Section 1: Rural Health Needs and Target Population

Illinois is the sixth most populous state in the nation and home to 12.7 million residents in 2024.[1]

Outside of the Chicago metro area, Illinois is largely rural. As further detailed below, individuals

living in rural parts of the state tend to have worse health

outcomes and face structural barriers in access to critical

healthcare services. The intent of Illinois' Rural Health

Transformation (RHT) project is to direct resources to reshape

the way healthcare is delivered across rural Illinois. The RHT

project is focused on interventions targeting individuals who

reside in census tracts spanning over two-thirds of the counties

in the state (85 of 102 counties) that are classified as rural as

defined by the Health Resources and Services Administration

(HRSA) using the following criteria: 1) Non-metropolitan counties, 2) Outlying metropolitan

counties with no population from an urban area of 50,000 or more people, 3) Census tracts with

Rural-Urban Commuting Area (RUCA) codes 4-10 in metropolitan counties, 4) Census tracts of

at least 400 square miles in areas with population density of 35 or fewer people per square mile

with RUCA codes 2-3 in metropolitan counties, 5) Census tracts with Research Report Series

(RRS) 5 and RUCA codes 2-3 that are at least 20 square miles in area in metropolitan counties.

Non-metro areas of the state are home to approximately 1.6 million rural residents,[2] and these

rural areas are located mostly in the southern and western parts of the state.[3]

Rural Demographics

In 2023, Illinois' median household income was approximately $81,000 with a poverty rate of

11.7%.[4] For rural areas, the median household income was $63,000[5] with 13.9% of rural

residents living in poverty.[6] Healthcare and social assistance, transportation and warehousing, and manufacturing and agriculture are among the top employment sectors in rural Illinois, however, 2020 data shows that employment has *declined* across all of these sectors in recent years .[7] Unemployment rates were slightly higher in rural areas (4.7%) compared to metro areas (4.4%) of the state.[8] Educational attainment in rural areas shows that a majority of residents have a high school education (35.6%) or some college experience (22.7%), with 9.4% having less than a high school education, 11.6% with an associate degree, and 20.7% holding a bachelor's or graduate degrees.[9] Across the state, approximately 6.95% of the population is uninsured while 16.7% are covered by Medicaid, 12.7% by Medicare, 1% by military or Department of Veteran Affairs (VA), 10.2% marketplace (non-group), and 52.6% by employers.[10] In counties classified as fully rural by the Federal Office of Rural Health Policy (FORHP), the uninsured rate is 5.45% and Medicaid enrollment is 19.1%.

Health Outcomes

According to America's Health Rankings, health outcomes are worse among the rural population in Illinois. Approximately 42.9% adults are obese (35% in metro areas), 38% have been diagnosed with hypertension (32.8% in metro areas), 14.3% have been diagnosed with diabetes (11.9% in metro areas), and 19.3% of adults smoke cigarettes (9.6% in metro areas) with an additional 10.3% using e-cigarettes (5.6% in metro areas).[11] Rural residents are less physically active as well: 27% of adults report no physical activity other than their job compared to 20.5% in metro areas.[12] In addition, cancer screening and early detection may lag in rural areas, contributing to worse cancer outcomes.[13] Lastly, many of the highest rates of overdose deaths and opioid prescriptions are in Illinois' most rural counties in southern and western Illinois.[14]

In 2022, Illinois had 128,493 live births.[15] Forty percent of births were financed by Medicaid and 42% of Medicaid births are in rural areas.[16] Birth outcomes, such as infant mortality rates, maternal mortality rates, and maternal morbidity are generally higher in rural areas. In 2021, the state infant mortality rate was 5.6 per 1,000 live births. The infant mortality rate among rural counties was even higher (6.4 per 1,000 live births).[17] Between January 2018 and December of 2023, there were 28 obstetric hospital closures, 7 of which were in rural counties, resulting in a 24% decrease in birthing hospitals in Illinois.[18]

Healthcare Access

Illinois has a network of Critical Access Hospitals, Rural Emergency Hospitals, Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Short-Term Hospitals to serve its rural population.[19] Small and rural hospitals account for 22% of the state's total outpatient visits and 9.8% of inpatient days. They treat a larger portion of older patients (45.3%) compared to other hospitals (37.3%) and thus are more dependent on Medicare as Illinois' aging population continues to grow.[20] Unfortunately, rural Americans often live twice as far from the nearest hospital compared to those in urban and suburban areas.[21] Access to care in rural Illinois is increasingly fragile as hospitals consolidate or downsize service lines, increasing travel distances to comprehensive care.

With greater distances to travel, transportation is key to healthcare access in rural communities. Rural transportation in Illinois can be challenging, as public transit options are limited and much less robust relative to metro areas. Transportation services in these regions often operate on a demand-response (call-ahead) basis due to low population density, though some areas are trying more frequent options.[22]

Although the state's healthcare network appears robust on a map, numerous rural counties continue to be designated as Healthcare Professional Shortage Areas (HPSAs). For primary care and behavioral healthcare practitioners, most rural counties face critical shortages.[23] The Illinois State Medical Society (ISMS) predicts that Illinois will face a shortage of 6,200 physicians by 2030.[24] This shortage will not just be in rural counties but also impact urban communities in the state. Healthcare facilities in Illinois are mapped in "Other Supporting Documents."

Rural Facility Financial Health

Rural hospitals and clinics are essential for sparsely populated areas in Illinois, but they see fewer patients and face unique challenges compared to the state's urban regions. These facilities operate with tighter budgets and fluctuating demand, making their role both significant and vulnerable. In response to looming federal cuts to Medicaid, Illinois policy makers estimate that over 270,000 residents could lose coverage, and rural Medicare/Medicaid funding reductions may total $6.36 billion – heightening the existential threat to already fragile rural providers.[25] Illinois was ranked in the top 25 of states with the most rural hospital closures in the past 19 years, with 4 rural hospitals having closed since 2005.[26,27] The University of North Carolina Sheps Center for Health Services Research identified 9 Illinois hospitals, predominantly located in rural communities, that are at risk of closure due to being in the top 10% Medicaid payer mix of rural hospitals across the country and/or having experienced 3 consecutive years of negative total margin.[28] Per the 2022 Medicare Hospital Cost Reports, rural Illinois hospitals have fewer financial reserves compared to non-rural hospitals. In aggregate, rural hospitals held 210 days cash on hand while non-rural hospitals held 485 days of cash on hand.[29]

Target Populations

Grounded in these needs, the RHT program will direct funding to entities that serve rural census tracts across Illinois – rather than relying solely on county designations – to ensure no rural community, including those embedded within metro counties, is overlooked. Within this framework, particular attention will be paid to sub-populations such as individuals living with chronic disease and those with mental health conditions. This targeted approach aligns resources with demonstrated need and positions partners closest to rural residents to deliver impact. The sections that follow detail how Illinois will translate this focus into specific initiatives, funding mechanisms, implementation plans, and performance measures to expand access, improve outcomes, and build a sustainable rural care system.

Section 2: Rural Health Transformation Program

2.1 Goals and Strategies

The Illinois Department of Healthcare Services (HFS), in strategic partnership with its sister agencies and interested parties, is committed to advancing the health of rural Illinois. HFS strives to "help Illinoisans access high quality healthcare and fulfill child support obligations to advance their physical, mental, and financial well-being."[30] Using the Centers for Medicare and Medicaid's (CMS) five strategic goals from the Rural Health Transformation (RHT) Program Notice of Funding Opportunity (NOFO), HFS has developed a clear plan for the future of rural healthcare in Illinois. This vision is built on the foundation of three key categories of initiatives which will incentivize the creation of hospital and provider partnerships, increase the use of technology and mobile health services, and expand the healthcare workforce within the state:

Initiatives	Strategic Goals	Key Activities of the Initiatives
Transforming Rural Healthcare Delivery Hospital Transformation Community Care Infrastructure Hospital Disease Prevention	Innovative care Make rural America healthy again Sustainable access	Catalyzing value-based care models, regional health care partnerships in the hospital and primary care practice spaces, practice transformation, and population health improvement through the development of: • Hospital transformation grants (planning grants in year 1, project funding in years 2-5) • Primary care and behavioral health integrated, team-based care • Value-based payment initiatives (beginning in year 2) • Chronic disease prevention programming
Overcoming Geographic Barriers to Care EMS and Mobile Healthcare Technological Innovation for Virtual Care	Sustainable access Tech innovation	Creating opportunities for individuals in rural settings to receive appropriate access to services while remaining in their communities across all budget years: • Infrastructure investment in EMS, mobile health clinics, and mobile crisis units • Investment in telehealth and technological innovation
Building a Resilient Rural Workforce Healthcare Workforce Expansion Training Healthcare Support Workers Rural Health Education Pipeline	Workforce development	Foundational investment to fill urgent gaps in the rural healthcare workforce through all budget years: • Scholarship and university program expansion • Regional training and certification programs • Expansion of community college programs • Expansion of high-school community outreach programs

Each of HFS' initiatives has been informed by significant engagement with Illinois' provider community, state government partners, community advocates, and other stakeholders. The Department prioritized consensus and collaboration, and received strong support and suggestions focused on three main goals: (1) incentivizing sustainable provider networks in rural areas by encouraging hospital-provider partnerships to ensure ongoing care and movement towards value-based payment (VBP) models that give residents access to comprehensive treatment; (2) breaking down barriers by bringing healthcare directly to the individual in rural communities through transportation, mobile services, and technology like telemonitoring; and finally (3) strengthening the local workforce by expanding clinical and non-clinical training opportunities for rural health professionals.

Each initiative will be implemented over the course of this grant award, aiming to increase community care capacity through workforce investments, expansion of mobile and technology-enabled services, and the development of new health care networks and partnerships intended to support the long-term sustainability of the health care infrastructure in rural Illinois. For example, HFS recently submitted for CMS approval a State Plan Amendment (SPA) to expand treat-no-transport services, allowing Medicaid payment for eligible medical care provided by emergency medical service (EMS) providers even if the patient is not transported. HFS is also evaluating state policies to support sustainable funding beyond the grant period, such as Medicaid reimbursement for services delivered via technology-enabled delivery systems and future VBP options as the grant initiatives develop. This will support the long-term sustainability of these efforts through commercial, Medicare, and Medicaid reimbursement when possible. HFS' chosen initiatives are interlinked with each other in a manner that builds the healthcare workforce, healthcare capacity, expands the reach of existing providers, and aligns with all of the strategic goals of the RHT program, as follows:

Improving Access & Technology Use: The proposed initiatives improve rural healthcare access by increasing service capacity at hospitals, community mental health centers (CMHCs), and FQHCs, funding the expansion of technology-enabled services like specialist e-consultations and telehealth visit modalities, expanding mobile care availability, and investing in workforce initiatives that grow availability of healthcare in rural Illinois. The Illinois Critical Access Hospital Network (ICAHN) will provide centralized planning and deployment of virtual technologies to hospitals' systems and provider collaboratives across rural Illinois. ICAHN will also support providers in expanding the use of consumer tools, such as mobile health apps, prenatal tracking, and teletherapy access, while also deploying AI and automation for eligibility

verification, scheduling, and clinical documentation to free up staff time for more direct care service provision.

Improving Outcomes: The state intends to use a portion of the grant funds to direct hospitals to leverage findings and perspectives gathered in their most recent community-health needs assessments to identify public health priorities within their communities and deploy evidence-based interventions to prevent and manage disease. Hospitals will be encouraged to think beyond the walls of their facilities and use these funds to bring wellness and prevention to community spaces, like schools, places of worship, grocery stores, gyms, and community centers to improve the health and overall wellbeing of the communities they serve. HFS' approach to measuring the impact across RHT initiatives is detailed further in Section 6: Metrics and Evaluation Plan.

