Rural Health Transformation Program Application

Opportunity number: CMS-RHT-26-001

PROJECT NARRATIVE
Submitted by the State of Montana, Department of Public Health and Human Services (DPHHS)

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Greg Gianforte, Governor | Charlie Brereton, Director

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

RURAL HEALTH NEEDS AND TARGET POPULATION

Montana has the third-lowest population density of any state, averaging fewer than eight people per square mile. The State has only one city with a population over 100,000 and only six with populations over 25,000.[i] 51 of Montana's 56 counties and 204 of 219 census tracts are defined as rural,[ii] based on the Health Resources and Services Administration's (HRSA) definition. Montana's Department of Public Health and Human Services (DPHHS) is acutely aware of the unique needs of rural populations and the specific challenges in delivering care in rural areas. These challenges manifest as shortfalls in health care access, worse health outcomes for those in rural communities, and financial stress and instability for rural health care providers. Montana has 77 physicians per 100,000 people in rural counties compared to 233 per 100,000 in urban counties[i] and 134 physicians per 100,000 in rural areas nationally.[iii] Individuals in Montana's rural counties bear a 30-40% greater chronic disease burden than those in urban counties[i]. Further, 89% of rural hospitals in Montana operate at a negative profit margin[i].

The State's analysis suggests that, at the most fundamental level, the health challenges faced by Montana's rural communities are driven by a clear set of root causes:

- An insufficient number of health care providers across both generalist and specialist care, and an inadequate utilization of available providers' existing and potential skillsets
- Ongoing financial pressures on rural health providers that, if left unaddressed, are likely to lead to further reductions in care services and access in the years ahead
- Underdeveloped health access and care models that have yet to take full advantage of innovative methods to improve access and quality for individuals in rural areas
- Under-resourced community health services, including too few access points
- Lack of access to nutritious food, physical inactivity, and related health factors

- Gaps in the adoption and use of modern health care technologies to improve care

Montana's application for Rural Health Transformation Program (RHTP) funds reflects a plan to address each of these root causes directly. The initiatives described in this application have been designed in partnership with stakeholders across Montana to address root causes and transform the State so that it can measurably and sustainably improve outcomes for rural populations.

These initiatives will transform rural health across the State, but the State maintains a specific focus on the following populations and geographic areas:

- Residents of the 51 rural counties and 204 rural census tracts in Montana
- The 8 tribal nations comprising 6.5% of Montana's population, and the 5 Urban Indian Organizations (UIOs)[iv] whose reach extends to tribal members in rural areas
- Individuals in rural areas with chronic diseases and those with behavioral health needs, including substance use disorders, and developmental disabilities
- Individuals on Medicaid, on Medicare, or who are dually enrolled
- Low-income individuals in rural areas in need of but without access to health services
- The existing, potential, and future health care workforce serving rural areas
- Rural hospitals and health care systems, Federally Qualified Health Center (FQHC) service sites, and Certified Community Behavioral Health Clinics (CCBHCs)
- Individuals in rural areas who are considering pregnancy, are pregnant or have recently been pregnant, and children themselves, with an emphasis on maternal and infant health

STATISTICS ON RURAL DEMOGRAPHICS

- 49% of Montana's population lives in entirely rural counties, with an additional 12% in rural census tracts of Montana's five non-rural counties[v]

- There are 4.1 individuals per square mile on average within rural counties[vi]
- The unemployment rate in rural counties is 3.1%, compared to 2.7% in non-rural counties. Health care comprises a smaller portion of the workforce in rural counties (19% vs. 29% in non-rural counties)[vii]
- 73% of adults in rural counties have less than a bachelor's degree, compared to 60% in non-rural counties[viii]
- Only 42% of individuals have employer-sponsored health insurance in rural counties, compared to 54% in non-rural counties; [vii] 7.1% of individuals are uninsured in rural counties, compared to 6.7% in non-rural counties[ix]

STATISTICS ON HEALTH OUTCOMES

- Adult rates of chronic disease are higher in Montana's rural counties than in Montana's non-rural counties[viii] or U.S. average (rural and non-rural):[x] COPD: 8.7% (MT rural), vs. 6.1% (MT non-rural), vs. 4.2% (U.S.); Diabetes: 11.3% vs. 8.1% vs. 8.9%; Coronary Heart Disease: 8.6% vs. 6.1% vs. 5%; Blood Pressure: 35.8% vs. 27.4% vs. 33%
- 45.7 deaths per 100,000 children in Montana, compared to U.S. average of 29.0[xi]
- 40.7 deaths per 100,000 live births in Montana, compared to U.S. average of 29.7[xii]

STATISTICS ON HEALTH CARE ACCESS

- In 15 Montana counties representing 9% of the State's population, the average distance to a hospital is greater than 20 miles; in 4 counties, the average distance is over 40 miles[xiii]
- 76.7 physicians (all types) per 100,000 rural county residents, compared to 233.3 in Montana's non-rural counties,[xiv] and 133.7 in rural counties nationally[xv]
- 89.2 nurse practitioners (NPs, all types) per 100,000 rural county residents, compared to 151.0 in Montana's non-rural counties[xv] and 110.0 NPs per 100,000 residents in U.S.

rural counties[xvi]

- The health sector is projected to see 8,500 annual job openings over the next 10 years[xvii]
- 8.0% of adults living in rural areas report unreliable transportation[xviii]

STATISTICS ON RURAL FACILITY FINANCIAL HEALTH

1) 88.9% of rural health care systems or individual rural hospitals operate at a negative profit margin, with 63.9% operating below a negative 10% profit margin[xix]
2) Hospitals in rural counties have an average utilization rate of 38.5%, with 61.6% having a utilization rate under 50%; non-rural hospitals have an average of 51.7%[xx]

RHTP PLAN: GOALS AND STRATEGIES

Montana's vision is to ensure that every resident has affordable access to high-quality, high-value care regardless of geography. The State's RHTP plan directly addresses the root causes of rural health disparities through five integrated initiatives that strengthen the workforce, secure financial solvency, modernize care delivery, embed prevention and community health at the center of care, and expand technology use.

The State believes outcome gaps are driven by compounding challenges, including rural Montanans having too few opportunities to engage with too few clinicians on services further upstream, and doing so without the full benefit of modern technologies or care models. These challenges are exacerbated by the fundamentally unfavorable economics of rural care for provider systems, resulting from a care model, workforce, and provider capital footprint not aligned with rural utilization, reimbursement, and care needs. The State's goals are grounded in addressing the root causes of rural outcomes gaps. Specific goals and strategies by objective:

IMPROVING ACCESS

Montana will expand and sustain access to hospitals, primary and specialty care, behavioral health, and maternal-child services by:

- **Right-sizing rural hospital capacity and expanding ambulatory care** through the *Montana Rural Health Center of Excellence (CoE)* **(Initiative 2.1 and 3.4)**, to align service delivery with county-level needs and optimize inpatient and outpatient balance by developing and incentivizing implementation of county- and facility-level restructuring plans aligning service supply with local health needs
- **Launching virtual specialty access statewide**, including tele-stroke, tele-ED, and tele-cardiology consults in 50+ rural hospitals (**Initiative 2.2**)
- **Modernizing EMS systems** via a new dispatch platform and expanded community paramedicine, reducing response times and unnecessary ED use (**Initiative 3.2**)
- **Expanding school-based and mobile preventive care** in ~200 locations and 10 mobile clinics to bring care directly to residents (**Initiative 4.1**)

Collectively, these actions will reduce travel distance to essential services, maintain emergency access points, and ensure rural residents receive care at the right place and time.

IMPROVING OUTCOMES

Montana will target measurable improvement in rural health outcomes, including:

- **Chronic-disease control** (diabetes, hypertension, and obesity) through expanded preventive infrastructure (**Initiative 4**) and data-guided care management (**Initiative 5**)
- **Maternal, infant, and child health**, reducing under-five and perinatal mortality through expanded prenatal care, perinatal telehealth, and enhanced EMS (**Initiatives 3 and 4**)

- **Behavioral health outcomes**, implementing Certified Community Behavioral Health Clinics and expanding crisis stabilization capacity (**Initiative 4.2**), virtual behavioral health services (**Initiative 2.2**), behavioral health ED admissions (**Initiative 4),** and reduction of deaths by suicide (**Initiative 4)**
- **Trauma, emergency, and crisis response** including ED length-of-stay (**Initiative 2**), ED high utilization (**Initiative 3)**

Outcome metrics will be continuously monitored via the Department's electronic data warehouse and population health analytics under **Initiative 5**. Monitoring will be done in partnership with the State's Data Management Office and Office of Research and Data Analytics (both housed within DPHHS).

TECHNOLOGY USE

Montana will jointly leverage new and existing technology to drive rural transformation through initiatives including:

- **Modernizing EHRs** for rural providers through community-connect models, ensuring interoperability, cybersecurity, and actionable analytics (**Initiative 5.2**)
- **Activating telehealth and remote monitoring tools** within EHRs to enhance chronic-disease management and specialist reach (**Initiatives 2.2 and 5.2**)

PARTNERSHIPS (BACK TO INITIATIVE 1, 2, 3, 4, 5)

Montana's plan builds on strong partnerships to deliver and sustain transformation, including:

- Partnership with the **Department of Labor and Industry** for workforce program implementation, and partnership with the **Montana State University Office of Rural Health** to manage stakeholder engagement and workforce expansion **(Initiative 1)**

- Collaboration with **Montana Hospital Association, Yellowstone High Value Network**, **Billings Clinic/Logan Health,** and other **Critical Access Hospital Collaboratives** to implement care delivery restructuring and shared service models (**Initiative 2**)
- Partnership with **Montana Healthcare Foundation** and community partner organizations on community-based care (**Initiative 4)**
- Partnership with **Montana Primary Care Association, Montana Pharmacy Association, EMS Advisory Committee, Montana Ambulance Association,** and other primary and ambulatory care partners for innovative care models (**Initiative 3**)
- Engagement with **tribal governments, Urban Indian Organizations,** and **Indian Health Service** for co-design of preventive and workforce programs (**Initiatives 1 and 4**)
- Collaboration with **Big Sky Care Connect**, **technology partners, hospitals, and rural health care providers** to advance data integration and interoperability (**Initiative 5**)

The stakeholders above, in addition to those listed here, will be consulted across all initiatives (cross-cutting stakeholders): Behavioral Health Alliance**,** FQHCs and RHCs, Montana Academy of Family Physicians, Montana Academy of Pediatrics, Montana Dental Association, Montana Health Care Association, Montana Medical Association, and Rocky Mountain Tribal Council. Stakeholders supporting individual initiatives are included in the Initiative Description sections. This is a preliminary list that the State will refine and augment over the course of the funding period.

WORKFORCE

In August 2025, Montana Governor Greg Gianforte announced the 406 JOBS initiative, an industry-led effort to modernize Montana's workforce. Among the priorities of this initiative are

increased attention to apprenticeships and industry-recognized credentials, innovative career awareness, and exploration programs focused on High-Demand Sectors, including health careers. Through Initiative 1, the State will build on its commitment to attract, train, and retain health care professionals in rural areas by:

- Expanding apprenticeships, credentials, and micro-pathways, and early exposure programs; offsetting training costs with time-limited education awards and tuition assistance
- Increasing clinical training capacity in rural communities by growing residency programs, offering preceptor incentives, and expanding rural training tracks
- Enhancing supportive services and professional development to better connect and sustain health workers in rural communities

By FY2031, these investments will sustainably increase provider density and access to skilled care across Montana's rural counties.

