost	Funds onetime connectivity startup; providers will absorb minimal ongoing costs, offset by EHR benefits.
	HIE interoperability	Provider assumed cost	Funds initial maintenance: providers will assume ongoing maintenance and subscription costs.
	Integrated data and analytics	Government funding	Funds ingestion, app development, and integration; State covers ongoing licensing, with base platform costs passed to providers.

Integration into Ongoing Policy and Financial Transition

Oklahoma is committed to ensuring that the lessons and goals from this RHT Program are incorporated into the State's long-term policy and broader healthcare strategy, with the intent to maintain the program impact for Oklahoma for years to come. For example, all initiatives related to currently uncompensated services (maternal health RPM, community paramedicine, Doula services, and CHWs) will require data and outcome collections serving as the basis for setting rates, refining coverage conditions, and demonstrating ROI for long-term Medicaid coverage. OHCA, the State Medicaid department, is committed to leveraging the data to assess incorporation of these services into Medicaid policy.

Additionally, Oklahoma expects some impact from recent Medicaid financing changes and will use RHT Program benefits to support the healthcare ecosystem through this transition. Oklahoma leverages provider taxes (currently 4%) to fund State directed payments, and because they are connected, Oklahoma will see effects from the reduced State Directed Payment reference rates but limited impact from the 3.5% cap on provider taxes. However, rural hospitals will likely require support to adjust to the reduction in State directed payments, which transformation from the RHT Program can help provide. The RHT Program will help build financially sustainable rural providers by reorienting care toward lower-cost settings, improving cost bases through regional collaborations, and supporting sustainable financing approaches through coverage expansions.

Sustaining these initiatives will also rely on targeted legislative and regulatory actions, including the development of State Plan Amendments, incorporation of proven models into Oklahoma Statutes and

administrative rules, and continued collaboration with the Oklahoma Legislature to align funding and policy frameworks with long-term RHT goals. Oklahoma's sustainability approach transforms short-term RHT investments into lasting change. Successful initiatives, such as rural affiliation models, IT infrastructure development, workforce expansion, and telehealth programs, will persist beyond the RHT funding period through permanent coverage benefits, legislative appropriations, and alternative payment models that generate continued savings. The partnerships and delivery models established under RHT are designed to be self-sustaining, supported by a mix of public, private, and provider-based funding. Lessons learned will be incorporated into State policy, Medicaid managed care contracting, and future health improvement planning. Through these measures, the State will maintain program benefits, strengthen rural resilience, and carry forward a transformed, sustainable system of care well beyond FY31.