Partnerships: Illinois initiated Health Transformation Collaboratives (HTCs) in FY2021 to fund hospital and provider partnerships to expand service offerings and care collaboration to implement integrated, person-centered, community-focused care throughout the state.[31] The mission of HTCs is to reorient Illinois' healthcare delivery system around people and communities. This includes investing in projects, large and small, that improve outcomes, decrease disparities, and are sustainable over time. HTCs focus on community needs for all levels of healthcare with an emphasis on improving health and wellness for individuals and communities.

HFS will fund both the expansion of successful examples of these initiatives and new initiatives that build on these same principles. A significant portion of Illinois' RHT funding will be used to seed partnerships across rural Illinois, between rural hospitals and community practitioners to expand care offerings and transform service lines and care delivery, as well as invest additional funds in scaling successful HTC programs in rural areas of the state. While hospitals will serve

as the backbone of these efforts, collaboration with other providers in their communities will be essential.

Workforce: In partnership with Illinois' state university system, the Illinois Community College Board (ICCB), and ICAHN, the state will expand scholarships, fellowships, and other training initiatives for clinical professionals, as well as training and certification programs for healthcare support staff. Funding will be dedicated to broadening access to training, certification, and apprenticeship opportunities in rural communities, thereby reducing barriers to participation for residents of these areas. Funding will also support the expansion of existing scholarship programs to include new slots for rural students and introduce scholarships for clinical and non-clinical fields, such as doulas, lactation consultants, and Community Health Workers (CHWs). Together, these initiatives will increase the availability of a variety of health professionals in rural Illinois.

Data-Driven Solutions: In partnership with ICAHN, Illinois will conduct healthcare provider specific assessments of technology infrastructure and interoperability capacity, provide Technical Assistance (TA), and coordinate vendor selection to assist providers with selecting customized technology solutions to meet their unique needs while simultaneously building the infrastructure necessary for statewide coordination and interoperability. Ultimately, this will enable providers to expand service offerings to include telehealth visits with specialists in areas of the state where those services may not otherwise be available, and to expand the use of e-consultations between primary practices and specialists to allow patients to receive appropriate, necessary care within their communities.

Financial Solvency Strategies: Illinois' RHT initiatives are designed to provide the up-front investments in partnerships, technology, and infrastructure needed to fund the care interventions

that are covered, or will be covered with updates to policy, under the Medicaid program. For example, in the "Transforming Rural Healthcare Delivery" initiatives, investments will be made in transformational partnerships between hospitals and community providers to right-size facilities, reduce reliance on inpatient models of care, reduce rural facility bypass by improving the quality of local healthcare options, and provide new revenue opportunities through new service offerings that were not available previously. These adaptations in healthcare provisions, coupled with a close examination by the state of reimbursement policies, will help move these hospitals to higher quality, higher efficiency, and lower cost models of care.

Similarly, the "Overcoming Geographic Barriers to Care" initiatives provide support for the infrastructure, capital investments, equipment, and expanded rural workforce to improve the mobile care capabilities of EMS providers. At the same time, state Medicaid policy is moving toward implementing a treat-and-no-transport payment structure in Medicaid to ensure that EMS providers can receive reimbursement for the new capabilities this funding will provide.

Cause Identification: Illinois hospitals, particularly standalone rural hospitals, have experienced significant financial distress over several decades as they struggle to maintain service lines and avoid closure. Factors that specifically impact rural standalone hospitals include exponential cost growth, low or inconsistent patient volumes, inadequate reimbursements, shifting patient care patterns, and lack of economies of scale. With recent advances in medicine and technology, more conditions, including serious chronic conditions, can be treated in an outpatient setting. Yet many rural hospitals maintain large, inpatient facilities that are rarely fully occupied. Patients will too often bypass independent rural hospitals that cannot offer the latest medical advancements, leaving them further struggling with patient volume. These hospitals are operating on thin margins with Medicare and Medicaid making up the vast majority of their

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claims. National reporting from 2023[32] indicates that Medicare covered a larger share of hospital

discharges in rural areas (53%) compared to private insurance (19%) illustrating a skewed payor

mix, which negatively impacts rural hospital financial solvency and supports the Illinois Health

and Hospital Association reporting of 29.4% of small and rural hospitals operating on negative

or thin margins. Further, when examining the most recent CMS hospital reporting data, hospitals

with the highest percentage of uncompensated care were located in downstate counties:

Montgomery (7.74%), Wayne (9.5%), Fayette (9.88%), Clay (10.57%), and Williamson

(11.97%).[33]

Illinois' RHT program addresses the challenges faced by these struggling, independent hospitals

by supporting their strategic transition away from inpatient to enhanced outpatient care, adoption

of telemedicine to expand access to specialty care, and partnerships that allow small hospitals to

create economies of scale by leveraging advanced patient care tools and back office support

technology. In addition, this model drives small hospitals to experiment with new VBP models

that can become sustainable when the proper infrastructure is in place. These investments are all

included in the "Transforming Rural Healthcare Delivery" category of Illinois' RHT program.

Program Key Performance Objectives: In alignment with the types of outcomes outlined in the

NOFO, HFS has designed key performance objectives to cover the following categories: access

to care, patient health outcomes, total cost of care, rural facility financial stability, access to

emergency services, provider to patient coverage ratios, and patient access to health data. For

example, Illinois' RHT program includes a metric for frequency of breast cancer screenings to

measure access to preventive care. A metric measuring the annual cost of care per member is

also included related to gauge cost-effectiveness. Each of the metrics outlined in Section 6:

Metrics and Evaluation, directly tie to HFS' overall program goals to CMS' vision for the RHT Program.

Strategic Goals Alignment: The proposed initiatives touch all five of the strategic goals identified in the NOFO. Initiatives in category #1, Transforming Rural Healthcare Delivery, aligns with the strategic goals of Innovative Care, Make Rural America Healthy Again, and Sustainable Access. HFS is confident that the formation of provider partnerships for hospitals and integrated care models for primary care and behavioral health practices built upon the state's successful HTC models will enable providers to provide significantly improved care coordination and chronic disease management to improve health outcomes. The partnerships will facilitate the sharing of resources and data systems to provide better care coordination for patients and the implementation of sustainable alternative payment models. Initiatives in category #1 will also address the Make Rural America Healthy Again strategic goal by funding chronic disease management, nutrition education programming, and other rural health initiatives provided at rural hospitals through partnerships between the Illinois Department of Public Health (IDPH), local health departments, primary care providers, and local community hospitals including Critical Access and Rural Hospitals.

Initiatives in category #2, Overcoming Geographic Barriers to Care, will address the Sustainable Access and Tech Innovation strategic goals through investments in mobile health services, expansion of EMS capabilities, and state investments in telehealth, interoperability, Electronic Health Record (EHR) modernization, and other technological innovations to expand healthcare service offerings, especially access to specialist services where they currently are not readily available, in rural areas of the state.

Finally, initiatives in category #3, Building a Resilient Rural Workforce, will address the Workforce Development strategic goal through the expansion of existing state scholarship programs for students in healthcare workforce programs covering both clinical and non-clinical specialty areas, by increasing the availability of training and apprenticeship programs, and growing the reach of local outreach activities that target individuals interested in pursuing certification and training in high-need health care workforce positions in rural areas of the state.

Legislative or Regulatory Action: Illinois submitted a SPA on September 30, 2025 to request CMS approval to provide Medicaid reimbursement for EMS "treat-no-transport" services, also known as "treatment in place," which allows EMS providers to treat a patient on site if they do not need to transport that individual to a hospital or other health care facility. HFS is pursuing this policy because providers are currently performing this service without reimbursement, and because it is critical to begin to pay for this and other similar activities in the Medicaid program as Illinois transitions to new care models that rely on far reaching interventions. HFS is also reviewing state policy options for implementing VBP in the Medicaid program and will aim to align the state's RHT efforts with other payment reform initiatives (e.g., Illinois' Transforming Maternal Health (TMaH) model) as appropriate, to ensure alignment between the state's RHT program broader HFS goals. Finalization of the policy approach to VBP will occur by the end of the 5-year grant period. Transition to VBP is necessary to continue the incentives initiated by these grant funds. These transformation models will change the way care is delivered and the way providers are organized in Illinois' rural communities, in effect amending provider payment structures to reward value and collaboration in a meaningful way and ensure these models are sustainable. Illinois's current policy by each state policy action identified in the NOFO are included in Table B below.

Other Required Information:

Table A: Rural Data Factors

Regional Facility and Population Factors	Illinois Data
A.1. Absolute size of rural population in a State	1,915,300
A.2. Proportion of Rural Health Facilities in the State	Critical Access Hospital: 55 Sole Community Hospital: 8 Medicare Dependent Hospitals: 6 Low Volume Hospitals: 11 Rural Emergency Hospitals: 0 Other Rural Hospitals: 10 **Hospital facilities: 83** Rural Health Clinic: 277 FQHC: 441 Community Mental Health Center: 1 Opioid Treatment Facility: 3 CCBHC: 11 **Other Rural Health Facility Types: 733**
A.3. Uncompensated care in a State	4.5%
A.4. % of State population located in a rural area	14.9%
A.5. Metrics that define a State as being frontier	0.5%
A.6. Area of a State in total square miles	55,519
A.7. % of hospitals in a State that receive Medicaid DSH payments	9.9%

Table B: State Policy Actions

Policy Factor	Illinois Policy
B2. Health and Lifestyle	Illinois schools are required to administer a physical fitness assessment per state statute.[34]
B3. SNAP Waivers	Illinois does not have an approved Supplemental Nutrition Assistance Program (SNAP) waiver and does not anticipate submitting a request for a SNAP food waiver restriction.
B.4. Nutrition and Continuing Medical Education	Illinois does not have a current requirement to include nutrition in continuing medical education for physicians.
C.3. Certificate of Need (CON)	The Cicero Report gives Illinois a total score of 65 indicating moderate Certificates of Need across facility categories.[35] The legislation authorizing CON in Illinois sunsets in 2029.
D.2. Licensure Compacts	Physician - IL is a member state of the Interstate Medical Licensure Compact (IMLCC).[36] Nursing – IL has legislation pending, HB 1706 (Morris), to join the Nurse Licensure Compact (NLC).[37] EMS – IL is not a member of the EMS Compact.[38] Psychology – IL is participating in the Psychology Interjurisdictional Compact (PSYPACT).[39] Physician Assistant (PA) – IL has legislation pending, SD 209 (Rezin), to join the PA Compact.[40]
D.3. Scope of Practice	PAs: IL PAs have an advanced scope of practice.[41] Nurse Practitioners (NPs) – IL NPs have a full scope of practice under Illinois state code 225 ILCS 65/65-43.[42] Pharmacists – IL Pharmacists have a formulary-based authority.[43]

	Dental Hygienist – IL Dental hygienists have a semi-restricted scope of practice.[44]
E.3. Short-term, limited duration insurance (STDLI)	Illinois state law currently prohibits STDLIs and is unlikely to amend this state policy.[45]
F.1. Remote Care Services	Live video – Illinois currently provides and reimburses for live video remote services. Store & Forward – Illinois only allows for Communication Technology Based Services. Remote Patient Monitoring (RPM) – Illinois currently provides and reimburses for RPM. In-state licensure exemptions – Some in-state licensure exemptions exist. Telehealth License/Registration Process – No telehealth license or registration process is currently in place. However, under the existing regulatory framework in Illinois, out-of-state physicians participating in the Interstate Medical Licensure Compact are allowed to render care via telehealth.[46] [47]

Section 3: Proposed Initiatives and Use of Funds

3.1 Transforming Rural Healthcare Delivery

Initiative 3.1.A: Hospital Transformation

Description: Problem statement: Rural hospitals across Illinois are facing unprecedented financial pressures, putting many at risk of closure. These closures threaten to deepen existing gaps in the continuum of care for rural communities, where access to essential health services is already limited by geographic isolation, workforce shortages, and resource constraints. As rural hospitals often serve as the backbone of local healthcare delivery, their instability jeopardizes not only emergency and inpatient care, but also the broader health and well-being of rural residents. As healthcare technology continues to evolve, the need to increase access to care via telehealth and other advanced technologies grows as well.