DATA-DRIVEN SOLUTIONS

All of Montana's proposed initiatives will use data to inform program design and monitor progress. Initiatives that are explicitly data-focused include:

- **Deploying statewide data dashboards,** including a behavioral health bed registry and population health analytics hub to track access, quality, and cost trends (**Initiative 5.1**)
- **Embedding a continuous improvement framework** for Medicaid interventions, linking funding to outcomes, and closing care gaps across counties (**Initiative 5.1**)

FINANCIAL SOLVENCY STRATEGIES

Montana's plan addresses the structural financial fragility of rural facilities by:

- **Comprehensive facility analysis and restructuring** to achieve positive operating margins by FY2031 **(Initiative 2.1)**
- **Incentive payments** tied to implementation of sustainability recommendations (~10% of net patient service revenue) **(Initiative 2.1)**
- **Group purchasing and shared services** to lower administrative and supply costs **(Initiative 2.3)**
- **Value-based Medicaid and dual-eligible contracting models** to incentivize rural quality and efficiency (**Initiative 3.1**)

These reforms will stabilize rural providers, improve margins, and sustain access beyond the grant period.

CAUSE IDENTIFICATION

Analysis of facility-level data shows Montana's rural hospitals face closures or service reductions due to:

- **Low inpatient utilization** (average < 50% of capacity)
- **High fixed costs and limited economies of scale**
- **Unfavorable payer mix and uncompensated care**
- **Workforce shortages** and limited clinical coverage
- **Geographic isolation and patient bypass to urban centers**

The Montana Rural Health CoE's data-driven approach **(Initiative 2.1)** directly addresses each cause, producing county-level recommendations to stabilize rural access and performance.

PROGRAM KEY PERFORMANCE OBJECTIVES

By FY2031, Montana aims to achieve:

Objective	Baseline	FY2031 Target

Ratio of NPs per 100,000 people in rural counties	76.7 per 100k	5% increase annually
Ratio of physicians per 100,000 people in rural counties	89.2 per 100k	5% increase annually
Ratio of RNs per 100,000 people in rural counties	860.9 per 100k	5% increase annually
Ratio of dental hygienists per 100,000 people in rural counties	90.7 per 100k	5% increase annually
Ratio of EMTs per 100,000 people in rural counties	115.0 per 100k	5% increase annually
Ratio of PAs per 100,000 people in rural communities, all rural counties	70.6 per 100k	5% increase annually
Rate of position turnover in rural counties (in health care)	Internal data on metric is not collected yet	At least to national average
Provider mental health rating	Internal data on metric is not collected yet	Higher behavioral health ratings
Average ED length-of-stay	3.9 hours	10% reduction
Rural facility operating margin	Estimated -14.48% net operating profit margin based on *Definitive* data; to be validated and refined during FY2026 Q2	0%; hospitals breakeven
Total facility inpatient days divided by staffed beds	39.49% average	30 pp increase
Percentage of total Medicaid visits conducted via telehealth	Expansion visits: 2.12%; expansion traditional: 2.33%	15 pp increase
% of Medicaid spend on outpatient care	72.8% spend on outpatient care	80% spend
Treat no Transport CPT use	0% (Treat no Transport not currently reimbursable)	10% of calls
Percentage of total pharmacists prescribing for Medicaid members	0% (Pharmacists currently not able to prescribe for Medicaid members)	50% participation
ED high utilizers	21.03% all; 19.86% Medicaid	10 pp decrease
Average dollar amount spent from Medicaid on Duals (PMPM)	$305 yearly average PMPM, non-disabled, no TPL, dual Medicare	Stable
Number of crisis safe spaces	1 crisis safe space	11 spaces
Percentage of children who receive a well-child visit in the first 30 months of life (W30-CH)	Internal data on metric is not collected yet	Comparable with national median
% of diabetics with A1c control	37.80% all; 27.31% Medicaid	10 pp increase
% of those with hypertension with BP control	36.75% all; 29.74% Medicaid	10 pp increase
% of specific population with BMI levels under control	Internal data on metric is not collected yet	Higher levels of control
Behavioral health ED admissions per 1,000	50.61 per 100k	6% reduction
Deaths by suicide per 100,000 total population	26.2 per 100k statewide	10% decrease
Prevalence of students reporting mental health and related risk behaviors	43% students reported feeling sad or hopeless for two weeks or more	10% decrease

Number of Community Health Aide Program Practitioners	0 (CHAP not launched)	200 CHAP providers
Average wait time for behavioral health bed placements across non-State facilities	Internal data on metric is not collected yet	Reduction in wait time
Percentage of rural facilities and clinics participating in HIE	73% of hospitals, 43% of providers	95% for hospitals; 75% for others
Percentage of rural sites connected with HITECH-certified EHRs	88% of hospitals	95% of hospitals
Rural facility financial performance after EHR modernization	Estimated -14.48% net operating profit margin based on *Definitive* data; to be validated and refined during FY2026 Q2	10% increase for participating facilities

Strategic Goals Alignment

Montana's initiatives directly map to CMS's five RHTP goals:

1. **Make Rural America Healthy Again** – Initiative 4 (community prevention)
2. **Sustainable Access** – Initiative 2 (facility restructuring)
3. **Workforce Development** – Initiative 1 (workforce)
4. **Innovative Care** – Initiative 3 (EMS, telehealth, value-based models)
5. **Tech Innovation** – Initiative 5 (EHR modernization, interoperability, data sharing & access)

Legislative or Regulatory Action

Complementing these five initiatives, the State plans a set of **legislative/regulatory actions** to strengthen the underpinnings of rural health. These are summarized in the table on page 14.

OTHER REQUIRED INFORMATION

State policies: Current state policies across all relevant factors are included in the table below.

Factor A.2: While Montana does not currently have any CCBHCs, the State has secured a SAHMSA planning grant and is in the process of applying for a demonstration grant with four providers identified for certification. The Montana Legislature passed legislation authorizing implementation of CCBHCs and appropriated associated Medicaid funding with the expectation these providers would be certified through the award of a demonstration grant beginning in CY2026.

Factor A.7: In 2024, no hospitals received DSH payments in Montana. Montana discontinued making DSH payments after 2018 due to an increase in Medicaid supplemental payments as a result of an increase in the state's Hospital Utilization Fee (HUF), coupled with its ability to leverage enhanced federal funds through Medicaid expansion as a match to revenue received through HUF. This extra revenue to hospitals virtually eliminated their uncompensated care and eligibility for DSH. Montana continues to commit to making DSH payments to qualifying hospitals, however, no hospitals have qualified since 2021.

Policy Area	Current Policy	Policy Action	Timeline	Link to Outcomes
B.2 Health and lifestyle	Presidential Fitness Test not reestablished or enforced (0 points)	DPHHS will coordinate with OPI to enable schools to implement independently.	N/A	Enabling schools to independently implement the PFT is consistent with Make rural America healthy again goals
B.3 SNAP waivers	No existing USDA-approved waiver, despite previous attempts (0 points)	Commitment to implementing a USDA-approved SNAP waiver (100 points)	Fully implemented by EOY 2026	The SNAP waiver will promote nutrition throughout the state and reinforce prevention initiatives like Initiative 4.
B.4 Nutrition Continuing Medical Education	No existing requirement for a Nutrition CME for physicians (0 points)	The State will work to introduce and enforce a nutrition CME for physicians (100 points)	Fully implemented by EOY 2027	This policy change enables nutrition to be developed alongside workforce in Initiative 1.
C.3 Certificate of Need (CON)	Throughout all the Cicero-tracked CON restrictions, Montana only has restrictions on long-term care facilities, indicating a score of 5 from Cicero per the latest report (75 points)	CON restrictions will be consistent, and Montana will remain in the limited CON category (75 points)	N/A	Rural hospitals are not burdened heavily by CONs, increasing sustainability and ability to provide care
D.2 Licensure compacts	Full membership for physicians, nurses, psychologists, and PAs (100 points each); not a member state for EMS (0 points)	The State will work to become a licensure compact state for EMS (100 points)	Fully implemented by EOY 2027	Supporting EMS through licensure compacts augments and supports the EMS work in Initiative 3.
D.3 Scope of practice	Full scope of practice for physicians, NPs, and pharmacists (100 points each); dental hygienists allowed to do 5 defined tasks, according to OHWRC (50 points)	Dental hygienists can diagnose and create a treatment plan; State will work to have this codified in OHWRC (100 points)	Fully implemented by EOY 2027	The broad scope of practice across these positions will increase access to care by further leveraging the workforce, like Initiative 1
E.3 Short-term, limited-duration insurance (STLDI)	STLDI fully allowed under federal max terms, currently (100 points)	STLDI will maintain alignment with federal terms (100 points)	N/A	Federally aligned STLDI offers rural Montanans another insurance option, increasing access to affordable care
F.1 Remote care services	Medicaid payment for at least one form of live video (100 points), in-state licensing exceptions (100 points), and license & registration process in place (100 points); no payment for store-and-forward (0 points) and RPM (0 points)	Medicaid reimbursement will be put in place for Store and Forward (100 points) as well as Remote Patient Monitoring (100 points)	Fully implemented by EOY 2027	Medicaid reimbursement for these programs will enable technology-based care to become more accessible, thus increasing access to rural care overall

PROPOSED INITIATIVES AND USE OF FUNDS

The State proposes five sustainable initiatives to transform rural health over the next five years. These initiatives involve strengthening Montana's workforce, supporting health providers in the state to transition to more sustainable long-term economics, innovating care models, reinforcing community health and existing care sites, and deploying innovative technology. Together, they will achieve the strategic goals outlined by CMS, fulfill key State priorities, and transform the State of Montana's rural health capabilities.

INITIATIVE 1. DEVELOP WORKFORCE THROUGH RECRUITMENT, TRAINING, AND RETENTION

To address Montana's growing health care workforce gap, the State, in strong partnership with the Montana Department of Labor and Industry (DLI), will implement a coordinated set of actions to recruit, train, and retain health care professionals in rural areas. This initiative sustainably strengthens and **expands the State's broader workforce strategy** under the 406 JOBS Initiative. This includes:

1.1 – Increasing recruitment of rural health care workers through early exposure programs, apprenticeships, and training programs

1.2 – Enhancing and increasing rural clinical training capacity and opportunities, including residencies, preceptor and apprenticeship incentives, and rural training tracks

1.3 – Retaining and upskilling rural health care workforce through additional supportive services and enhanced training (including BH)

Sub-initiative details:

1.1. Increase recruitment of rural health care workers

- **Expand early exposure programs that establish early career interest and sustained entry points into Montana's health care workforce pipeline:**
    - *Pilot health care registered pre-apprenticeship programs* that connect rural high school students with local employers. This pilot will offer direct experience and career exploration opportunities, while also directly leading to a registered apprenticeship pathway in a health occupation, creating an integrated pathway from school to employment for health care support careers
    - *Expand health care Career and Technical Student Associations*, including Health Occupations Students of America (HOSA) and Area Health Education Centers (AHEC) for programs including MedStart, REACH, and Heads Up, reaching more than 1,500 rural students
    - *Support initial rollout costs for industry recognized credential attainment* to accelerate health care credentials for high school students in rural communities
    - *Expand state's online career exploration platform with health care specific content* to support new entrants, career changers, and talent attraction. This program will also grow middle school career awareness programs statewide.
- **Fund training programs for health care professionals**, including physicians, nurse practitioners, physician assistants, registered nurses, midwives, dental hygienists, EMT pilots, and other trainees. The initiative will provide four-year funding for a cohort of 100 medical students over the five-year period. Additional training programs will train 15 psychiatric nurse practitioners and 50 community-based paraprofessionals (e.g., Certified Behavioral Health Peer Support Specialists) trainees who are residents of certain high-needs rural counties. Funds may be used to support additional training programs to

support critical gaps in the state. Professionals participating in these programs will receive hands-on, community-based training on crisis intervention, behavioral health, maternal health, and preventive care**.**

- **Expand health care apprenticeship programs in rural areas** for licensed health professions in the State. This includes expanding existing apprenticeship programs, developing new bridge programs (e.g., LPN to RN, dental assistant to dental hygienist), and adding high-priority new Registered Apprenticeship pathways, including radiologic technicians, dental laboratory technicians, and medication aides.
- **Scale Montana's HELP-Link** workforce initiative to triple current capacity and train 3,000 more Medicaid expansion beneficiaries in credentialed, in-demand health care occupations such as medical assistants radiology technicians, and other early and mid career occupations vital to rural health facilities
- **Build a comprehensive talent attraction campaign** that focuses on recruiting health care workers to eastern Montana and other rural communities throughout the State for critical health care workforce gaps. This effort will build on emerging campaigns led by the State's major health systems (e.g., Billings Clinic/Logan Health), creating a coordinated and sustainable approach to recruitment.

  All individuals benefiting from training programs that lead to careers related to direct patient care (e.g., physicians, NPs, RNs) will commit to serving a minimum of five years in rural communities.

1.2. Expand rural clinical training capacity and opportunities

- **Expand residency training capacity in high-need specialties** by increasing residency slots at existing in-state programs (e.g., Billings Family Medicine Residency) and

covering all associated costs. This will support the training of at least 10 additional residents during the funding period. Funding may be used to assess feasibility and provide start-up costs for a new residency program.

- **Offer targeted financial incentives and training to attract and increase the capacity of qualified preceptors and apprenticeship mentors across the State** who supervise and train MD/DO students, advanced practice providers (APPs), and apprenticeship trainees in rural areas. Recruiting efforts will also focus on increasing the teaching capacity of more than 400 new or existing community preceptors through both virtual and in-person education modeled after existing WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) Medical Education Program trainings. These incentives are designed to strengthen and expand supervisory capacity among already existing and tenured providers with no additional career-enabling credentialing.
- **Expand rural training tracks** to provide clinical education experiences for more than 30 APPs annually, including through the expansion of the Montana Area Health Education Center Scholars Program and other rural training opportunities. Additional rural training opportunities may include expanding 12-month rural training tracks with out-of-state partners, enabling residents from specialties not yet available in Montana (e.g., surgery) to complete portions of their training in rural communities.

1.3. Upskill and retain rural health care workforce

- **Provide supportive services for health care workers in or relocating** to rural communities. The program would offer time-bound relocation assistance funds during the period of performance, facilitate interfacility collaboration and personalized community resource linkages, and fund wellness and resilience programs to reduce isolation, prevent

provider burnout, improve provider behavioral health, and ultimately retain medical and dental providers in these communities.

- **Invest in advanced clinical, operational, and behavioral health training programs** that strengthen the skills of health care professionals serving rural communities by incorporating a train-the-trainer model that equips clinicians and leaders to upskill their peers**.** This will include expanding surgical technology training (e.g., robotics) to enhance provider capability and patient care, as well as deploying targeted trainings for rural health clinics on team-based care, chronic disease management, telehealth integration, and operational best practices that enable clinicians to practice at the top of their license. This will also include training all providers to manage non-specialty Behavioral Health, including diagnosis, and how to connect to specialized resources. Programs will also evaluate additional trainings in priority areas such as pediatrics (e.g., children and youth BH, child abuse prevention) to provide tailored resources for health care professionals.

Main strategic goal: Workforce development

Use of funds: D. Training and technical assistance; E. Workforce Recruitment and Retention

Technical score factors: B.1, C.2, D.1

Key stakeholders: **Cross-cutting stakeholders listed in the partnership section and the following initiative specific stakeholders**: Community Health Support Network, GME Council, Montana Area Health Education Center, Montana Office of Public Instruction, Montana State Workforce Innovation Board, Montana University System, MSU College of Nursing, Rocky Vista University Montana College of Osteopathic Medicine, Touro College of Osteopathic Medicine Montana, WWAMI**.**

Outcomes and Projected Impact (detailed table included in Metrics section)**:**

- A foundational determinant of access to care is the availability of a qualified health care workforce. Current data show that the State faces significant gaps in health care workers, particularly in rural regions. **In-state health care training capacity,** including post-secondary education and apprenticeship programs, remains limited. Costs of training and a shortage of qualified preceptors further constrain opportunities for potential students to train and serve in their home communities.
- At the same time, **recruiting and retaining providers** in rural areas is a persistent challenge (to be tracked by rate of **position retention;** turnover baseline to be collected annually, target at least the national average by FY2031). Expanding the number of providers delivering care in rural communities by strengthening the entire health care workforce pipeline, from entry-level roles such as pharmacy technicians with expanded scopes of practice to advanced providers in paramedicine and other high-need disciplines, will **increase the number of primary care access points** and ensure communities are better equipped to meet the evolving needs of rural populations (to be tracked by density of specific health care workers; **nurse practitioners** baseline 76.7 per 100k, **physician** baseline 89.2 per 100k, **physician assistant** baseline 70.6 per 100k, **registered nurses** baseline 860.9 per 100k, **dental hygienists** baseline 90.7 per 100k, **EMTs baseline** 115 per 100k, target across all is 5% annual growth from FY2027 to FY2031).
- Clinicians, especially physicians and dentists, experience higher rates of depression, burnout, and suicide compared to the general population. In addition, those relocating to rural communities may find themselves increasingly isolated from their peers. Expanding supportive services for health care workers in or relocating to rural communities,

including wellness programs will **improve provider mental health**. By FY2026 State will determine rural-specific baseline and precise target, given no current data.

Impacted counties: Montana's 51 rural counties and rural portions of 5 metropolitan counties.

Estimated required funding: ~$20.5 million for FY2026; Sustainability Plan for this Initiative is in Sustainability Plan Section below

Workplan and monitoring: High-level Implementation Plan included below; detailed Implementation Plan for Initiative 1 included in Supporting Documentation

INITIATIVE 2. ENSURE RURAL FACILITY SUSTAINABILITY AND ACCESS THROUGH PARTNERSHIPS AND RESTRUCTURING

As described in the Rural Health Needs and Target Population section, 89% of Montana rural hospitals have a negative operating margin, given high operating costs relative to volume and reimbursement, indicating a care delivery supply and demand mismatch. At the same time, rural populations face critical access gaps for essential time-sensitive care, such as high-quality emergency medicine and stroke care and specialized care for residents with intellectual and developmental disabilities (IDD) and medically complex children, driven partially by long distances and partially by a lack of transport coordination between health care facilities. The State will lead a statewide rural care delivery system transformation focused on supporting rural systems to right-size services and restructure costs to sustainably meet their communities' needs by optimizing **population health clinical infrastructure**, while leveraging **remote care services** and **rural provider partnerships** to protect and expand access. This will include:

2.1 – Launching a time-limited Montana Rural Health Center of Excellence to develop and oversee the implementation of data-backed financial sustainability recommendations

2.2 – Protecting and increasing access by fostering and incentivizing clinical partnerships

2.3 – Facilitating shared services for rural facility cost efficiency

Sub-initiative detail:

2.1. Launch a Montana Rural Health Center of Excellence to develop and oversee the implementation of data-backed financial sustainability recommendations

- **Stand up the Montana Rural Health Center of Excellence (CoE)** to rapidly create a rural health supply and demand fact base for Montana and develop recommendations to align care delivery services with rural health needs at the county and facility level. The State is considering a board-like governance structure to ensure impacted stakeholders, including independent hospitals in rural communities, have representation and take part in decision-making. The State anticipates discontinuing the CoE after 2028. Leveraging the State's existing analytics from ongoing initiatives, the CoE will conduct a deep analysis of rural community disease burden projections and inpatient and outpatient utilization trends by service line, and cross-reference this with Montana's current care delivery footprint across access points to identify critical areas of misalignment at the county and facility levels. This research will build on the State's current assessment that in many rural communities, inpatient capacity exceeds community needs (with average inpatient utilization in Montana rural hospitals below 50% of staffed capacity[xxi]). The CoE will also develop a profile of Montana rural hospital cost structures and the most significant areas of financial opportunity through clinical and operational efficiency levers, including potential value-based care models. A core CoE deliverable will be a set of detailed recommendations, at the facility- and county-level, for restructuring inpatient and outpatient services to match projected rural health care demand through the RHTP period and beyond, while achieving persistent positive operating margins for the 2031-

2035 period without any additional State support.

- **Offer an opt-in program providing incentive payments to rural care delivery systems to implement Montana Rural Health CoE recommendations,** including right-sizing select inpatient services to match rural community demand. This program is designed to help hospitals align services with community needs, improve financial sustainability, and ensure continued access to care.

  During Year One, the CoE will be in the process of developing transformation recommendations. Initiative 2 incentives disbursed by DPHHS to participating provider organizations in Year One will be allocated for the following purposes:

  (i) Strategic service provision: Provision of health care services to rural communities to expand access to primary or specialty care (e.g., expanding primary / urgent / emergent care hours, expanding telemedicine capabilities), sustainably improving operating margin (e.g., reducing underutilized staff beds, shifting services out of acute settings, providing post-discharge home visits to reduce avoidable readmissions), and / or measurably improving health outcomes (e.g., expanding evidence based testing, screenings, and medications). Funds will be allocated to provider organizations based on evidence of changes made. Provider organizations will be asked to report on how funds were used after one year.

  (ii) Cover costs of CoE program entry: To offset in-house or outsourced staff time associated with preparing data requests and participating in administrative processes for CoE program entry. This will directly enable the work of future years, as this data will be necessary for the CoE to develop facility-level service line rightsizing recommendations.