Objective: Addressing these challenges requires bold, creative solutions that rebalance and transform the rural healthcare landscape—ensuring that all residents, regardless of location, have access to high-quality, sustainable care. This transformation will demand innovative care models, strategic partnerships, and targeted investments to stabilize rural hospitals, close access gaps, and build a resilient and sustainable healthcare system for the future. This initiative will build upon

progress and lessons learned from Illinois' HTC initiative. The state has provided funding since 2021 to regional partnerships between healthcare providers and community-based organizations to test innovative models of care delivery to bridge gaps in care and address root causes of disease. There are 4 HTCs that serve rural communities today. Existing HTCs have already begun demonstrating positive health and healthcare cost outcomes, including increases in adult annual preventive visits, increases in outpatient care, decreases in emergency department (ED) utilization, achieving blood pressure control, and positive birth outcomes.[48]

Funding approach: The Hospital Transformation initiative is intended to catalyze the modernization of Illinois' rural healthcare delivery system through three strategic investments:

1. Transformation funding to hospitals to reshape healthcare delivery to better align with community needs and improve the long-term financial viability of rural hospitals. Funds may be used to support service line transformation and develop sustainable, high-quality care models through investment to:

- Establish regional partnerships and governance structures.

- Develop a transformation plan to identify delivery system gaps and unmet community needs and outline strategies to transform service lines, deploy new models of care delivery, and test sustainable VBP methodologies.

- Hire clinical and non-clinical staff across hospitals and partnership entities to carry out the strategies identified in the transformation plan.

- Support capital expenditures for renovations to transition lines of service.

The first year will award planning grants to hospitals to develop a regionally tailored and data-driven transformation plan, followed by selection of hospital partnerships in years 2-5 to carry out their transformation plans based on the merits and expected impacts of their proposals.

Because these funds are expected to support the infrastructure needed to enable success under VBP models, in years 4 and 5, additional funds will be allocated to support participating hospitals' transition to VBP models. While further development is needed, HFS expects this to take the shape of performance improvement payments or incentives to engage in downside risk contracting, not to exceed the 15% limit on provider payments.

Regional partnerships must include representation from at least one local hospital, primary care provider, behavioral health provider, and local health department. Partnerships should also include provider organizations that can help address the most pressing specialty, behavioral health, pediatric, and maternal care gaps. Existing regional governance structures like Illinois Children's Behavioral Health Transformation Initiative (CBHTI) Community Networks or the local Area Agencies on Aging will be encouraged to apply. Priority will be given to partnerships with distressed hospitals that show promising approaches to build a more sustainable operating model and partnerships in regions experiencing significant misalignment between community health needs and availability of care to address those needs.

2. Expansion funding for successful transformation projects for existing rural HTCs to scale models that have demonstrated initial success in improving access, quality, health outcomes, and/or cost effectiveness – particularly in counties across central, southern, and eastern Illinois. Because the intent of the HTC initiative is closely aligned with the strategic goals of the RHT program, these existing partnerships are already making an impact on RHT goals and represent a logical vehicle to build upon. HFS expects these entities to submit proposals with compelling evidence of impact for direct awards as subrecipients of RHT funds. Expected projects include:

- Carle Health: Expansion of a maternal and child Registered Nurse home visiting program, investment in mobile market capacity, expanding the reach of a mobile health clinic, and expanding behavioral health service capacity in Vermillion County.

- Egyptian Health Department and their participating hospitals: Scaling and expanding the reach of the Integrated Hub (iHub) model of care coordination between physical and behavioral healthcare providers, schools, community agencies, and families in rural southern Illinois, including Saline, Gallatin, White, Hamilton, and Wayne counties.

- OSF Healthcare: Scaling and expanding the Medicaid Innovation Collaborative (MIC) Perinatal program to reach 600 rural mothers annually across 16 communities. The initiative includes trimester-specific education, remote patient monitoring (RPM), regular patient check-ins, patient support, virtual visits, and post-partum visits.

- SIHF Healthcare (SIHF): Establishment of two InstaCare locations in Centralia and Mascoutah County, a model of urgent care that can address acute needs and provide more convenient access to primary care and specialty care through telehealth. Each site embeds comprehensive substance use disorder (SUD) services and support in addressing root causes of disease through CHWs and registered dieticians.

3. Technical Assistance (TA) to facilitate the development of regionally tailored and data-driven transformation plans. TA will help transformation grantees to identify community needs, conduct any additional community and provider-capacity needs assessment, and provide hands-on practice facilitation to support the transition to new operating models. HFS will leverage its longstanding partnership with the University of Illinois' Office of Medicaid Innovation (OMI) to retain local and national health system transformation experts and develop TA programming in support of this initiative. TA is expected to be supported over the 5-year program, first to support

hospitals in developing their transformation plans, second to support implementation and change management as hospitals execute their transformation plans, and third to support the design of VBP models and performance management structures to succeed under them.

Main Strategic Goal: Innovative Care

Use of Funds: A, B, D, G, H, I, J, K (non-exhaustive)

Technical Score Factors: B1, B2, C1, E1, F2 (non-exhaustive)

Key Stakeholders: Examples of key stakeholders may include the four rural HTCs, rural hospitals, primary care providers, behavioral health providers, local health departments, community organizations, rural health clinics, CBHTI, Local Area Agencies on Aging, and OMI.

Outcomes: 9 Evaluation Measures: ED Visits for Behavioral Health; ED Visits for Primary Care Sensitive Cases; Telehealth Utilization; Follow-Up After ED Visits for Mental Illness; Follow-Up After ED Visits for Substance Abuse; Rural Hospital Financial Stability: Cash on Hand; Participation in Value-Based Payment Models; Preventive Care and Screening: Screening for Depression and Follow-Up Plan; Member Level Total Cost of Care

Impacted Counties: 85 counties based on the rural census tracts a defined by HRSA using the following criteria: 1) Non-metropolitan counties, 2) Outlying metropolitan counties with no population from an urban area of 50,000 or more people, 3) Census tracts with RUCA codes 4-10 in metropolitan counties, 4) Census tracts of at least 400 square miles in area with population density of 35 or fewer people per square mile with RUCA codes 2-3 in metropolitan counties, 5) Census tracts with RRS 5 and RUCA codes 2-3 that are at least 20 square miles in area in metropolitan counties. Initiative will be targeted at entities that serve populations within a rural census tract (hereafter referred to as counties identified in rural census tract criteria).

Estimated Required Funding: $299,500,000

Initiative 3.1.B: Community Care Infrastructure

Description: Problem statement: Rural regions outside of northeast Illinois continue to face significant gaps and fragmentation in health care delivery, particularly in terms of access to primary care, with patients often experiencing limited access to essential preventive services and inconsistent coordination across providers and settings. These challenges are compounded by workforce shortages, geographic isolation, and resource constraints, resulting in disparities in health outcomes, barriers to achieving whole-person care, and avoidable utilization in high-cost settings. In particular, access to mental health and SUD services for adults and children are often limited and siloed.[49] As the first point of contact for the patients they serve, primary care and outpatient behavioral health settings serve as the optimal foundation for building innovative and integrated models of health care in rural communities. The intent of this initiative is to strengthen primary care and behavioral health infrastructure and embed team-based, integrated models of care that can address primary care, behavioral health, and root causes of disease holistically. By investing in these models, rural health systems can reduce fragmentation, improve access, and deliver comprehensive, person-centered care that meets the unique needs of rural populations and shifts care to lower cost settings.

Objective: This initiative will provide targeted funding to rural primary care and behavioral health providers to develop the infrastructure, staffing, and workflows necessary for implementing integrated models of care. Funds to provider entities may support:

- Standing up evidence-based, integrated models of care such as the Collaborative Care Model (CoCM)[50].

- Implementing regionalized, enhanced care coordination and health system navigation models.

- Building clinical connections between rural primary care providers and specialists, such as specialists at academic hospitals in the Chicagoland area, including those outside the immediate region, through telehealth or mobile healthcare.

- Embedding primary care providers and services in outpatient behavioral health settings.

- Embedding new provider types, such as CHWs, peer support professionals, and doulas into care teams.

- Enhancing health IT infrastructure to improve integration and coordination, population health management, and/or AI-enabled clinical decision supports.

In addition, the initiative will offer TA and establish learning collaboratives to provide hands-on care transformation support from local and national experts and establish quality management systems for tracking and reporting outcomes.

Funding approach: Funds for this initiative will be provided to FQHCs, RHCs, CMHCs, Certified Community Behavioral Health Clinics (CCBHCs), Opioid Treatment Programs (OTPs), and other outpatient primary care, behavioral health, and SUD providers located in rural communities. The Illinois Primary Health Care Association (IPHCA) and the Community Behavioral Health Association (CBHA) will be awarded as subrecipients to develop mechanisms to efficiently distribute funds to primary care and behavioral health providers, respectively, and establish reporting and oversight processes. Centralized TA will be provided through OMI or other university partnerships.

Main Strategic Goal: Innovative Care (non-exhaustive)

Use of Funds: A, B, D, G, H, I (non-exhaustive)

Technical Score Factors: B.1, C.1 (non-exhaustive)

Key Stakeholders: Examples of key stakeholders may include OMI, universities, FQHCs, RHCs, CMHCs, CCBHCs, OTPs, and other outpatient primary care and behavioral health providers, non-traditional provider types, and provider associations.

Outcomes: 8 Evaluation Measures: ED Visits for Behavioral Health; ED Visits for Primary Care Sensitive Cases; Breast Cancer Screening; Colorectal Cancer Screening; Early Entry into Prenatal Care; Telehealth Utilization; Participation in Value-Based Care Models; Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Impacted Counties: 85 counties identified in rural census tract criteria, as described under initiative 3.1.A

Estimated Required Funding: $124,5000,000

Initiative 3.1.C: Hospital Disease Prevention

Description: Problem statement: The burden of chronic disease disproportionately affects rural Illinoisans, as the prevalence of these conditions and associated risk factors tend to be higher, while resources for prevention and treatment remain limited in rural communities.[51] Rural hospitals often serve as hubs for community health and wellness, going beyond providing emergency and inpatient care to engage, educate, and promote public health. In recognition of this vital role, this initiative will provide funding to hospitals in rural Illinois to invest in strategies to prevent disease in the communities they serve.

 Objective: Under this initiative, RHT funds will be allocated to support rural hospitals in implementing disease prevention programming, in partnership with local public health departments, and other key public health partners. Because each community is unique, HFS will direct rural hospitals to define the highest population health priorities and leverage the expertise

and infrastructure available to deploy evidence-based programming that can achieve the biggest impact.

Hospitals will be directed to leverage findings and perspectives gathered in their most recent community-health needs assessments to identify public health priorities within their communities and deploy evidence-based interventions to prevent and manage disease. Hospitals will be encouraged to think beyond the walls of their facilities and use these funds to bring wellness and prevention to community spaces, like schools, places of worship, grocery stores, gyms, and community centers. Programming may include:

- Diabetes prevention programs

- Mental health first aid

- Nutrition and physical activity programs

- Chronic disease self-management

- Remote self-monitoring

- Tobacco cessation

Funding approach: HFS identified ICAHN as a subrecipient to administer funds to rural hospitals. Funds will be awarded to hospitals through a formula driven approach, based proportionally on the number of individuals residing in rural census tracts within a hospital's service area. Hospitals may use funds for the development (including needs assessments), distribution, outreach, and dissemination of materials related to disease prevention programming. Funds may also be used to host informational sessions and classes for rural populations. Depending on the project, funds may be used for the purchase of items such as nutritional foods, exercise equipment, or technologies to assist in monitoring of chronic conditions.

Main Strategic Goal: Make Rural America Healthy Again

Use of Funds: A, B, C, H, I, K (non-exhaustive)

Technical Score Factors: B1, B2, F3 (non-exhaustive)

Key Stakeholders: Examples of key stakeholders may include IDPH, local health departments, ICAHN, hospitals, providers serving rural areas, and community organizations.