CoE recommendations on financial transformation and health care access will be finalized in Year Two (FFY27). Incentives from Year Two onwards will *only* be awarded to support the implementation of these recommendations to ensure appropriate care availability for rural residents, sustainably improve rural facilities' operating margins, and measurably improve health outcomes. Participating provider organizations will receive an incentive payment linked to the implementation of the recommended changes (in line with national best practices, though the exact amount for each hospital will depend on scale of patients served, scope of recommendations, and rurality factors). Payments will, on average, be equivalent to 10% of net patient service revenue (but not necessarily be determined based on organization revenue). Changes will be specific and tailored to the circumstances of individual facilities and networks and will enable providers to provide the right services at the right scale and at the right time. Examples may include:

- Rightsizing a given provider's current health care supply to match current and projected demand across preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care including training and technical assistance to promote new care pathways. In some cases, this may include downsizing, but there is no expectation of across-the-board downsizing. (Category G Use of Funds – primary category)
- Investing in existing rural health care buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions in the funding policies and limitations – for example, to transition

inpatient operating rooms and other facility resources to outpatient clinic space or transition inpatient hospitals to new models leveraging lean infrastructure, swing beds, and transport capabilities. (Category J Use of Funds)

Receiving incentive payments will also be linked to protecting and expanding ambulatory services through sub-initiatives 2.2 and 3.4, per CoE recommendations. The CoE and implementing partners will tailor each recommendation and contract to the unique needs of individual facilities and rural and tribal communities, recognizing rural hospitals often represent major employers in these areas, while maintaining a rigorous focus on the changes that are required for facilities to achieve breakeven without additional State support by 2031. The State's approach to support care delivery transformation builds on the experience of the Pennsylvania Rural Health Model and other experiences from other states. Based on stakeholder conversations, the State expects more than half of rural hospitals to opt into this transformation program. Incentive payments will be completed by the final RHTP budget cycle, with final payment contingent on completion of the agreed-upon restructuring.

2.2. Protect and increase access through clinical partnerships

- **Support virtual care availability for rural residents to expand access to care**. The State will support the deployment of virtual interfacility specialty consultations to address shortages of critical specialists at rural hospitals and emergency departments through a hub-and-spoke model. Building on the success of the existing tele-stroke pilot in 11 rural hospitals, the State will support implementation of tele-stroke services along with other specialist tele services (e.g., tele-ED, tele-cardiology) across 50+ rural hospitals. Funding will cover initial costs, including teleservice equipment, provider onboarding, and in-

person "train the trainer" training for on-site staff. Hospitals will be required to cover ongoing costs, replicating the current model of the pilot. The State will also support priority rural clinics in regions with critical access gaps (as identified by the CoE) to develop telehealth capabilities. In most instances, the State expects this to be achieved through Initiative 5.2, which supports rural providers with modern EHRs. In cases where priority clinics cannot access this service or otherwise require connectivity, the State will support the clinic with upfront technology and implementation costs to enable telehealth, with the agreement that the clinic will cover ongoing maintenance costs. Telehealth platform access will be offered through the Group Purchasing Organization (GPO)-facilitated vendor sourcing process in sub-initiative 2.3.

- **Scale Intellectual and Developmental Disabilities (IDD) telehealth services**. The Department's initial IDD virtual care pilot providing urgent telemedicine services to complex members resulted in 91% of acute IDD encounters being treated in place and resulting in an estimated cost-avoidance of $2.3M through preventing ~450 avoidable ED, urgent care visits, or hospitalizations. Building on the early success of the IDD telehealth initiative, the program will expand from two Montana DDP regions to all five regions, increasing reach from 19 counties to all 56 counties, and increasing access to services to an estimated 1,400 IDD patients. The program will also be expanded to incorporate behavioral health services for this population. Given the proven cost-avoidance from the pilot, the State will pursue Medicaid coverage through the 1915(c) Home and Community-Based Services (HCBS) Waiver to sustain this sub-initiative.
- **Roll out pediatric virtual care delivery** for rural children with special health care needs. The State will evaluate vendors providing innovative at-risk models guaranteeing cost

reductions driven by avoidable hospital and emergency utilization (~25%) while maintaining high family satisfaction. Services such as virtual pediatric urgent care and behavioral health teletherapy would be made available to rural communities in partnership with existing Montana pediatric providers.

- **Establish sustainable interfacility patient transport coordination system** to direct emergent and non-emergent patients to appropriate sites of care, including coordinating transport between facilities. The success of rural care delivery transformation depends on ensuring patients can quickly access the right level of care (e.g., trauma care). The State will support implementation of a statewide hub to be housed by participating hospitals and larger systems in Montana to streamline transfers by tracking inpatient and surgical care availability, bed space, and real-time ground and air transport data. The system will leverage existing geolocation and communications devices used by EMS and receiving facilities. Funding will cover startup costs, including coordination software, system integration, and core dispatch setup, with participating hospitals maintaining the system beyond year 5 through a cost-sharing agreement based on fees per patient.

2.3. Facilitate vendors and shared services for rural facility cost efficiency

- **Facilitate rural providers to collectively access vendors at scale for priority functions,** including back-office services, other forms of administrative activities, and clinical efficiency tools. Rural providers are especially vulnerable to high administrative costs relative to revenue, frequently lack access to modern technology, and face low purchasing and negotiating power for supplies and vendors. To address these challenges and enable rural provider financial sustainability, the State will work with the Montana Hospital Association (MHA) and independent and separate coalitions of Critical Access

Hospitals to evaluate the need to facilitate improved vendor access for back-office services and other functions, enhancing or extending current offerings. Functions may include revenue cycle management, patient engagement, provider credentialing, procurement, clinical workflow, remote patient monitoring, clinical decision-making, or a 340B pharmacy operator. Vendors offering favorable rates to leverage the latest AI-enabled technology, with a clearly demonstrated history of success with similar-sized providers, will be prioritized. The State may facilitate providers contracting with a single GPO to negotiate rates to enable low prices. In addition, the State will also ensure vendor selection, and the resulting contracts include favorable terms and conditions, such as optimized governance processes, favorable termination and notification clauses, robust Service Level Agreements (SLAs), and reporting requirements. The State will assist with the coordination of implementation with selected vendors for participating providers and will provide technical assistance on how to track and realize cost savings.

Main strategic goal: Sustainable access

Use of funds: B. Provider Payments; G. Appropriate care availability

Technical score factors: B.1, C.1, F.1

Key stakeholders: Cross-cutting stakeholders listed in the partnership section and Montana's Stroke Workgroup

Outcomes and Projected Impact (detailed table included in Metrics section)

- Inpatient footprint does not match the needs of rural communities. The recommendations, incentives, and transformation support will result in most rural facilities making sustainable changes. The State will track **utilization of staffed beds** (baseline 39%, target 30 p.p. increase) to assess how well inpatient capacity matches community need.

- Facility changes, in addition to increased back-office vendor usage, are anticipated to drive improved rural provider financial performance, measured by **operating margin improvement** (estimated baseline to be refined: -14%; target: 0%). This metric complements revenue cycle management improvements from EHR modernization.
- Other key components of improving rural provider efficiency and meeting community needs include protecting and expanding access through telehealth, anticipated to increase the number of **Medicaid visits conducted via telehealth** (baseline 2%, target 15 p.p. increase)**,** improving interfacility coordination to get patients where they need to be, thus reducing **ED length of stay** (baseline 3.9hrs, target 10% reduction), and shifting service delivery to outpatient sites of care, increasing the **proportion of Medicaid spend on outpatient services out of total spend** (baseline 73%; target 80%).

Impacted counties: Montana's 51 rural counties and rural portions of 5 metropolitan counties

Estimated required funding: ~$82.4 million for FY2026; Sustainability Plan for this Initiative is in Sustainability Plan Section below

Workplan and monitoring: High level Implementation Plan included below; detailed Implementation Plan for Initiative 2 included in Supporting Documentation

INITIATIVE 3. LAUNCH INNOVATIVE CARE DELIVERY AND PAYMENT MODELS

Montana's rural health care system faces ongoing challenges in ensuring that care is accessible and financially sustainable. Primary care clinics face critical capability gaps in technology and population health, and there are no dedicated programs for Dual-eligible residents. Gaps in EMS resources driven by lack of infrastructure and use of EMS services for non-emergent cases lead to gaps in emergent care. Similar gaps are found across rural communities in accessing needed outpatient and diagnostic services. This initiative aims to innovatively transform how care is

delivered both on-demand via **rural strategic partnerships**, accelerating primary care participation in **Medicaid provider payment incentives**, identifying and standing up programs to provide integrated care for **individuals dually eligible for Medicare and Medicaid**, and modernizations that strengthen **EMS** and, in the community, while simultaneously transforming financing to incentivize quality care in rural Montana:

3.1 – Implementing innovative payment and care models that prioritize patient outcomes and access to care

3.2 – Modernizing Emergency Medical Service care model to increase capacity and reach

3.3 – Extending access to lower-cost care through pharmacist point-of-care testing sites

3.4 – Increase outpatient services based on Montana Rural Health CoE recommendations

Sub-initiative detail:

3.1. Implement innovative payment models

- **Expand technical support for Montana PCPs participating in Medicaid value-based contracting** as part of the State's Primary Care Case Management (PCCM) program. The State currently provides technical support to primary care practices participating in the PCCM program. The State will fund additional technical support for an expanded number of clinics, accelerating what is currently planned for PCCM. The State expects that providing personalized technical assistance will lower the cost and barriers to participation and increase the uptake and success rate of providers in the program.
- **Strengthen Montana's innovative payment and care delivery models for rural Dual-eligible and long-term care members** by evaluating programs to improve member outcomes and reduce costs. The State will assess the potential impact of strengthening D-SNP contracting and oversight through robust governance, data sharing and care

coordination, and evaluate the benefit of deploying integrated care models leveraging remote services and community partners to adapt traditional models, such as Program for Advanced Care for the Elderly (PACE), in alignment with the challenges faced by rural communities. If interventions with a clear value proposition are identified and there is sufficient capacity, the State will develop a plan to implement and sequence the proposed approach and evaluate the impact over the funding period to determine sustainability. The State will also assess acuity-based reimbursement and value-based contracting with nursing facilities to determine the anticipated impact on member access, rural nursing facility economic sustainability, and long-term care costs and implement payment changes dependent on the assessment.

3.2. Modernize Emergency Medical Service (EMS) care model

- **Train community paramedics** to provide in-home clinical and wellness evaluations, chronic disease management, and behavioral health interventions. This is designed to reduce the frequency that an individual utilizes emergency departments for routine care and to avoid costly readmissions for chronic disease management and crisis services. Given the anticipated downstream cost savings through reduced avoidable ED transport and hospitalization, the State will pursue Medicaid coverage for "Treat and No Transport" codes, such as A0998, along with behavioral health modifiers in the 2027 legislative session to ensure sustainability of the community paramedicine model onward. Additionally, the State will work to collaborate with commercial payers to pursue consistency in coverage of these services.
- **Invest in foundational emergency services infrastructure** through a one-time funding of essential infrastructure needs (e.g., vehicles, cot systems) to enable lasting operations

and to increase the efficiency and reach of EMS and community paramedicine services in rural communities. The State will conduct an assessment to evaluate the need to replace Montana's outdated emergency medical dispatch system to better support advanced triage, including nurse navigation services, behavioral health response systems, and community paramedicine services. If the State moves forward with the upgrade given assessment, the State will commit to covering the minimal ongoing annual costs for maintenance of this dispatch system, given the lasting impact and downstream cost savings through efficient triage of services. Funding will also be used to purchase infrastructure, including ambulances, stretchers, and cardiac monitors, which will enable expanded operations and reduced response times in rural counties and tribal communities identified as facing critical gaps.