Outcomes: 7 Evaluation Measures: ED Visits for Behavioral Health; ED Visits for Primary Care Sensitive Cases; Breast Cancer Screening; Colorectal Cancer Screening; Early Entry into Prenatal Care; Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%); Controlling High Blood Pressure

Impacted Counties: 85 counties identified in rural census tract criteria, as described under initiative 3.1.A

Estimated Required Funding: $80,000,000

3.2 Overcoming Geographic Barriers to Care

Initiative 3.2.A: EMS and Mobile Healthcare

Description: Problem statement: Compounding the impact of healthcare shortages in many rural regions of the state, a major barrier to care is a lack of available transportation in rural areas of the state.[52] Without dependable transit options, rural residents face delays or forego essential preventive, primary, and specialty care, exacerbating health inequities and increasing avoidable utilization of high-cost emergency services. Stakeholders identified lack of reliable, consistent transportation as one of the largest barriers to care in the rural regions of the state which affects individuals of all ages and care needs. Mobile service offerings present an opportunity to overcome geographic and transportation-related barriers to care.

Objective: This initiative will provide funding for infrastructure and testing of promising mobile health care models. Eligible recipients of funds will include the county Resource Hospitals which

oversee EMS providers, local county health departments, primary care providers, outpatient behavioral health providers, and other providers of community paramedicine and mobile health programming. These entities will partner with rural health systems and community health providers to bring care to individuals in their homes and communities. The funds issued in this initiative will be used to support the purchase of vehicles, modification of existing vehicles, equipment, supplies, IT infrastructure, training, and staffing to support evidence-based models of mobile medicine, such as community paramedicine, emergency medical services, mobile health clinics, and behavioral health mobile crisis units. One example of such an approach that can be adapted to meet rural health needs is the Chicago EMS Mobile Integrated Healthcare – Community Paramedicine (MIH-CP) model, which provides healthcare outside the hospital setting using community paramedics for high-risk patient care management, chronic disease management, preventive care, post-discharge follow ups, and non-emergency medical transport.[53]

This initiative has two overarching components:

1. Funds to IDPH to support EMS Resource Hospitals to enhance rural EMS: To ensure that EMS providers are able to expand upon services they currently offer and move towards treat-in-place and other mobile integrated care models, Illinois must first build the critical infrastructure to support greater use of mobile health services. Resource Hospitals[54] are well suited to identify infrastructure, equipment, supplies, and systems needs in their oversight role related to statewide EMS. Resource hospitals work closely with county EMS to also determine their training and staffing needs, which are also supported by the funding under this initiative. The funding provided to IDPH to distribute to Resource Hospitals may be used for:

- EMS-related expenses in expanding care in rural communities and standing up innovative models to treat people in place, such as community paramedicine or treat-and-refer models.

- Training, coordination, and staffing, such as supporting staff physician medical director roles or using paramedics or emergency medical technicians (EMTs) to augment care models or population health improvement activities.

- Capital infrastructure such as vehicles, equipment, supplies, and technology to modernize rural pre-hospital EMS Programs.

- Support for local training, apprenticeship, and hiring of new EMTs and paramedics.

Subrecipients of the funding are required to partner with local and regional acute care, primary care, and behavioral health providers.

2. <u>Funds for mobile healthcare innovation</u>: Funds will be provided to primary care and community behavioral health providers to invest in mobile health infrastructure, staffing, technology, and data systems to deploy new and reinforce existing mobile health clinics and mobile crisis units. Funds may support purchase of vehicles, equipment, supplies, technology, or data systems and may fund direct service and indirect staff to support the planning and deployment of these models. A subset of these funds will be used to purchase tablets for mobile crisis teams to enable real-time connectivity with dispatching provider entities, treatment in place services, prevention and chronic disease management as well as a reduction in cost for cardiac, stroke, and trauma care and an improvement in outcomes. The long-term goal of this initiative is to build community infrastructure to provide mobile preventive care, behavioral health, home visits, and other mobile health services which would be eligible for commercial and non-commercial reimbursement through regular medical billing. Heritage Behavioral Health Center in Macon County, Illinois has used tablets to expand behavioral health care access and can be a

model for similar programs.[55] As services become available and more providers are equipped to support a more robust mobile service offering, HFS is preparing to provide Medicaid reimbursement for the recently submitted SPA for EMS "treat-no-transport" services, also known as "treatment in place."[56] This enables EMS providers to provide necessary care on-site without requiring the patient be transported to a hospital or other health care facility.

Funding approach: For component 1, IDPH will serve as a sub-recipient for this initiative and will administer funds to Resource Hospitals that serve rural communities using a formula driven approach, based proportionally on the number of individuals residing in rural census tracts within a Resource Hospital's service area. For component 2, IPHCA and CBHA will be awarded as subrecipients to develop mechanisms to efficiently distribute funds to primary care and behavioral health providers to stand up or augment mobile health models that meet HFS criteria (to be established). These associations will also establish reporting and oversight processes.

Main Strategic Goal: Sustainable Access

Use of Funds: A, G, H, I, J (non-exhaustive)

Technical Score Factors: B1, C.2, F.1 (non-exhaustive)

Key Stakeholders: Examples of key stakeholders may include county emergency medical service corps, local county health care districts, local county ambulance districts, county health clinics, community primary care and behavioral health providers, IPHCA, and CBHA.

Outcomes: 6 Evaluation Measures: ED Visits for Behavioral Health; ED Visits for Primary Care Sensitive Cases; Low Acuity EMS calls that Don't Result in Transport to ED; Breast Cancer Screening; Colorectal Cancer Screening; Early Entry into Prenatal Care

Impacted Counties: 85 counties identified in rural census tract criteria, as described under initiative 3.1.A

Estimated Required Funding: $117,500,000

Initiative 3.2.B: Technological Innovation for Virtual Care

Description: Problem statement: The lack of sufficient access to physician specialist services, emergency medical clinicians, behavioral health services, and obstetric care in rural areas of the state creates significant gaps in care for rural populations. Many of these provider types are more widely available in other areas of the state – such as in Cook County, its collar counties, or other areas with a higher population density. Illinois is committed to connecting people to their healthcare providers with as few barriers as possible between the individual and their care provider.

Objective: To ensure that individuals in rural areas have consistent access to specialty care in their communities, this investment in technology interventions aims to bring specialty care to those high-need rural populations through technology solutions, rather than transporting individuals out of their communities. This initiative will support technological innovation through the Illinois Connected Care Collaborative (IC3) initiative, led by ICAHN which uses technology and collaboration to advance access, quality, outcomes, and cost efficiency across all rural hospitals, rural health clinics, FQHCs, pharmacies, and clinicians serving rural Illinois. IC3 will strengthen the entire rural care ecosystem, enabling healthcare providers to better connect with each other and their patients. ICAHN will serve as the Technology Navigator and Implementation Partner, coordinating statewide assessments, education, vendor selection, and technical support. In Year 1, ICAHN will lead a comprehensive rural digital readiness and needs assessment to determine each rural hospital's current infrastructure, interoperability, and capacity to adopt new technologies. Based on those findings, hospitals will choose from a menu of pre-identified, vetted technology solutions—ranging from cybersecurity and broadband expansion to

EHR modernization and automation tools that support evidence-based clinical care—aligned to their specific needs and readiness level. ICAHN will administer funds to hospitals to cover the cost of technology build and maintenance through the life of the RHT program.

This initiative also represents a true model of sustainability and transformation. By building digital readiness, interoperability, and data-sharing capacity, rural hospitals will be positioned to participate in population health initiatives and alternative payment models that reward quality and outcomes rather than volume. Historically, these models have been difficult for rural hospitals to access due to limited upfront funding and a lack of payer support for infrastructure and analytics. IC3 directly addresses this gap by creating the technological and organizational foundation needed for long-term success. With this investment, Illinois will not only expand access and efficiency in rural healthcare but also achieve the kind of systemic transformation that ensures sustained access to care and financial stability in communities that have too often been left behind.

Funding approach: ICAHN will serve as a subrecipient for this initiative and distribute funds to hospitals that serve individuals residing in rural communities. Funds may support investments within the following technology priorities: Cybersecurity & Physical Security, Broadband Expansion, EHR Modernization, Automation & AI, Data Analytics & Predictive Modeling, Consumer Tools, Shared Infrastructure. In addition, ICAHN will provide training and TA to hospitals.

Main Strategic Goal: Tech Innovation

Use of Funds: A, C, D, F, G, I, and K (non-exhaustive)

Technical Score Factors: B.1, F.1, F.3

Key Stakeholders: Examples of key stakeholders may include rural health specialty providers, rural hospitals, rural health ED providers, primary care providers, and ICAHN.

Outcomes: 6 Evaluation Measures: ED Visits for Behavioral Health; ED Visits for Primary Care Sensitive cases; Telehealth Utilization; Follow-Up After ED Visits for Mental Illness; Follow-Up After ED Visits for Substance Abuse; Member Level Total Cost of Care**.**

Impacted Counties: 85 counties identified in rural census tract criteria, as described under initiative 3.1.A

Estimated Required Funding: $135,000,000

3.3 Building a Resilient Rural Workforce

Initiative 3.3.A: Healthcare Workforce Expansion

Description: Problem statement: Rural communities face significant difficulties in recruiting and retaining healthcare professionals, a challenge that is particularly severe when it comes to attracting providers for high-need specialties, such as behavioral health, obstetrics, and primary care. These gaps in the workforce result in limited access to essential services for rural populations, exacerbating health disparities and negatively impacting community well-being. To address these challenges and build sustainable capacity, targeted incentives, bonuses, and support mechanisms are needed to encourage professionals to serve in rural settings and remain there for extended periods.

Objective: To strengthen healthcare delivery in rural communities, this initiative will focus on attracting and retaining health professionals. HFS will provide funds to state universities, community colleges, and hospitals to expand scholarship programs; bonuses to relocate and/or stay in rural communities; fellowships; apprenticeships; and other successful training programs. This initiative will begin with a centralized planning process with key stakeholders to identify

the highest priority professions to address the most urgent workforce gaps and rural population health disparities. This may include physicians, advanced practitioners, and allied professionals, and may reflect a focus on maternal health, behavioral health, primary care, paramedicine, or other specialties. This will lead to the identification of workforce programs offered through state universities, community colleges, or hospitals that are best suited to meet needs. This will allow Illinois to deploy dollars strategically, addressing the most pressing needs and customize programming to rural communities. Programs with demonstrated success, such as Southern Illinois University's (SIU) Lincoln Scholars program, which places future physicians on care teams in rural clinical settings, will be prioritized. An example of a program in another state is the Tufts School of Medicine's Maine Track Program, which offers a $25,000 annual scholarship to medical students with the aim of providing experience in rural medicine.[57] This initiative is *not* a loan repayment program. However, it is designed to *complement* existing federal and state efforts—such as the National Health Service Corps State Loan Repayment Program (SLRP), the Underserved Health Care Workforce Provider Workforce Program (UHWP), and the Community Behavioral Health Loan Repayment Program. Additionally, it will focus **exclusively** on individual providers who commit to serving in rural communities for a minimum of 5 years.

Funding Approach: This initiative will be designed as a strategic expansion of state university administered scholarship programs, residencies, or fellowships, like SIU's Lincoln Scholars program. State universities are the optimal vehicle for this initiative, as they already implement programs to train and place students in clinical settings. Following the centralized planning process led by HFS, funds will be allocated through intergovernmental agreements (IGA) to state universities and the ICCB. Additionally, ICAHN will be awarded as a subrecipient to administer

funds to hospitals who have developed their own scholarship, apprenticeship, or training

programs.

Main Strategic Goal: Workforce Development

Use of Funds: E, G

Technical Score Factors: D.1

Key Stakeholders: Examples of key stakeholders may include ICCB, state universities, ICAHN,

critical access hospitals and other rural healthcare providers, specialty providers, students,

hospitals, and rural-based clinics.