- **Pilot a pre-hospital blood administration program** leveraging the Montana Interfacility Blood Network (MT-IBN) to enable ambulances to coordinate with rural hospital blood banks to carry blood products on board and deliver to trauma patients in need of lifesaving transfusions during transport. Unused products will be returned to the hospital partner prior to expiration for use to ensure no waste. Funding will cover the startup costs for blood storage equipment and placement into ambulances for targeted EMS agencies serving rural counties.

3.3. Extend access to lower-cost care through pharmacists

- **Support limited diagnostic and treatment capabilities in pharmacies** for prescription management of previously diagnosed conditions and for diagnosis of self-limited conditions. The State will pursue Medicaid coverage for a select set of services to enable this initiative, which is expected to decrease costly clinical interventions otherwise

covered by the State's existing Medicaid budget. Montana will additionally collaborate with private payers to establish consistent reimbursement pathways for these select services, ensuring access for more patients and long-term sustainability for participating pharmacies. The exact scope of services covered will be determined by state assessment. Funding will be used to cover startup costs, including medical equipment and the initial purchase of rapid, near-patient diagnostic tests for screenings and monitoring, across selected pharmacies in rural communities.

3.4. Increase needed outpatient services

- **Protect and increase outpatient access through targeted outpatient site improvements** for hospitals participating in the rural hospital transformation incentive program outlined in sub-initiative 2.1. In line with CoE recommendations, participating hospitals will receive funding to pursue minor renovations to existing infrastructure to maximize ambulatory capacity for priority services and make limited initial investments in outpatient technology and equipment to create the lower-acuity footprint and access that rural communities need. Example investments may include renovating inpatient rooms to accommodate specialized outpatient services, renovating clinic rooms to accommodate more capacity or specialty services, adding observation capacity to a hospital that is reducing inpatient capacity, or purchasing the provider-facing technology to leverage remote patient monitoring for specialty care. All investments will be one-time-only during the funding period to facilitate the changes recommended, with the agreement that providers will maintain their infrastructure.

Main strategic goal: Innovative care

Use of funds: G. Appropriate Care Availability; H. Behavioral Health; I. Innovative Care

Models

Technical score factors: C.1, C.2, E.1, E.2

Key stakeholders: Cross-cutting stakeholders listed in the partnership section and the following initiative specific stakeholders: EMS agencies, Montana Association of Sheriffs and Peace Officers Association, Montana Association of Public Safety Communications Officials, American Red Cross

Outcomes and Projected Impact (detailed table included in Metrics section)

- Montana primary care practices struggle with standing up processes and technology to participate in Medicaid value-based payment programs, and the State has no ongoing programs focused on Dual-eligible members. Technical assistance to primary care practices to incentivize high-value care is expected to increase the **proportion of Medicaid spend on outpatient care compared to total spending** (baseline 72%; target 80%) and evaluating interventions focused on integrated care for Dual-eligibles is anticipated to limit the growth in **Medicaid PMPM spending on Duals** for rural residents (baseline $305, target no net growth from current spend in 2031).
- EMS resource shortages and volume of non-emergent calls lead to a 25% rate of unanswered emergency calls and EMS access gaps in rural communities. Launching community paramedicine programs which are fit to address non-emergent high frequency use cases (e.g., chronic disease exacerbation) in the home setting is anticipated to decrease the **number of high utilizers** (baseline: 21%; target: decrease by 4%) that have 2 ED visits within 60 days and increase the number of uses of the **Treat no Transport CPT code** (baseline: 0; target: 10,000), showing increase of care in non-hospital settings.

This initiative will additionally reduce avoidable admissions, which is not currently tracked by the State and therefore not included as an outcome.

- The health care access problem facing rural community members driven by low provider density can be addressed by enabling pharmacists to practice at the top of their license. The State will pursue Medicaid coverage of selected services such as treatment of minor self-limited conditions and chronic disease management. The **percentage of pharmacists prescribing for Medicaid members under new coverage** (baseline: 0%; target 30%) will be tracked to show the increase in access to care in rural areas.

Impacted counties: Montana's 51 rural counties and rural portions of 5 metropolitan counties

Estimated required funding: ~$28.94 million for FY2026; Sustainability Plan for this Initiative is in Sustainability Plan Section below

Workplan and monitoring: High-level Implementation Plan included below; detailed Implementation Plan for Initiative 3 included in Supporting Documentation

INITIATIVE 4. INVEST IN COMMUNITY HEALTH AND PREVENTIVE INFRASTRUCTURE

Rural populations in Montana often lack health care infrastructure that provides access to preventive care and promotes healthy lifestyles, resulting in adverse chronic disease outcomes and unnecessary hospitalizations for care that could have been delivered in lower acuity settings. This initiative addresses this gap through investments in community-oriented care that builds out **population health clinical infrastructure** and bolsters positive **health and lifestyle** changes, including:

4.1 – Implementing community-based models to make preventive care accessible for rural communities

4.2 – Updating rural health care infrastructure through critical repairs and modernizations

4.3 – Investing in rural healthy lifestyles to prevent root causes of disease

Sub-initiative detail:

4.1. Implement community-based care

- **Extend school-based health care** by building off the success of 80+ existing sites across 20+ organizations, including FQHCs, RHCs, and tribal health departments. Funding will support startup costs, such as facility renovation and medical equipment for both the enhancement of services at existing sites and the establishment of new sites across locations in rural counties and tribal communities. Forty-five percent of current school-based sites only offer behavioral health services and will be extended to include primary and dental care for students. Provider capacity for school-based care coverage will be assessed to determine sites for rollout. All services offered are currently reimbursable by Medicaid, which will ensure the ongoing sustainability of this initiative. This effort aligns with the State's role in facilitating partnerships between schools and local providers, while making preventive care in rural communities more accessible.
- **Purchase and equip mobile care vans** as a one-time investment to travel to targeted rural communities at regular cadences to offer preventive services, including dental care, mammography screenings, and immunizations. Building off the success of existing mobile mammography vans operated by hospital systems, this initiative will increase services offered and geographies reached. Funding will allow for the purchase and equipment retrofitting of mobile care vans. Providers will be responsible for the distribution of funds to procure and retrofit mobile vans for use. The reimbursable services offered are intended to cover ongoing operational costs.
- **Launch community health strengthening efforts for Montana Tribes** to increase

access to essential care. Programs include supporting the launch of the Community Health Aide Program (CHAP) and extension of training opportunities like the Caring for Our Own workforce program to increase access to emergent, acute, and chronic care within tribal communities. Funding will be used to cover initial training and development costs for CHAP and to initiate training and education opportunities as needed.

4.2. Update rural health care infrastructure

- **Fund critical facility repairs and modernization** projects across rural facilities, including Certified Community Behavioral Health Clinics (CCBHCs), tribally operated clinics, Federally Qualified Health Clinics (FQHCs), environmental laboratories, and other community-based ambulatory facilities that provide preventive care, behavioral health services, and chronic disease management. Investments will focus on minor renovations and critical technology upgrades (e.g., IT infrastructure, laboratory safety enhancements, updates to modern EHRs) to improve operating efficiency. Rural community health centers operating at or near capacity will be prioritized, along with those for which repairs can significantly increase access and capacity (e.g., an electrical repair that could reopen a set of clinic rooms).
- **Enhance targeted CCBHCs and establish partner facilities with crisis center "safe places for help"** as defined by SAMHSA to provide an alternative for crisis patients outside of hospitalization (e.g., crisis stabilization centers, respite centers). Montana currently only has three receiving and/or stabilization centers; this initiative would help extend the reach of the four providers pursuing a demonstration grant for CCBHC certification to provide crisis services across the state. CCBHCs will partner with facilities hosting "safe places for help" to help provide required CCBHC services and fill

capacity gaps; the ongoing operational costs of these programs will be incorporated into the CCBHC's Medicaid PPS rate through Designated Collaborating Organization (DCO) partnerships. Funding will not supplant demonstration grant funding but would be used to increase the impact and coverage of CCBHCs through covering initial costs to set up safe places, including minor space renovations and the purchase of necessary equipment.

4.3. Invest in healthy lifestyles to prevent root causes of disease

- **Invest in creating high-impact community spaces promoting nutrition and healthy lifestyles**, in accordance with Make rural America healthy again principles. This will include one-time grants for communities to create environments that encourage healthy eating and engagement with local food systems, such as food banks and farmers, for years to come. The program allows communities to establish Food System Action plans that may consider launching community gardens, farmers' markets, school nutrition initiatives, and other interventions in rural and tribal communities classified as food deserts. These will only be established in communities that identify local sponsors (e.g., MSU Extension).

Main strategic goal: Make rural America healthy again

Use of funds: A. Prevention and chronic disease, F. Information technology advances, G. Appropriate care availability, H. Behavioral Health, K. Fostering collaboration

Technical score factors: B.1, B.2

Key stakeholders: Cross-cutting stakeholders listed in the partnership section and the following initiative specific stakeholders: Confluence Public Health Alliance, Farm Connect Montana, League of Cities, Local Health Departments, Montana Association of Counties, Montana Department of Commerce, Montana Food Bank, Montana Office of Public Instruction, Montana

Partnership to End Childhood Hunger, MSU Extension, Public Health Institute, Rural Behavioral Health Institute.

Outcomes and Projected Impact (detailed table included in Metrics section)

- Rural communities lack access to critical preventive care, such as well-child visits and behavioral health screenings. This results in higher downstream spending and adverse health outcomes, including high-risk factors. By implementing community-based care (e.g., schools) and building out rural infrastructure that encourages healthy lifestyles, these initiatives will help increase the **percentage of children receiving well child visits** (baseline: 36.75%, target: 2% increase), **improve youth mental health and risk behavior** (baseline 43%, target: 10% decrease), and improve risk factor controls such as **glycemic status** (baseline: 37.8%, target: 4% increase), **BMI** (baseline: TBD, target: TBD) and **high blood pressure** (baseline: 36.75%, target: 2% increase). Anticipated **downstream cost savings** are not included as an outcome, given evidence indicating that savings would be seen after FY2031.
- Limited crisis receiving, stabilization, and safe spaces result in patients with behavioral health crisis incidents being hospitalized when they could be cared for at a lower cost of care. Through the build-out of SAHMSA-defined crisis safe spaces, crisis patients can receive care outside of the hospital setting. The increase in **number of SAHMSA defined crisis spaces** (baseline: 3, target: 11) and the associated **decrease in ED behavioral health visits** (baseline: TBD, target: TBD) in regions with added crisis spaces will be tracked along with a reduction in **suicide rates** (baseline: 26.2 per 100K, target: 10% decrease) to reflect the increase of crisis support outside of hospitalization, decreased health care costs, and improved health outcomes.