Outcomes: 6 Evaluation Measures: Follow-Up After ED Visits for Mental Illness; Follow-Up

After ED Visits for Substance Abuse; Timely Follow-Up After Acute Exacerbations of Chronic

Conditions; Rural Non-Traditional Health Professionals Receiving Training; Total Nursing

Hours per Patient Day (Medical-Surgical)

Impacted Counties: 85 counties identified in rural census tract criteria, as described under

initiative 3.1.A

Estimated Required Funding: $151,000,000

Initiative 3.3.B: Training Healthcare Support Workers

Description: Problem statement: In addition to general healthcare workforce shortages, rural

communities face significant gaps in non-traditional, non-physician healthcare workers that can

augment healthcare delivery, enhance care coordination, and serve as extensions into the

community. This limitation restricts healthcare providers' ability to fully utilize their skills and

expertise, preventing them from practicing at the top of their license and further constraining

access. The shortage of these essential roles, such as CHWs, doulas, lactation consultants, and

peer support professionals directly impacts the quality and accessibility of care available in rural

regions. Additionally, these positions frequently act as an essential gateway for individuals starting a career in healthcare and, more broadly, contribute to job growth within these communities.

A primary driver of these workforce gaps is the lack of accessible training and certification programs *within* rural communities. Without local opportunities for education and professional development in non-traditional healthcare roles, individuals are less likely to pursue these career paths. Addressing this issue requires the establishment and expansion of training initiatives specifically designed to meet the needs of rural areas, ensuring that healthcare providers have the support necessary to deliver comprehensive care.

Objective: This initiative will strengthen rural healthcare by expanding and establishing new training and certification programs tailored to local needs. The focus will be on developing a larger workforce for roles such as CHWs, doulas, lactation consultants, and peer support professionals and offering training opportunities that can keep rural learners in their communities. Collaboration is essential to this initiative; the effort will involve establishing and strengthening partnerships between educational institutions, local health systems, and community organizations. Together, these partners will develop training, certification, and apprenticeship programs specifically designed to address local workforce needs and fill critical gaps. Additionally, funding awards and other incentives will be offered to encourage individuals in rural areas to enroll in these programs and remain in the community, expanding access to essential healthcare roles.

Funding approach: Funding will be allocated to the ICCB as a subrecipient to distribute funds to community colleges to expand or establish new training, certification, and apprenticeship programs for CHWs, doulas, lactation consultants, peer support professionals, EMTs, and other

appropriate professions that address workforce gaps and align with RHT strategic goals. Funds

will also be administered through the University of Illinois Chicago (UIC) to administer to

community-based training programs that meet certification requirements defined by IDPH.

Academic and community-based training programs will be required to solidify partnerships with

healthcare providers in the region they serve to facilitate job placement upon completion of

training.

Main Strategic Goal: Workforce Development

Use of Funds: E, G (non-exhaustive)

Technical Score Factors: B.1, D.1 (non-exhaustive)

Key Stakeholders: Examples of key stakeholders may include IDPH, ICCB, community

colleges, rural educational institutions, health systems, community organizations, CHWs, doulas,

lactation consultants, peer support professionals, and rural healthcare providers.

Outcomes: 11 Evaluation Measures: ED Visits for Behavioral Health; ED Visits for Primary

Care Sensitive Cases; Follow-Up After ED Visits for Mental Illness; Follow-Up After ED Visits

for Substance Abuse; Timely Follow-Up After Acute Exacerbations of Chronic Conditions;

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%); Controlling High Blood Pressure;

Preventive Care and Screening: Screening for Depression and Follow-Up Plan; Rural Non-

Traditional Health Professionals Receiving Training; Total Nursing Hours per Patient Day

(Medical-Surgical)

Impacted Counties: 85 counties identified in rural census tract criteria, as described under

initiative 3.1.A

Estimated Required Funding: $55,000,000

Initiative 3.3.C: Rural Health Education Pipeline

Description: Problem statement: Rural communities are confronted with persistent difficulties in cultivating a robust healthcare workforce, oftentimes due to the absence of structured career pathways and limited opportunities for younger people to explore healthcare professions. Insufficient exposure to these careers can reduce overall community awareness and interest, impeding efforts to develop a sustainable pipeline of local healthcare professionals and threatening the long-term health and vitality of rural regions.

Objective: The primary objective of this initiative is to expand career pathways and workforce development programs for rural high school students through the UIC Area Health Education Center (AHEC). The programs are designed to build awareness and stimulate interest in healthcare careers by providing hands-on experiences, such as job shadowing, mentorship and workshops. While UIC's main campus is in Chicago, the AHEC program operates out of a satellite campus in Rockford – in Winnebago County in northern Illinois. The investment will advance UIC-AHEC's initiatives through its regional centers, with a specific focus on supporting rural communities.[58]

To ensure students gain real-world exposure and the program remains aligned with current workforce needs, AHEC will partner with rural hospitals and provider organizations. The initiative will showcase a diverse array of roles in healthcare, encompassing both clinical and non-clinical careers. Additionally, the program will be integrated with school initiatives to enhance accessibility and promote long-term sustainability.

Funding approach: Funding will be directed to UIC AHEC to expand programming, leveraging the existing AHEC framework at the regional centers. The general phases of implementation would include:

- *Program expansion:* Expand program design to include a rural-specific emphasis, formalize new partnerships with local hospitals, provider organizations, and schools, and develop hand-on activities such as job shadowing and mentorship.

- *Outreach and infrastructure development:* Enable student enrollment, integrate programs with school initiatives, and promote awareness of both clinical and non-clinical healthcare career options.

- *Program rollout and monitoring:* Deliver experiential learning opportunities and monitor student participation to ensure the program aligns with local workforce needs and supports long-term sustainability.

Main Strategic Goal: Workforce Development

Use of Funds: E, G (non-exhaustive)

Technical Score Factors: B.1, D.1 (non-exhaustive)

Key Stakeholders: Example of key stakeholders include UIC AHEC, university students, rural healthcare providers, community healthcare providers, local hospitals, and provider organizations.

Outcomes: 5 Evaluation Measures: ED Visits for Behavioral Health; ED Visits for Primary Care Sensitive Cases; Rural Non-Traditional Health Professionals Receiving Training; Total Nursing Hours per Patient Day (Medical-Surgical)

Impacted Counties: 85 counties identified in rural census tract criteria, as described under initiative 3.1.A

Estimated Required Funding: $22,500,000

Section 4: Implementation Plan and Timeline

HFS recognizes implementing the RHT program requires a rigorous staffing and management plan. HFS plans to structure the staff team of 9 FTEs to include: a general RHT program director (1 FTE), one finance administrator (1 FTE), one project manager for each category of initiatives (3 FTE), one grant manager (1 FTE), one staff analyst (1 FTE), one data analyst (1 FTE), and one administrative assistant to support the program director, grant manager, and finance manager (1 FTE). Each of these staff members will have designated roles and responsibilities which will be outlined in the Illinois HFS RHT Charter.

Along with managing the program, the staff outlined above will engage with interested parties as outlined in the stakeholder engagement plan (Section 5). HFS will also engage a vendor for TA and consulting services to augment the staffing plan and support implementation. The Program Director will report to the Deputy Director of Special Initiatives, an existing role within HFS, and provide regular updates and a direct line to the HFS Director and executive leadership team to ensure ongoing leadership buy-in and support. This reporting structure will also facilitate coordination with the Governor's Office to enable cross-agency collaboration and alignment with broader administration policy efforts.

As described in the Section 5 stakeholder engagement plan, HFS will engage with sister agencies and other interested parties to ensure the implementation plan is successful and targets are met. As the project evolves, HFS expects to adjust the implementation plan as described below. The implementation plan is designed similarly to the other sections where there are three main categories 1) Transforming Rural Healthcare Delivery, 2) Overcoming Geographic Barriers, 3) Building a Resilient Workforce, with key activities for the overall project outlined under "4.1 Other Activities."

4.1 Other Activities

Activity and Proposed Timing
HFS to create staffing plan and hire new RHT Project Team (Q1-2026 – Q3-2026)
Implement policy changes as indicated in Table B in Section 2 (Q1-2026 – Q4-2027)
Quarterly Funding Recipients Meetings (Q1-2026 through demonstration end)
RHT Advisory Workgroup (Q1-2026 through demonstration end)
Annual RHT Public Forum (Q4-2026 through demonstration end)
Medicaid Advisory Committee (MAC) (Q1-2026 through demonstration end)
Interagency Working Group (Q2-2026 through demonstration end)
Ad Hoc Meetings (as needed, through demonstration end)

4.2 Implementation Plan for Transforming Rural Healthcare Delivery

Initiative	Milestone and Estimated Timeline
Hospital Transformation	**1. Hospital Transformation:** *Stage 0*: Develop planning grant NOFO (Q1 and Q2-2026) *Stage 1*: Issue planning grant NOFO to rural hospitals and award planning grants to rural hospitals (Q3-2026) *Stage 2*: Hospitals propose transformation projects based on performance metrics (Q2-2027) *Stage 3*: Award transformation projects to hospitals (Q3-2027) *Stage 4*: Finalize design of VBP models (Q3-2027); Distribute VBP funds based on performance (Q1-2028) *Stage 5*: Pursue managed care and regulatory paths to sustain VBP models (ongoing)
	2. HTC Expansion *Stage 0*: Release instructions for rural HTCs to propose new projects (Q1-2026) *Stage 1*: Award funds to 4 rural HTCs as subrecipients (Q1-2026) *Stage 3*: Finalize design of VBP models (Q3-2027) *Stage 4*: Distribute VBP funds based on evaluation of performance (Q1-2028) *Stage 5*: Pursue managed care and regulatory paths to sustain VBP models (ongoing)
	3. Technical Assistance *Stage 0*: Establish IGA with OMI for TA (Q1-2026) *Stage 1*: Provide TA to rural hospitals to complete a transformation plan (Q3-2026) *Stage 2*: Provide ongoing TA to rural hospitals to carry out the transformation plan (Q3-2026 and ongoing) *Stage 3*: Provide TA to support design of VBP (Q1-2027 – Q4-2027) *Stage 4-5*: Provide TA to support change management and performance improvement under VBP (Q1-2027 and ongoing)
Community Care Infrastructure	**1. Team-based care** *Stage 0*: Establish agreement with IPHCA and CBHA (Q2-2026)

Initiative	Milestone and Estimated Timeline
	Stage 1: Establish parameters for award to primary care and behavioral health providers to implement team-based care (Q3-2026) *Stage 2*: IPHCA and CBHA to release opportunities and select primary care and behavioral health providers to receive funds (Q3 and Q4-2026) *Stage 3*: Monitor performance through quarterly reports (Q1-2027 and ongoing) *Stage 4*: HFS to identify regulatory levers to reimburse successful models (Q1-2028) *Stage 5*: Transition successful programs to sustainable funding model (VBP) (Q1-Q3 2031)
	2. Technical Assistance *Stage 0*: Establish IGA with OMI for TA (Q1-2026) *Stage 1*: Provide TA to primary care and behavioral health providers to complete a transformation plan (Q3-2026) *Stage 2*: Provide ongoing TA to primary care and behavioral health providers to carry out the transformation plan (Q3-2026 and ongoing) *Stage 3*: Provide TA to support design of VBP (Q1-2027) *Stage 4-5*: Provide TA to support change management and performance improvement under VBP (Q1-2027 and ongoing)
Hospital Disease Prevention	*Stage 0*: Establish agreement with ICAHN (Q2-2026) *Stage 1*: Establish funding distribution formula for funding to rural hospitals (Q2-2026) *Stage 2*: Award hospitals funding based on formula-driven approach (Q3-2026) *Stage 3-5*: Monitor activities and performance through quarterly reports (ongoing)