Impacted counties: Montana's 51 rural counties and rural portions of 5 metropolitan counties

Estimated required funding: ~$56.3 million for FY2026 Sustainability Plan for this Initiative is in Sustainability Plan Section below

Workplan and monitoring: High-level Implementation Plan included below; detailed Implementation Plan for Initiative 4 included in Supporting Documentation

INITIATIVE 5. DEPLOY MODERN HEALTH CARE TECHNOLOGIES TO GUIDE RURAL HEALTH INTERVENTIONS

Rural communities often face limited access to care, fragmented clinical infrastructure, and gaps in data integration that hinder timely, informed decision-making. Strengthening technology and data capabilities is essential to improve coordination, **enable remote care**, and enhance population health outcomes. This initiative focuses on **advancing technology innovation** and building data-driven interventions by:

5.1 – Improving data usability and statewide operational tools (e.g., bed registry) utilizing HIE data to drive decisions and **population health interventions**

5.2 – Modernizing EHRs for rural providers, including an opt-in model via regional hub 'community connect' enabling interoperability, telehealth capabilities, and data sharing while promoting **consumer-facing technologies**

This initiative is a key enabler of Montana's broader rural health transformation strategy and is intricately linked to financial sustainability and access in Initiative 2, EMS and virtual care models in Initiative 3, and behavioral health impact in Initiatives 3 and 4.

Sub-initiative details:

5.1. Improve data usability and population health interventions

- **Develop tools that generate actionable and valuable insights** for providers and the

State, leveraging Montana's existing data (e.g., HIE) to improve provider operations and efficient care delivery to rural communities. This effort will include creating and validating critical tools for rural care delivery, such as a statewide hospital and behavioral health bed registry to enable CAH transfers. The State will demonstrate HIE usability, reduce delays in care, and optimize the use of limited rural health care resources.

- **Deploy monitoring, evaluation, and continuous improvement programs for interventions** impacting rural communities. This initiative will focus on designing rural health interventions to improve outcomes and reduce care costs, with initial investments evaluated for impact and long-term sustainability through cost savings. Focus may include rigorous evaluation and improvement of interventions targeting:
    - ED utilization for conditions that could be treated in primary care or urgent care
    - Preventable chronic disease exacerbation episodes that drive unnecessary inpatient utilization
    - High-value specialty care, including the creation of a high-value network assessing quality and cost of prioritized specialties

This sub-initiative supports other parts of the RHTP strategy, including the Montana Rural Health CoE and care delivery transformation for rural systems, and virtual care models.

5.2. Support EHR modernization for select providers

- **Modernize EHR systems** for priority rural providers and facilities currently operating on legacy or limited interoperability platforms, focusing on those who are not HITECH compliant or who lack full interoperability. This effort will support both shared and independent EHR modernization efforts. This program will establish an opt-in regional hub model to incentivize larger health systems to provide community connect features

within their EHR platforms to extend access to regional rural providers. Rural facilities will gain interoperability and access to shared data infrastructure without needing to deploy standalone systems. Incentives for larger systems will also be contingent on onboarding, training, and ongoing technical assistance for rural partners. Rural providers who choose not to opt in will be eligible for subsidies to purchase new platforms, with partial coverage of implementation costs. A special focus will be given to tribal providers, with funding used to modernize non-HITECH-certified systems to appropriate EHR platforms. The State will not be responsible for ongoing maintenance and operations costs, subscription contracts, etc.

- **Support and fund consumer-facing EHR modules** and strengthen provider engagement to support nutrition and chronic disease management. As part of EHR modernization, providers will be eligible for funding to activate mobile platforms and apps to engage patients with nutrition, disease prevention, and chronic disease management. Participating providers may integrate evidence-based remote patient monitoring devices that interface with selected modules.

Main strategic goal: Technology innovation

Use of funds: C. Consumer tech solutions, F. IT advances

Technical score factors: B.1, F.1, F.2, F.3

Key stakeholders: Cross-cutting stakeholders listed in the partnership section and the following initiative-specific stakeholders: Montana University System, EMS agencies

Outcomes and Projected Impact (detailed table included in Metrics section)

- Montana has developed a comprehensive data warehouse that integrates HIE and claims data to inform population health strategies, but lacks dedicated capacity to evaluate how

these insights have an impact on health outcomes and costs of care. As a result, HIE data remains underutilized. Without provider-facing tools to translate analytics into actionable insights at the point of care, the system delivers limited value to providers and fails to realize the potential of data-driven care improvement and reduction in costs of care. This initiative will use existing data to create tools such as a bed registry to **decrease the wait time for placements into behavioral health beds** in rural communities (no baseline, target to be determined after bed registry is rolled out FY2029).

- Increased use of modern EHRs **will increase connectivity across providers and facilities**, particularly for those in rural communities who are currently operating on legacy systems (baseline: 88% of hospitals currently have HITECH-certified EHRs, target for hospitals 95% by FY2031). EHRs allow providers to operate more efficiently and better coordinate care and increase revenue cycle improvements, **resulting in improved operating margin for participating providers** (estimated baseline to be refined: -14%; FY2031 target: operating margin at breakeven, 0%).
- Increasing HIE data sharing and developing tools within the HIE will increase the State's ability to get patients to the right location faster, evaluate providers, and create a foundation for future value-based care models that include clinical data. This initiative will improve the percentage of **rural facilities and providers participating in the HIE** (baseline 43% of providers and 73% of hospitals, target over 95% of hospitals and 75% of other providers connected by FY2031).

Impacted counties: Montana's 51 rural counties and rural portions of 5 metropolitan counties

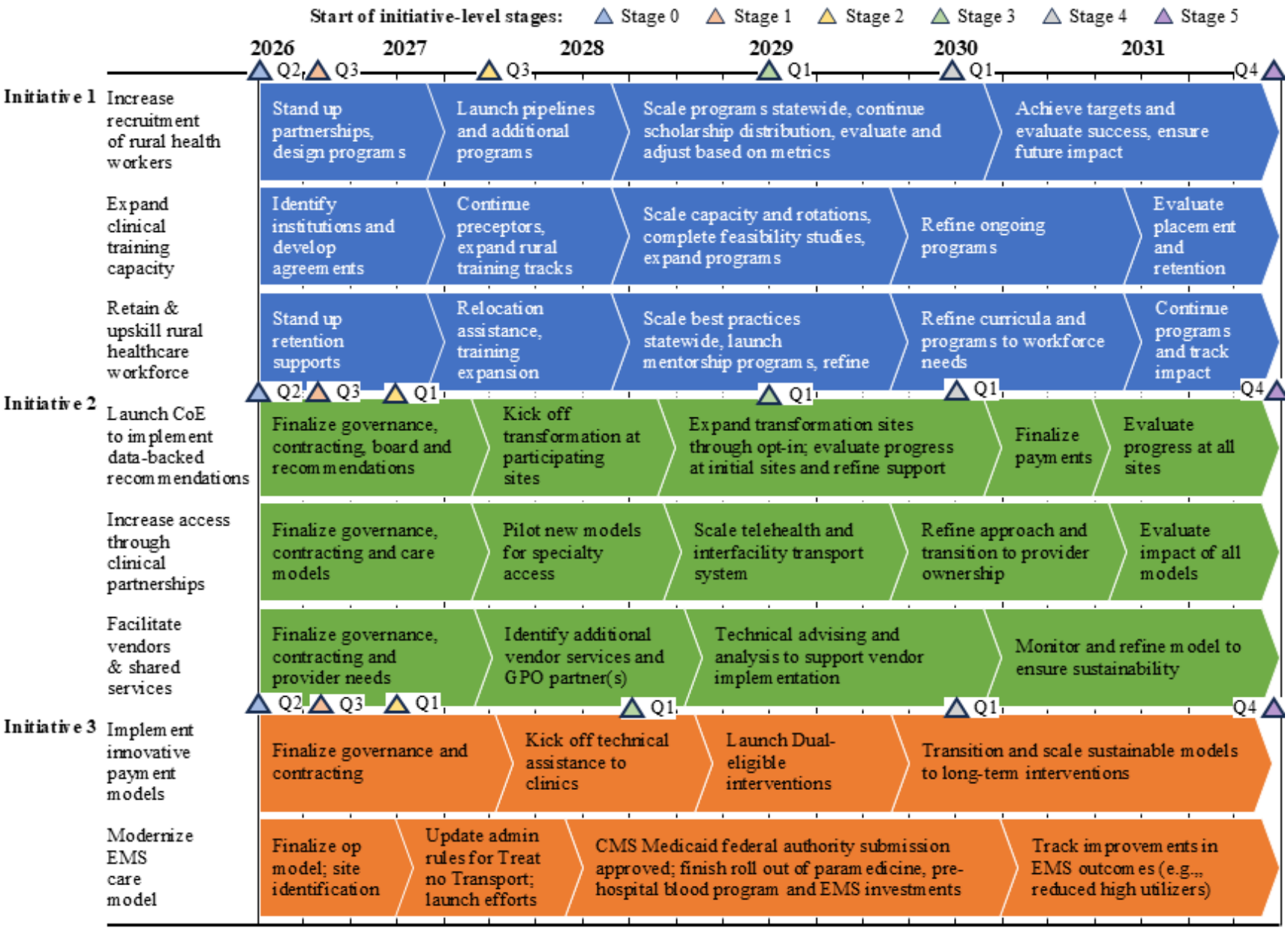
Estimated required funding: ~$33.3 million for FY2026; Sustainability Plan for this Initiative is in Sustainability Plan Section below

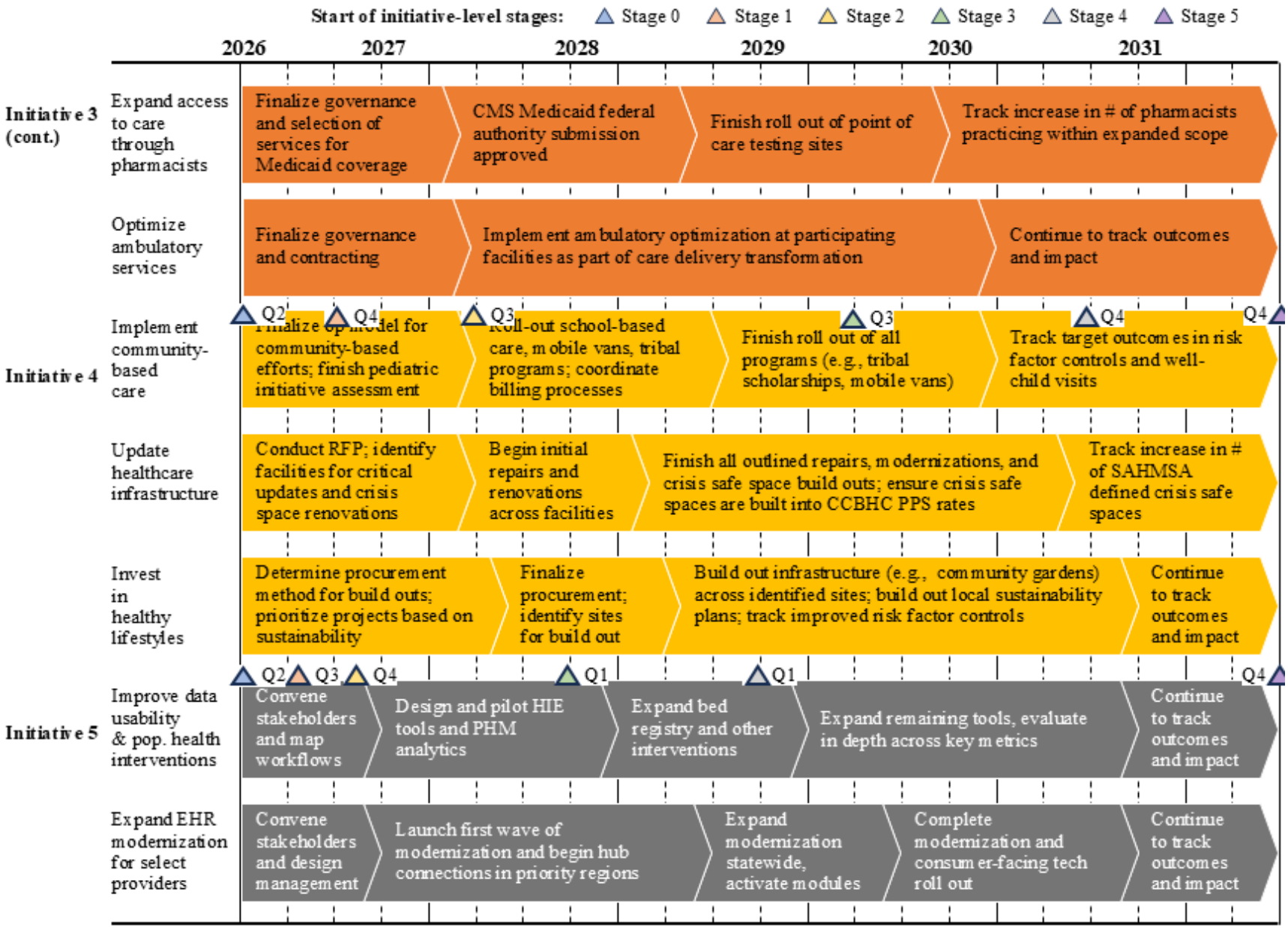
Workplan and monitoring: High-level Implementation Plan included below; detailed Implementation Plan for Initiative 5 included in Supporting Documentation