4.3 Implementation Plan for Overcoming Geographic Barriers to Care

Initiative	Activity and Estimated Timeline
EMS and Mobile Healthcare	**1. Funds to Resource Hospitals** *Stage 0*: Establish IGA with IDPH (Q1-2026) *Stage 1*: Establish funding distribution formula for funding to rural hospitals (Q2-2026) *Stage 2*: IDPH awards Resource Hospitals funding based on formula-driven approach (Q2-2026) *Stage 3-4*: Monitor activities and performance through quarterly reports (ongoing) *Stage 5*: HFS to identify financing or regulatory levers to support sustainable reimbursement for successful models (e.g., treat and no transport) (ongoing) **2. Funds to build mobile health infrastructure** *Stage 0*: Establish agreement with IPHCA and CBHA (Q2-2026) *Stage 1*: Establish parameters for award to primary care and behavioral health providers to implement mobile health infrastructure (Q3-2026)

Initiative	Activity and Estimated Timeline
	Stage 2: IPHCA and CBHA select primary care and behavioral health providers to receive funds (Q3 and Q4-2026) *Stage 3*: Monitor performance through quarterly reports (Q1-2027 and ongoing) *Stage 4*: HFS to identify regulatory levers to reimburse successful models (Q1-2028) *Stage 5*: Transition to sustainable funding model for successful models (Q1-Q3 2031)
Technological Innovation for Virtual Care	1. **Vendor for Statewide Telehealth and e-consult platform** *Stage 0*: Establish agreement with ICAHN (Q2-2026) *Stage 1*: ICAHN conducts rural digital readiness and needs assessments among hospitals (Q2 and Q3-2026) *Stage 2*: Establish parameters for award to hospitals and other rural providers to implement technology priorities (Q4-2026) *Stage 3*: ICAHN awards funds to hospitals (Q4-2026) *Stage 4*: Technology solutions implemented and TA provided by ICAHN (Q1-2027) *Stage 5*: Ongoing monitoring and evaluation (ongoing)

4.4 Implementation Plan for Building a Resilient Workforce

Initiative	Activity and Estimated Timeline
Healthcare Workforce Expansion	*Stage 0*: Carry out centralized planning process to define priority workforce needs (Q1 and Q2-2026) *Stage 1*: Select workforce programs to be funded through universities, colleges, hospitals (Q1 and Q2-2026) *Stage 2*: Formalize IGAs with state universities and ICCB; formalize agreement with ICAHN (Q2-2026) *Stage 3*: Award funds to selected programs (Q3-2026) *Stage 4*: Implement programs (Q4-2026) *Stage 5*: Monitor performance through quarterly reports (ongoing)
Training Healthcare Support Workers	*Stage 0*: Formalize IGA with ICCB (Q1-2026) *Stage 1*: Planning process to identify specific programs to receive funding (Q2-2026) *Stage 2*: ICCB develop plans and programming (Q2-2026) *Stage 3*: ICCB award funds to selected programs (Q3-2026) *Stage 4*: Implement programs (Q4-2026) *Stage 5*: Monitor performance through quarterly reports (Ongoing)
Rural Health Education Pipeline	*Stage 0*: Formalize IGA with UIC *Stage 1*: AHEC submits detailed program expansion plan for rural communities (Q1-2026) *Stage 2-4*: UIC expands programming (Q2-2026 and ongoing) *Stage 5*: Ongoing monitoring and evaluation (ongoing)

Section 5: Stakeholder Engagement

HFS prioritizes stakeholder engagement in its RHT program. Stakeholders provide valuable local insight crucial to identifying barriers and solutions for improving health outcomes in rural Illinois. Their involvement shapes initiatives that are responsive, effective, and sustainable. This plan describes how HFS collaborates with stakeholders to promote transparency, inclusivity, and responsiveness throughout the RHT initiative.

During the RHT application process, HFS consulted with six key stakeholder groups to identify challenges and shape proposed initiatives. Engagement spanned 9 state agencies, over 20 provider associations, as well as discussions with rural hospitals, community health centers, CMHCs, universities and community colleges, legislators, and vendors. Some examples of stakeholders included, IDPH, four HTCs, IPHCA, FQHCs, CCBHCs, EMS, University of Chicago, Lurie Children's Hospital, and CBHA. HFS held 38 individual discussions, a public listening session with nearly 300 attendees, received 120+ public comments, and had 46 follow-up conversations. HFS is committed to ongoing engagement with their tribal partners and will continue to include them as applicable. This comprehensive input informed the application, with several stakeholders providing letters of support included in the Other Supporting Materials section.

Meaningful stakeholder engagement must continue well beyond the initial application process. Ongoing collaboration is essential for the successful implementation and sustained impact of the RHT initiative. To support continuous communication and transparency, HFS will create a dedicated email inbox overseen by designated RHT staff. This platform will function as an ongoing feedback mechanism, as well as a central means of communication for funding recipients and other interested parties.

HFS will also facilitate stakeholder engagement through several forums designed to ensure dialogue, collaboration, and accountability.

- *Quarterly Funding Recipients Meetings:* Meetings between HFS RHT staff and funding recipients designed to review progress, share updates, address questions, offer technical support, and discuss subsequent steps.

- *RHT Advisory Workgroup:* Collaboration workgroup with HFS RHT staff, key stakeholders, and funding recipients to discuss general updates and next steps on each RHT initiative.

- *Annual RHT Public Forum:* Annual event hosted by HFS RHT staff to provide updates on the key initiatives and outcomes. This forum will be open to the public and attended by providers, patients, governing entities, local organizations, and other interested parties.

- *Medicaid Advisory Committee (MAC):* Standing quarterly meeting where HFS RHT staff will provide ongoing updates.
  - *Subcommittee:* A to-be-established MAC subcommittee to dive deeper into content and provide additional support around RHT where needed.
  - *Beneficiary Advisory Council (BAC):* In accordance with Section II.A. of the Access Final Rule updates § 431.12, Illinois will establish a MAC subcommittee to include Medicaid beneficiaries in rural communities, their families, and/or caregivers.

- *Interagency Working Group:* Bi-monthly meeting to bring sister agencies together to help guide RHT program implementation and ensure RHT initiatives are aligned with other state programs and policies.

- *Ad Hoc Meetings:* Interested parties may request meetings at any time during the program. HFS RHT staff will assess the need and manage arrangements as needed.

Regular communication with funding recipients will occur outside of formal meetings.

Communication may include updates regarding fund distribution, milestone tracking, and

performance metrics. As part of this process, funding recipients will be required to submit

quarterly progress reports, which HFS will review and summarize. These summaries will be

provided to the RHT Advisory Workgroup so that lessons learned and feedback can inform

program implementation. HFS will also engage with the Governor's Rural Health Affairs

Council throughout the duration of the project to provide updates and ensure alignment across

other rural health initiatives.

This approach aims to support transparency, collaboration, and accountability among all parties

involved. Stakeholder feedback will be incorporated into decision-making throughout the

duration of the RHT program. By maintaining strong communication channels and engagement

practices, HFS and its partners intend to support efforts to strengthen the healthcare system and

outcomes for rural communities across Illinois.

Section 6: Metrics and Evaluation Plan

Table C: Evaluation Plan Measures

Measure Name	Initiative Number							
	1.A	1.B	1.C	2.A	2.B	3.A	3.B	3.C
1. Follow-Up After ED Visits for Mental Illness*	X				X	X	X	
2. Follow-Up After ED Visits for Substance Abuse*	X				X	X	X	
3. Preventive Care and Screening: Screening for Depression and Follow-Up Plan*	X	X					X	
4. ED Visits for Behavioral Health	X	X	X	X	X		X	X
5. ED Visits for Primary Care Sensitive Cases	X	X	X	X	X		X	X
6. Breast Cancer Screening		X	X	X				
7. Colorectal Cancer Screening		X	X	X				
8. Early Entry into Prenatal Care		X	X	X				
9. Telehealth Utilization	X	X			X			
10. Rural Non-Traditional Health Professionals Receiving Training						X	X	X

Measure Name	Initiative Number							
	1.A	1.B	1.C	2.A	2.B	3.A	3.B	3.C
11. Rural Health Profession Students Receiving Training						X	X	X
12. Total Nursing Hours per Patient Day (Medical-Surgical)						X	X	X
13. Timely Follow-Up After Acute Exacerbations of Chronic Conditions						X	X	
14. Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)			X				X	
15. Controlling High Blood Pressure			X				X	
16. Participation in Value-Based Payment Models	X	X						
17. Member Level Total Cost of Care	X				X			
18. Low Acuity EMS calls that Don't Result in Transport to ED				X				
19. Rural Hospital Financial Stability: Days Cash on Hand	X							
Total measures per initiative	**9**	**8**	**7**	**6**	**6**	**6**	**11**	**5**

*Early Indicator Measure

Rationale for Measure Selection: HFS identified 19 measures to track program success in improving access to care, health outcomes, and cost of care for rural populations. To allow time for program award and implementation, three early indicator measures will have improvement targets beginning in 2027 and the remainder will have improvement targets beginning in 2028. The selected measures comprehensively support the RHT program's five strategic goals by promoting preventive health, addressing root causes of disease and fostering sustainable access by strengthening rural providers' efficiency and capacity to serve as reliable care access points. Workforce development is advanced through tracking the training of rural health profession students and non-traditional health professionals, as well as monitoring nursing hours per patient day and ensuring rural communities have skilled providers practicing at the top of their license. The commitment to innovative care and tech innovation is reflected in the support for integration of digital health tools and sustainable business models for rural healthcare providers. Together, this evaluation plan ensures that rural health transformation efforts are evidence-based, patient-centered, and positioned for lasting impact.

Measure Overlap: Most measures were identified for evaluation across initiatives. This is because the outcomes selected are ambitious and specific to rural health in Illinois. HFS expects the identified initiatives to work together to advance the service capabilities of existing rural providers, expand access to virtual and mobile care, and build a sustainable workforce pipeline. For example, transforming rural healthcare delivery through regional collaboratives, expanding integration of behavioral health and primary care, and overcoming geographic barriers to care are all intended to reduce the need for behavioral health care in the ED.

Baseline Data: Once participants are selected for RHT funded initiatives, HFS will further define the evaluation population and establish baselines for each measure using the data sources described in table D. Baseline statistics in table D use proxy data where available to provide context and justify the state's target setting methodology.

Table D: Evaluation Plan Measure Details

1. Follow-Up After ED Visits for Mental Illness (NCQA)	
Measure Description	The percentage of ED visits for persons 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Follow-up within 7 and 30 days.
Data Source	Payer data (State data for Medicaid and possibly other payers)
Data Timing	6+ month data lag
Evaluation Population	Rural counties with active RHT initiatives
Baseline Statistic (Proxy)	In 2023, the Illinois Medicaid program ranked last among all state Medicaid programs for rates of follow-up after ED visits for Mental Illness for adults, with 7.9% of members receiving follow-up within 7 days (national Median is 35.4%) and 13.8% receiving follow-up within 30 days (national median is 51.3%)[59]
2027 Target	5% gap closure towards the 90th percentile in hospitals participating in selected health transformation collaboratives
2028 – 2030 Targets	5%, 10%, and 15% gap closure towards the 90th percentile of rural counties with active RHT initiatives
2. Follow-Up After ED Visits for Substance Abuse (NCQA)	
Measure Description	The percentage of ED visits among persons age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. Follow-up within 7 and 30 days.