IMPLEMENTATION PLAN AND TIMELINE (BACK TO INITIATIVE 1, 2, 3, 4, 5)

Implementation plans for the five initiatives for FY2026 through FY2031 are shown starting on the next page (including milestones from Stage 0 to Stage 5), and for policy changes below:

Policy	Milestones	Completed by
B.3 SNAP waivers	• Waiver designed, USDA application planned, and proposal drafted by Q2 2026 • Waiver sent to USDA for approval by end of Q3 2026	End of Fiscal Year 2026
B.4 Nutrition CME	• Proposal drafted Q3 2026 and finalized Q4 2026 • Initial implementation by end of 2027	End of Fiscal Year 2027
D.2 Licensure compacts	• Legislative proposal drafted by end of 2026 • Introduce EMS compact in 2027 legislative cycle • Montana EMS becomes part of compact by end of 2027	End of Fiscal Year 2027
D.3 Scope of practice	• Process developed for OHWRC recognition of current dental hygiene policies by end of Q2 2026 • Formalization and needed adjustments made by end of 2026	End of Fiscal Year 2027
F.1 Remote care services	• Reimbursements conceptualized by end of Q2 2026 • Medicaid policy formalized in Q1 2027	End of Fiscal Year 2027


Start of initiative-level stages: Stage 0 Stage 1 Stage 2 Stage 3 Stage 4 Stage 5
2026 2027 2028 2029 2030 2031
Q2 Q3 Q3 Q1 Q1 Q4
Initiative 1
Increase recruitment of rural health workers
Stand up partnerships, design programs
Launch pipelines and additional programs
Scale programs statewide, continue scholarship distribution, evaluate and adjust based on metrics
Achieve targets and evaluate success, ensure future impact
Expand clinical training capacity
Identify institutions and develop agreements
Continue preceptors, expand rural training tracks
Scale capacity and rotations, complete feasibility studies, expand programs
Refine ongoing programs
Evaluate placement and retention
Retain & upskill rural healthcare workforce
Stand up retention supports
Relocation assistance, training expansion
Scale best practices statewide, launch mentorship programs, refine
Refine curricula and programs to workforce needs
Continue programs and track impact
Q2 Q3 Q1 Q1 Q1 Q4
Initiative 2
Launch CoE to implement data-backed recommendations
Finalize governance, contracting, board and recommendations
Kick off transformation at participating sites
Expand transformation sites through opt-in; evaluate progress at initial sites and refine support
Finalize payments
Evaluate progress at all sites
Increase access through clinical partnerships
Finalize governance, contracting and care models
Pilot new models for specialty access
Scale telehealth and interfacility transport system
Refine approach and transition to provider ownership
Evaluate impact of all models
Facilitate vendors & shared services
Finalize governance, contracting and provider needs
Identify additional vendor services and GPO partner(s)
Technical advising and analysis to support vendor implementation
Monitor and refine model to ensure sustainability
Q2 Q3 Q1 Q1 Q1 Q4
Initiative 3
Implement innovative payment models
Finalize governance and contracting
Kick off technical assistance to clinics
Launch Dual-eligible interventions
Transition and scale sustainable models to long-term interventions
Modernize EMS care model
Finalize op model; site identification
Update admin rules for Treat no Transport; launch efforts
CMS Medicaid federal authority submission approved; finish roll out of paramedicine, pre-hospital blood program and EMS investments
Track improvements in EMS outcomes (e.g.,, reduced high utilizers)


Start of initiative-level stages: Stage 0 Stage 1 Stage 2 Stage 3 Stage 4 Stage 5
2026
2027
2028
2029
2030
2031
Initiative 3 (cont.)
Expand access to care through pharmacists
Finalize governance and selection of services for Medicaid coverage
CMS Medicaid federal authority submission approved
Finish roll out of point of care testing sites
Track increase in # of pharmacists practicing within expanded scope
Optimize ambulatory services
Finalize governance and contracting
Implement ambulatory optimization at participating facilities as part of care delivery transformation
Continue to track outcomes and impact
Initiative 4
Implement community-based care
Q2
Q4
Finalize optimized model for community-based efforts; finish pediatric initiative assessment
Q3
Roll-out school-based care, mobile vans, tribal programs; coordinate billing processes
Q3
Finish roll out of all programs (e.g., tribal scholarships, mobile vans)
Q4
Track target outcomes in risk factor controls and well-child visits
Q4
Update healthcare infrastructure
Conduct RFP; identify facilities for critical updates and crisis space renovations
Begin initial repairs and renovations across facilities
Finish all outlined repairs, modernizations, and crisis safe space build outs; ensure crisis safe spaces are built into CCBHC PPS rates
Track increase in # of SAHMSA defined crisis safe spaces
Invest in healthy lifestyles
Determine procurement method for build outs; prioritize projects based on sustainability
Finalize procurement; identify sites for build out
Build out infrastructure (e.g., community gardens) across identified sites; build out local sustainability plans; track improved risk factor controls
Continue to track outcomes and impact
Initiative 5
Improve data usability & pop. health interventions
Q2
Q3
Q4
Convene stakeholders and map workflows
Q1
Design and pilot HIE tools and PHM analytics
Q1
Expand bed registry and other interventions
Expand remaining tools, evaluate in depth across key metrics
Q4
Continue to track outcomes and impact
Expand EHR modernization for select providers
Convene stakeholders and design management
Launch first wave of modernization and begin hub connections in priority regions
Expand modernization statewide, activate modules
Complete modernization and consumer-facing tech roll out
Continue to track outcomes and impact

GOVERNANCE AND PROJECT MANAGEMENT STRUCTURE

Lead agency/interagency team: Montana's Department of Public Health and Human Services

Key personnel: Department Director, Department Deputy Director, Department CFO, State Medicaid Director/Executive Director of Medicaid and Health Services, Deputy Medicaid Director, Department CDO, Department Strategy & Transformation Officer, Department Office of Research and Data Analytics, Department Chief Analytics Officer, Department Office of Health Data and Analytics

Steering committee: Charlie Brereton (Director), Kim Aiken (Deputy Director), Rebecca de Camara (Medicaid Director), Gene Hermanson (Deputy Medicaid Director), Natalie Smitham (CFO), Brett Carter (Strategy & Transformation Officer), Amanda Harrow (Project Manager)

Advisory groups: Stakeholder Advisory Committee, convened by the Montana Office of Rural Health and including active participation from the Department of Public Health and Human Services (also responsible for Medicaid) and Montana's Tribal Nations, among other stakeholders**;** Montana Rural Health Center of Excellence designed 2026 Q1 through 2028

Staff: 20 positions (decreasing over the duration of the program); see headcount section below

External partners: See "Partnerships" in the Goals and Strategies section

Headcount and function of DPHHS RHTP unit: 20 positions (decreasing over the duration of the program) across Program Management, Workforce Development, Data and Evaluation, Technology and Telehealth, Community Engagement, and Finance and Compliance functions.

Additional external support: DPHHS expects to engage contractors for care delivery transformation implementation support, school-based care site development, supporting implementation of rural provider telemedicine platforms and interfacility transport system implementation support, IDD telehealth expansion, modernizing EMS system modernizations, clinic technical support and payment model interventions, facility renovations and community infrastructure build, HIE usability improvements and population health analytics, and general administrative support across initiatives.

Stakeholder coordination: Stakeholder engagement is detailed in the following section. Regarding the coordination of State health agencies, the Stakeholder Advisory Committee will function as the focal point of this coordination and related communication. Groups within the Stakeholder Advisory Committee will be responsible for reaching out and communicating with smaller, specific groups to ensure clear communication channels. Feedback will be solicited early and often through a robust intake process to ensure the success of the transformation.

STAKEHOLDER ENGAGEMENT

Stakeholder engagement during plan development

Stakeholders were engaged during the development of this submission through three channels:

1) The State hosted a public webinar allowing open comment, which attracted 996 registered participants
2) The State launched a Request for Information, which attracted >300 responses
3) Individual, personalized consultations were held separately with the following 20 stakeholders: Billings Clinic/Logan Health, Blue Cross Blue Shield of Montana, Confluence Public Health Alliance, Flathead Industries, Tribal Nations and UIOs, GME Council, Touro College of Osteopathic Medicine - Montana, Rocky Vista, Montana

Ambulance Association, Behavioral Health Alliance of Montana, Montana Big Sky Care Connect, Montana Health Care Foundation, Montana Hospital Association, Montana Medical Association, Montana Pharmacy Association, Montana Primary Care Association, MSU Office of Rural Health, Pacific Source, Public Health Institute, WWAMI

Stakeholder support for submission

The State incorporated many recommendations from stakeholders in creating this submission. Stakeholder support is reflected in the letter signed by 70 stakeholders, who are included in the State's application packet.

Engagement with stakeholders during implementation

During the five-year implementation period, the State will continue to engage with rural health care stakeholders through biannual meetings with a Stakeholder Advisory Committee, convened by the Montana Office of Rural Health and including active participation from the Department of Public Health and Human Services (also responsible for Medicaid), and Montana's Tribal Nations, among other stakeholders.

Furthermore, as previously mentioned, **Initiative 2** will include a CoE governance board that includes essential stakeholders to successfully restructure rural facilities for long-term sustainability. Likewise, other specific initiatives will have work groups that consist of important rural stakeholders whose valuable input is essential for meeting initiative outcomes.