Data Source	Payer data (State data for Medicaid and possibly other payers)
Data Timing	6+ month data lag
Evaluation Population	Rural counties with active RHT initiatives
Baseline Statistic (Proxy)	While Illinois does not currently have a baseline for this measure, given the state's performance on a similar measure of Follow-Up After Hospitalization for Mental Illness we expect that there will be room to demonstrate improvement in this measure in rural regions
2027 Early Indicator Target	5% gap closure towards the 90th percentile in hospitals participating in selected health transformation collaboratives
2028 – 2030 Targets	5%, 10%, and 15% gap closure towards the 90th percentile of rural counties with active RHT initiatives
3. Preventive Care and Screening: Screening for Depression and Follow-Up Plan (NCQA)	
Measure Description	Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive, (2) had a follow-up plan documented
Data Source	Participating clinic EMR
Data timing	3 to 6 month data lag
Evaluation Population	Participating providers
Baseline Statistic (Proxy)	HRSA UDS IL Clinics: 81.1%[60]
2027 Early Indicator Target	5% gap closure towards the 90th percentile in hospitals participating in selected health transformation collaboratives
2028 – 2030 Targets	5%, 10%, and 15% gap closure towards the 90th percentile of rural counties with active RHT initiatives
4. ED Visits for Behavioral Health	
Measure Description	ED visits for "Behavioral Health" expressed as a crude rate per 10,000 area population. "Behavioral Health" ED visits include mental health, alcohol and substance abuse-related visits.[61]
Data Source	DPH Hospital Discharge Data Set (State data)
Data Timing	Monthly collection; 6+ month data lag
Evaluation Population	All rural counties in the state
Baseline Statistic (Proxy)	Statewide rate from 2020 – 2022 is 111 ED visits per year per 10,000 population. However, rates in some rural counties such as Vermillion County reach 194 ED visits per 10,000 population. In general, rates are highest in Western, Central, and Southern Illinois.[62]
2028 – 2030 Targets	2.5%, 5%, and 7.5% reduction in ED Visits for BH By 2030, 20% gap closure towards the state average in ED Visits for BH in the 5 worst performing rural counties during the baseline year
5. ED Visits for Primary Care Sensitive Cases	
Measure Description	ED visits for "All Primary Care Sensitive" cases expressed as a percentage of all ED visits. "All Primary Care Sensitive" ED cases include the categories of "Non-Emergent", "Emergent-Primary Care Treatable", and "Emergent Primary Care Avoidable". This screening

	measure highlights all ED visits that may have been prevented with effective access and utilization of primary care.[63]
Data Source	DPH Hospital Discharge Data Set (State data)
Data Timing	Monthly collection; 6+ month data lag
Evaluation Population	All rural counties in the state
Baseline Statistic (Proxy)	Statewide rate from 2020 – 2022 averages 43.43% of ED visits being for primary care sensitive cases. However, rates in some rural counties such as Massac, Pope, and Hardin in Southeastern Illinois range from 49 - 52%. Rates are highest in Southwestern Illinois.
2028 – 2030 Targets	1%, 2%, and 3% reduction in the percentage of ED visits for primary care sensitive cases. By 2030, 20% gap closure towards the state average in ED Visits for Primary Care Sensitive Cases in the 5 worst performing rural counties during the baseline year
6. Breast Cancer Screening (NCQA)	
Measure Description	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the Measurement Period
Data Source	Participating clinic EMR or Payer Data
Data Timing	~3 to 6 month data lag
Evaluation Population	Participating providers
Baseline Statistic (Proxy)	HRSA UDS: IL Statewide data: 52.3%, however rural clinics show variation in performance for example - Cass County: 50.7% - Rural Health Inc: 66.6% - Macoupin County Health Department: 38.8%[64]
2028 – 2030 Targets	5%, 10%, and 15% gap closure towards the 90th percentile in participating primary care clinics and health centers
7. Colorectal Cancer Screening (NCQA)	
Measure Description	Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer
Data Source	Participating clinic EMR or Payer Data
Data Timing	~3 to 6 month data lag
Evaluation Population	Participating providers
Baseline Statistic (Proxy)	Statewide: 55.4% Rural: 55.8% [65] [66]
2028 – 2030 Targets	5%, 10%, and 15% gap closure towards the 90th percentile in participating primary care clinics and health centers
8. Early Entry into Prenatal Care (HRSA)	
Measure Description	Live births where the mother entered prenatal care during the first trimester of pregnancy
Data Source	Payer data (State HFS data for Medicaid. Other payers may be possible)
Data Timing	6+ month data lag
Evaluation Population	Rural counties with active RHT initiatives

Baseline Statistic (Proxy)	HRSA UDS Illinois: 77.58% in 2024[67] Illinois vital statistics data indicate prenatal care rates may be lowest in Southwestern Illinois with some rural counties like Alexander, Warren, and Douglas having rates well below the state average.[68]
2028 – 2030 Targets	1%, 2%, and 3% improvement in births with first trimester prenatal care By 2030, 20% gap closure towards the state average in the 5 worst performing rural counties during the baseline year
9. Telehealth Utilization	
Measure Description	People with one or more telehealth services during the measurement year. Two rates can be reported: 1) people with any telehealth encounter during the measurement period, and 2) the total number of telehealth encounters during the measurement period.
Data Source	Payer data (State HFS data for Medicaid. Other payers may be possible)
Data Timing	6+ month data lag
Evaluation Population	All rural counties in the state
Baseline Statistic (Proxy)	Statewide, approximately 13% of Medicaid managed care members had a telehealth encounter in SFY2024. Utilization was lower in some rural counties - Cass, Randolph, and Wabash with less than 7%. Statewide utilization rate was 564 telehealth encounters per 1,000 members, however Cass, Fayette, and Wabash with utilization rates of 210 telehealth encounters.[69]
2028 – 2030 Targets	2%, 4%, and 6% improvement in telehealth utilization By 2030, 20% gap closure towards the state average in the 5 worst performing rural counties during the baseline year
10. Rural Non-Traditional Health Professionals Receiving Training	
Measure Description	Increase in the number of rural, health professions students receiving training annually in rural areas
Data Source	State Universities & ICCB
Data Timing	Quarterly Reporting
Evaluation Population	All rural counties in the state
Baseline Statistic	To be developed during the first year of the initiative
2028 – 2030 Targets	UIC AHEC will expand the number of regional sites (currently 9) to 13 by adding 4 new ones All awardees will demonstrate year over year increases in enrollment
11. Rural Health Profession Students Receiving Training	
Measure Description	Increase in the number of rural health profession students receiving training annually in rural areas
Data Source	State Universities & ICCB
Data Timing	Quarterly Reporting
Evaluation Population	All rural counties in the state
Baseline Statistic	To be developed during the first year of the initiative

2028 – 2030 Targets	UIC AHEC will establish 1 Rural Health Profession Training Center for the state of Illinois All awardees will demonstrate year over year increases in enrollment
12. Total Nursing Hours per Patient Day (Medical-Surgical)	
Measure Description	Total combined hours worked by registered nurses, licensed practical nurses, and nurse assistants in Medical/Surgical per patient day
Data Source	IDPH Nurse Staffing Data
Data Timing	Quarterly reporting with a limited data lag
Evaluation Population	Hospitals in rural counties in the state
Baseline Statistic (Proxy)	Current data indicates significant variance in nurse staffing for rural hospitals. In 2024, the ten smallest hospitals in Illinois reported a range of 0.4 to 34.4 total nursing hours per medical-surgical patient day, while the ten largest hospitals reported less variability ranging from 6.7 to 11.4 hours per medical-surgical patient day.[70]
2028 – 2030 Targets	Reduce the number of rural hospitals with below state average nursing hours per day by 25% by 2030
13. Timely Follow-Up After Acute Exacerbations of Chronic Conditions	
Measure Description	Rate of follow-up for patients with chronic conditions who have experienced an acute exacerbation: Hypertension, Asthma, Heart failure, Coronary Artery Disease, COPD, Diabetes (Based on measure in ACO REACH program)
Data Source	Payer data (State and possibly other payers)
Data Timing	6+ month data lag
Evaluation Population	Rural counties with active RHT initiatives
Baseline Statistic	To be developed during the first year of the initiative
2028 – 2030 Targets	2.5%, 5%, and 10% improvement in follow-up rates for counties with active RHT initiatives
14. Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	
Measure Description	Percentage of patients 18-75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) > 9.0% during the measurement period
Data Source	Participating clinic EMR
Data Timing	~3 to 6 month data lag
Evaluation Population	Participating providers
Baseline Statistic (Proxy)	HRSA UDS IL: 29.80%[71]
2028 – 2030 Targets	5%, 10%, and 15% gap closure towards the 90th percentile in participating primary care clinics and health centers
15. Controlling High Blood Pressure	
Measure Description	Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period

Data Source	Participating clinic EMR
Data Timing	~3 to 6 month data lag
Evaluation Population	Participating providers
Baseline Statistic (Proxy)	HRSA UDS IL: 66.6%[72] • Macoupin County: 67.7% • Rural Health Inc: 88.7% • Cass County: 88.3%
2028 – 2030 Targets	5%, 10%, and 15% gap closure towards the 90th percentile in participating primary care clinics and health centers

16. Participation in Value-Based Payment (VBP) Models	
Measure Description	The total number of new VBP arrangements for hospitals, clinics, and providers in rural regions
Data Source	Medicaid VBP Report (State data)
Data Timing	Annual Reporting
Evaluation Population	All rural providers in the state
Baseline Statistic (Proxy)	Few Medicaid managed care plans report a strategy to contract with rural providers, and many reported challenges recruiting rural providers to participate in alternative payment models.
2028 – 2030 Targets	25% increase in the number of rural healthcare provider entities participating in value-based care arrangements by 2030

17. Member Level Total Cost of Care	
Measure Description	The total cost of care during a measurement year, calculated as spending per member month stratified by age and disability
Data Source	Payer data (HFS Medicaid data, other payers may be considered)
Data Timing	6+ Month Data Lag
Evaluation Population	Rural counties with active RHT initiatives
Baseline Statistic (Proxy)	Literature supports that rural residents on average have higher total cost of care as compared to non-rural residents.[73] [74] [75] HFS will develop a baseline for member level annual total cost of care during the initial year of the HTC program and will use historic Medicaid data to inform the baseline calculation.
2028 – 2030 Targets	5% reduction in total cost of care by 2030 15% reduction in total cost of care disparities in the five worst performing rural counties with RHT initiatives

18. Low-Acuity EMS Calls that Don't Result in Transport to ED	
Measure Description	The rate of low acuity EMS calls that don't result in transport to a hospital, out of all low acuity EMS calls
Data Source	EMS Prehospital Data Program (State data)
Data Timing	Monthly Data Collection
Evaluation Population	Rural counties with active RHT initiatives
Baseline Statistic (Proxy)	To be established during the first program year
2028 – 2030 Targets	By 2030, 20% improvement in the rate of low acuity EMS calls that are treated on site and do not result in transport

19. Rural Hospital Financial Stability: Days Cash on Hand	

Measure Description	Days cash on hand is measured as (Cash on Hand and in Banks + Temporary Investments + Investments) / (Operating Expense - Depreciation Cost) / 365)
Data Source	Medicare Cost Reports (Provider reported)
Data Timing	150 days after the close of a fiscal year
Evaluation Population	Participating hospitals
Baseline Statistic (Proxy)	Per 2022 Medicare Hospital Cost Reports, rural hospitals in Illinois have fewer financial reserves compared to non-rural hospitals. In aggregate, rural hospitals held 210 days cash on hand while non-rural hospitals held 485 days of cash on hand.[76]
2028 – 2030 Targets	By 2030, increase rural hospital aggregate cash on hand by 20%.

Strategy for Program Evaluation

In addition to cooperation with CMS-led evaluation efforts, HFS intends to hire data analytics

staff to manage program evaluation and to partner with IDPH and other state public health

authorities to ensure that the awarded initiatives have a measurable and lasting impact on health

in rural Illinois. Evaluation reporting requirements will be built into initiative grants and

subrecipient awards. While HFS can commit to using Medicaid data for evaluation purposes, the

state will also explore options to utilize Medicare FFS data and commercial data such as through

the state's employee and retiree plans as well as through commercial plans. While IDPH has

access to hospital and ED discharge data, partnering directly with payers and academic

institutions further entrenches the success of the RHT program within rural communities.

Section 7: Sustainability Plan

General approach

Sustainability is at the heart of Illinois' approach to rural healthcare transformation. Illinois is

committed to ensuring that the most impactful initiatives – those that expand access, improve

outcomes, and foster innovation – continue to thrive beyond the initial funding period. By

prioritizing long-term planning and building strong partnerships, Illinois will secure ongoing

support for programs that demonstrate measurable benefits for rural communities. HFS' goal is

to create lasting change, so that the advances made today become the foundation for healthier, more resilient rural populations in the years to come.

Approach to sustainability by initiative

1.A Hospital Transformation: Sustainability planning will be built into program design at the outset. The purpose of this initiative is to right-size rural healthcare delivery by providing funding for the infrastructure and planning necessary to transform lines of service, fill gaps in the care continuum, and revamp business models to reduce reliance on volume-based revenue models. Currently, health systems are operating in an unsustainable manner, relying on high-cost models of care that generate revenue through volume, while recent innovations in healthcare enable people to be treated in lower cost settings. Illinois' RHT investments are meant to catalyze and enable transformation of rural healthcare delivery, providing the necessary up-front investments while maintaining the solvency of safety net providers through the transition. Funding will support a thorough and data-driven planning process, to make sure transformation plans are grounded in community needs and sustainability from the beginning, so hospitals can strategically align their projects with a viable business model. Additionally, a transition to VBP is expected over the course of the program. Understanding that there will be significant changes to current hospital payment streams due to changes to federal law, it is imperative for participating hospitals to use this as an opportunity to plan their operations around business models that will be sustainable in the long term. HFS will remain committed to ensuring that payment structures are modified to reward the positive outcomes of a transformed rural healthcare delivery system, for example, by allowing hospitals to retain cost savings for demonstrating a shift in utilization from inpatient to outpatient care. TA will be provided to engage with participating hospitals to design payment models that can sustain care delivery and

demonstrate improvement in quality and cost outcomes. HFS will use its available managed care

contracting and regulatory levers to support the transition to VBP for initiatives that have

demonstrated success and readiness. HFS may also engage the Center for Medicare and

Medicaid Innovation (CMMI) to explore opportunities for payer alignment in VBP efforts.

1.B Community Care Infrastructure: Illinois is already undertaking efforts to support the

sustainable financing of models planned under this initiative. HFS received approval for a SPA

to cover CHW services in 2021,[77] and in 2022[78] legislation was passed to mandate

reimbursement for the CoCM, so vehicles for sustainable reimbursement for some components

are already in place with implementation underway. Additionally, IPHCA has spearheaded an

FQHC capitation model, and the state is implementing a CCBHC demonstration using a

prospective payment system-1 methodology, so many rural providers are already gaining

experience under innovative VBP models. As the RHT initiative is carried out, HFS will partner

with stakeholders to apply lessons learned from these experiences and identify additional

elements of these models that have proven positive impacts but are not reimbursable under

current Medicaid rules. HFS will explore VBP opportunities where feasible and permitted,

ensuring any next steps build on the program's existing design. Complementary steps will

include encouraging multi-payer participation, promoting alignment on common quality

measures, and supporting learning collaboratives to help effective practices continue without

reliance on short-term grants. Taken together, these strategies are intended to reduce dependence

on time-limited funds and position community care models to adapt and persist beyond the grant

period.

1.C Hospital Disease Prevention: To lay the groundwork for long-term continuation, the state

will implement strategies that align disease prevention activities with managed care mechanisms

– such as leveraging managed care organization (MCO) Pay-for-Performance and Pay-for-Reporting metrics – and other policy tools where feasible and permitted. This could include encouraging plans to offer select programs as value-added services and consider in-lieu-of services as interventions that improve outcomes and reduce costs, while assessing opportunities for SPA or waiver authorities to strengthen coverage for high-impact prevention activities.

Hospitals will be asked to dedicate community investment resources toward collaborative prevention efforts with local public health and community partners, helping sustain outreach, education, and remote monitoring capabilities beyond the initial grant period.

Additional steps will include promoting alignment on quality measures and exploring multi-payer incentives tied to reductions in avoidable utilization, with any realized gains considered for reinvestment and local prevention programs. These approaches aim to reduce reliance on short-term funding and position successful prevention models to continue after the grant ends, consistent with the program's emphasis on community-driven, evidence-based strategies.

Ultimately, a major advantage of investing in preventive care lies in the substantial cost savings achieved by reducing the need for high-acuity, expensive healthcare services such as ED visits. These savings not only enhance efficiency but also play a critical role in ensuring the long-term sustainability of the rural health system as a whole.

2.A EMS and Mobile Healthcare: To support long-term continuation beyond initial grant support, HFS will advance strategies that pair early investments in foundational infrastructure like vehicles, equipment, connectivity, and workforce with pathways for ongoing reimbursement of services delivered through mobile care and telehealth models. Today, EMS providers face challenges in receiving payment for encounters that do not result in hospitalizations, which creates funding challenges for providers and disincentivizes providers from treating in place

when appropriate. Where feasible and permitted, payers could recognize billable encounters such as virtual triage, community paramedicine visits, mobile primary and behavioral health services, and remote monitoring touchpoints, helping shift day-to-day operations from reliance on the grant to routine reimbursement streams.

Complementary steps will include clarifying managed care contracting and billing guidance, encouraging alignment on codes and documentation, and developing practical resources for providers to operationalize mobile workflows. As programs demonstrate improved access and reductions in avoidable utilization, stakeholders could consider reinvesting a portion of realized savings to maintain essential components such as fleet, staffing, and technology infrastructure.

2.B Technological Innovation for Virtual Care: To support long-term continuation, HFS will implement strategies that pair initial investments in telehealth and virtual care infrastructure with mechanisms for ongoing maintenance and operational funding. This could include encouraging managed care plans to recognize virtual care encounters within reimbursement structures and, where feasible, in alignment with sustainability approaches described under 1A and 1B, leveraging VBP arrangements so that any savings from improved access and reduced avoidable utilization can be reinvested into health IT maintenance costs.

Additional considerations will include identifying state-level funding opportunities—such as technology grants or economic development programs—and promoting alignment on technical standards to reduce duplication and cost. Acknowledging that health IT maintenance requires predictable resources, these strategies aim to reduce reliance on short-term grants and position virtual care innovations for continued growth into the future.

More broadly, telehealth offers significant cost savings by minimizing the need for expensive in-person visits, reducing patient travel expenses, and potentially lowering rates of ED utilization.[79]

Beyond its ability to enhance access to care, these efficiencies contribute meaningfully to the long-term sustainability of rural healthcare systems.

3.A Incentives for Clinicians and Non-Clinicians: At its core, this initiative is designed to create a lasting rural healthcare workforce by embedding long-term service commitments into training and placement programs. By leveraging state university-administered scholarships, residencies, and fellowships in partnership with local providers, the program aims to ensure that participants not only enter rural practice but remain there beyond their initial commitment period. As successive cohorts complete training and integrate into local communities, these efforts help stabilize provider capacity and strengthen the pipeline for high-need specialties, such as behavioral health, maternal health, and primary care. This approach builds sustainability into the workforce itself—each participant represents a durable investment in rural health access. Program-specific sustainability may include structuring incentives and bonuses to encourage retention, aligning placements with regional workforce priorities, and coordinating with existing federal and state programs to maximize impact without duplicating efforts. Universities and provider partners can support participants through mentorship and professional development, while outcome tracking on placement and retention informs future program design. HFS also aims to help hospitals and employers develop retention plans to maintain staff and meet workforce needs after the grant ends. Together, these strategies aim to reduce reliance on short-term funding by institutionalizing rural training pathways and fostering strong community ties that keep providers in place, ensuring continued access to essential services for rural populations.

3.B Training and Recruitment Program for Non-Traditional Healthcare Workers: As with other workforce initiatives, this initiative builds sustainability into the workforce itself by developing *local* talent pipelines for nontraditional roles—such as CHWs, doulas, lactation consultants, and

peer support professionals—through training and certification programs that keep rural learners in their communities. By rooting education and hands-on experience in partnerships with community colleges, universities, local health systems, and community organizations, successive cohorts can strengthen care coordination and extend services beyond clinic walls. As participants complete training and enter practice locally, communities gain enduring capacity that supports comprehensive, team-based care and helps providers operate at the top of their license. These training programs serve as a valuable springboard for individuals newly entering the healthcare sector, providing them with opportunities to build foundational skills and advance in their careers. Program-specific sustainability will include embedding curricula within ongoing offerings administered by community colleges and state universities, aligning programs to recognized certification standards, and using structured placements with local providers to reinforce retention. Partners could maintain learning collaboratives, mentorship, and "train-the-trainer" supports to reduce ongoing delivery costs, while simple placement and retention tracking informs program refinement and regional targeting over time. Together, these steps are intended to lessen reliance on short-term funds by institutionalizing locally delivered training pathways and strengthening community ties that keep graduates in rural roles.

3.C Rural Health Education Pipeline: Because the UIC AHEC program is an established framework, sustainability will focus on embedding rural-specific enhancements into its ongoing operations rather than creating new structures. This may include formalizing recurring agreements with rural school districts and provider organizations to ensure consistent student participation and experiential learning opportunities year after year. By integrating these activities into existing school curricula and leveraging UIC AHEC's established infrastructure, the program can maintain continuity without requiring significant new administrative layers.

Partnerships can also identify practical contributions—such as preceptor time, space for workshops, and transportation support—that reduce delivery costs and make participation feasible for rural students.

To further strengthen sustainability, the program may implement mentorship networks and alumni engagement strategies to keep students connected beyond initial exposure, creating a cycle of peer support and role modeling for future cohorts. Tracking participation and outcomes—such as progression into health-related education or employment—can inform refinements and help target resources where they have the greatest impact. Over time, these measures aim to institutionalize rural health career pathways within the existing UIC AHEC structure, ensuring that the pipeline remains active and aligned with workforce needs even after initial grant funding concludes.

C. Commitment to use cross-agency policy levers to reduce barriers to sustainability:

Illinois will incorporate lessons from the RHT program into standing policy instruments and operations by: (1) embedding rural transformation aims and proven activities into statewide planning (e.g., the State Health/Improvement planning cycle and Medicaid quality strategy); (2) aligning managed care contract requirements and VBP levers to recognize effective elements from each initiative that demonstrates promising impact; and (3) standardizing data sharing, core measures, and learning collaborative structures used during the program so they become part of routine accountability and TA. Where feasible and permitted, HFS will translate demonstration practices (e.g., care coordination models, virtual access workflows, CHW/peer supports, and regionally governed shared services) into explicit coverage, performance, and reporting expectations that can be referenced in MCO contracts, guidance, and program manuals, ensuring that effective approaches persist after time-limited awards conclude. This will require strong

partnership with MCOs throughout the five-year program.

To move from grants to ongoing funding, Illinois will use program findings to inform updates to Medicaid purchasing and policy—such as clarifying when services are reimbursable under existing authorities, exploring value-based incentives that reward access and outcomes in rural settings and enable ongoing innovation/investment, and identifying where State Plan or waiver adjustments are appropriate to support high-impact elements (e.g., integrated teams, mobile/virtual care enablement, and workforce supports that demonstrably improve access). Concurrently, the state will assess any legacy financing approaches that are reduced or phased out under federal law and use RHT results to guide a responsible shift toward transparent, predictable mechanisms (e.g., prospective payments and quality-linked incentives in managed care), supplemented—where appropriate—by hospital/community co-investment for shared regional priorities. Together, these steps are intended to ensure that federal investment yields durable changes in how rural healthcare is delivered and paid for, reduces reliance on short-term funds, and embeds successful components of every initiative into the state's ongoing policy and contracting environment.

[1] https://www.census.gov/popclock/

[2] https://www.ruralhealthinfo.org/states/illinois

[3] https://mchb.tvisdata.hrsa.gov/Admin/FileUpload/DownloadStateUploadedPdf?filetype=PrintVersion&state=IL&year=2025

[4] https://datausa.io/profile/geo/illinois

[5] https://www.census.gov/programs-surveys/saipe.html

[6] https://www.ruralhealthinfo.org/charts/60

[7] https://www.illinoisworknet.com/WIOA/Resources/Documents/2022%20Illinois%20Unified%20State%20Plan%20Mod%20Final%20DOL%20Approved.pdf

[8] https://www.ers.usda.gov/data-products/county-level-data-sets

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