Through these and other ad hoc engagements, the State will ensure project governance reflects the communities and individuals across rural Montana. As funds are deployed to various groups and communities, project governance will track progress toward milestones and assess the impact of the deployed funds and programs for stakeholders. When feedback is received, the State will take the time to understand the context and work to incorporate the stakeholder's

perspective, as appropriate, and while staying within the RHTP's guidelines.

METRICS AND EVALUATION PLAN

Across each initiative, metrics have been outlined to track impact and progress on goals. Each initiative has at least four (4) quantifiable metrics that comprise the outcomes, at least one of which will be measured at the county or community level. These metrics are outlined in the tables below, along with additional program implementation metrics. The first five tables are grouped by initiative, and the final table includes additional "Program implementation" metrics. Details about how initiatives drive changes in these metrics are included in the "Proposed initiatives and use of funds" section. Each metric will be tracked, at a minimum, on an annual basis in partnership with ORDA and DMO. The State will cooperate with any CMS evaluation or monitoring required.

The metrics and targets included in this application demonstrate the transformative nature of the proposed initiatives while remaining supported by research on proven examples of what is possible, Montana's characteristics both in absolute and in reference, and analysis on how the initiatives will drive change. The provided targets are not meant to be unachievable aspirations. Rather, the State views them as ambitious yet grounded goals for what Montana's rural health care systems should achieve by the end of FY2031 as a result of the RHTP. The State expects significant impact to continue accruing from these initiatives after the RHTP project period due to the nature of the initiatives and the sustainability plans DPHHS is putting in place. In some cases, the State expects that only a minority of the total impact of initiatives will accrue during the project period.

INITIATIVE 1 OUTCOMES (BACK TO INITIATIVE 1 DESCRIPTION)

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Category
Ratio of NPs per 100,000 people in rural communities, all rural counties **(county specific)**	76.7 per 100k	By FY2026, internally sourced baselines developed; every year	Current data is sourced through Definitive Healthcare. Going forward,	4. Workforce metrics

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Category
		from FY2027 to FY2031, increase by 5% annually	internal source with be developed; annual tracking	
Ratio of physicians per 100,000 people in rural communities, all rural counties	89.2 per 100k	By FY2026, internally sourced baselines developed; every year from FY2027 to FY2031, increase by 5% annually	Current data is sourced through Definitive Healthcare. Going forward, internal source with be developed; annual tracking	4. Workforce metrics
Ratio of RNs per 100,000 people in rural communities, all rural counties	860.9 per 100k	By FY2026, internally sourced baselines developed; every year from FY2027 to FY2031, increase by 5% annually	Current data is sourced through BLS. Going forward, internal source with be developed; annual tracking	4. Workforce metrics
Ratio of dental hygienists per 100,000 people in rural communities, all rural counties	90.7 per 100k	By FY2026, internally sourced baselines developed; every year from FY2027 to FY2031, increase by 5% annually	Current data is sourced through BLS. Going forward, internal source with be developed; annual tracking	4. Workforce metrics
Ratio of EMTs per 100,000 people in rural communities, all rural counties	115.0 per 100k	By FY2026, internally sourced baselines developed; every year from FY2027 to FY2031, increase by 5% annually	Current data is sourced through BLS. Going forward, internal source with be developed; annual tracking	4. Workforce metrics
Ratio of PAs per 100,000 people in rural communities, all rural counties	70.6 per 100k	By FY2026, internally sourced baselines developed; every year from FY2027 to FY2031, increase by 5% annually	Current data is sourced through BLS. Going forward, internal source with be developed; annual tracking	4. Workforce metrics
Rate of position turnover (in health care), statewide	Internal data on metric is not collected yet	By FY2026, determine rural specific baseline and precise target; by FY2031, reach target turnover rate, at least to national rural average	Going forward, internal source with be developed; annual tracking; target to be developed	4. Workforce metrics
Metric of provider mental health, such as burnout date, professional fulfillment index, Mayo well-being index, or other similar metric, potentially sourced through a survey	State data on metric is not collected yet	By FY2026, determine rural specific baseline and precise target; by FY2031, reach target.	Going forward, internal source with be developed; annual tracking in partnership with relevant stakeholders (e.g., Board of Medical Examiners)	2. Quality and health outcomes

INITIATIVE 2 OUTCOMES (BACK TO INITIATIVE 2 DESCRIPTION)

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Metric category
Average ED length-of-stay prior to admission or discharge in hours for Montana Trauma Registry records, all rural counties	3.9 hours for hospitals located in rural counties	By FY2028, reductions begin to manifest; by FY2030, 5% reduction; by FY2031, 10% reduction	Currently tracked by PHSD annually	2. Quality and health outcomes
Rural facility operating margin, all rural counties	Estimated -14.48% net operating profit margin based on	By FY2028, improvement in net operating margin; by	Current baseline provided by Definitive Healthcare. Going	3. Financial metrics

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Metric category
	Definitive data; to be validated and refined during FY2026 Q2	FY2031 operating margin increases to 0% (i.e., breakeven). By FY2031, hospitals will have the foundation to become profitable in the following years.	forward, internal measures to determine financial performance will be implemented to ensure accurate representation of hospitals. The metric will be tracked yearly at a minimum	
Total facility inpatient days divided by staffed beds, all rural counties	39.49% average across hospitals in rural counties	By FY2026, baseline and target will be developed for this metric but for licensed beds; by FY2028, improvements begin to manifest; by FY2030, 15 percentage point increase; by FY2031, 30 percentage point increase	Medicare cost reports will be used to provide this data and will be used to track results annually	3. Financial metrics
Percentage of total Medicaid visits conducted via telehealth, all rural counties **(county specific)**	Traditional visits: 2.12%; expansion visits: 2.33%	By FY2030, 10 percentage point increase; by FY2031, 15 percentage point increase	Progress will be measured through the Medicaid claims, with periodic, at least annual, review to ensure the State remains steady with established goals	5. Technology use
% of Medicaid spend on outpatient care over total Medicaid spend across critical access hospitals, all rural counties	72.8% of Medicaid spend, excluding Medicare crossovers	By FY2028, foundations for transition established; by FY2031, 80% of spend on outpatient care (7 percentage point increase)	Medicaid claims will be used to provide this data and track results annually	3. Financial metrics

INITIATIVE 3 OUTCOMES (BACK TO INITIATIVE 3 DESCRIPTION)

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Metric category
Yearly number of uses of Treat no Transport CPT code as percentage of ED encounters, all rural counties	0% (Treat no Transport not currently reimbursable)	By FY2029, new CPT code begins to be used; by FY2031, 10% of EMS calls	Not currently tracked. Medicaid claims will track this annually, once policy changes are enacted and CPT code is in use	1. Access metrics
Percentage of total pharmacists prescribing for Medicaid members, all rural counties	0% (Pharmacists currently not able to prescribe for Medicaid members)	By FY2028, 10% participation; by FY2030, 30% participation; by FY2031, 50% participation	Not currently tracked. Medicaid claims will track this, once policy change enacted, at least annually	1. Access metrics

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Metric category
Yearly average number of individuals with 2 transports to ED (high utilizers) within 60 days divided by total ED encounters, all rural counties **(county specific)**	21.03% all; 19.86% Medicaid	By FY2030, 5% absolute decrease; by FY2031, 10% absolute decrease	HIE tracks quarterly and annual trends	2. Quality and health outcomes
Average dollar amount spent from Medicaid on Duals (PMPM), all rural counties	$305 average PMPM, non-disabled, no TPL, dual Medicare	Throughout the first 3 years of RHTP, PMPM spend may increase given pre-existing trends. By FY2031, return to current baseline	Medicaid claims will be used to provide this data and track results annually	3. Financial metrics
% of Medicaid spend on outpatient care over total Medicaid spend across critical access hospitals, all rural counties	72.8% of Medicaid spend, excluding Medicare crossovers	By FY2028, foundations for transition established; by FY2031, 80% of spend on outpatient care (7 percentage point increase)	Medicaid claims will be used to provide this data and track results annually	3. Financial metrics

INITIATIVE 4 OUTCOMES (BACK TO INITIATIVE 4 DESCRIPTION)

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Metric category
Number of crisis safe spaces, according to SAMHSA definition, all rural counties	1 crisis safe space	By FY2028, at least 1 new safe space. By FY2031, 11 crisis safe spaces in rural counties	SAMHSA-certified crisis safe spaces measured through CCBCHs at least annually	1. Access metrics
Percentage of children who receive a well-child visit in the first 30 months of life (W30-CH), all rural counties	Internal data on metric is not collected yet	By FY2026, internally sourced baselines and official target develop considering national median of 56.6%. By FY2031, target reached	Going forward, internal paths to source this metric will be developed used to track this metric at least annually.	1. Access metrics
% of those with A1c less than 8% out of all non-excluded individuals between 18 and 75 with type 1 or 2 diabetes, all rural counties **and county specific**	37.80% all; 27.31% Medicaid	By FY2030, 5% absolute increase; by FY2031, 10% absolute increase	Currently tracked by HIE at the county level using metric methodology and patient data at least annually	2. Quality and health outcomes
% of those with BP less than 140/90 mmHg out of all non-excluded individuals between 18 and 85 with hypertension, all	36.75% all; 29.74% Medicaid	By FY2030, 5% absolute increase; by FY2031, 10% absolute increase	Currently tracked by HIE at the county level using metric methodology and patient data at least annually.	2. Quality and health outcomes

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Metric category
rural counties **and county specific**				
% of adult population with BMI>30, all rural counties and county specific, all rural counties	Internal data on metric is not collected yet	By FY2026, internally sourced baselines and official target developed; by FY2031, target reached	Going forward, internal paths to source this metric will be developed used to track this metric at least annually. As internal Montana data regarding growth does not exist yet, a specific target cannot yet be created	2. Quality and health outcomes
Behavioral health ED admissions per 1,000 in counties with implemented crisis safe spaces, all rural counties	50.61 per 100k across rural counties	By FY2028, 3% reduction; by FY2031, 6% reduction	Currently tracked by DPHHS annually	2. Quality and health outcomes
Deaths by suicide per 100,000 total population, all rural counties	26.2 per 100k statewide	By FY2026, county-specific and rural-specific baseline developed; by FY2028, pathways developed and active that directly impact deaths by suicide; by FY2031, decrease by 10%	Baseline data currently sourced through CDC PLACES. Going forward, a consistent internal tracking system will be implemented to establish a rural baseline and track this metric at least annually	2. Quality and health outcomes
Prevalence of students reporting mental health and related risk behaviors (as identified by YRBSS)	43% of students reported feeling sad or hopeless for two weeks or more	By FY2030, target reached, likely 10% reduction at minimum	Baseline data sourced through Montana Office of Public Instruction	2. Quality and health outcomes
Number of Community Health / Aide Practitioners, all rural counties	0 (CHA/P program not launched)	By FY2028, CHA/P pathways developed. By FY2031, 200 CHA/Ps across rural Montana	As the CHA/P program develops, program owners will be responsible for tracking and monitoring progress to reach metric goals	1. Access metrics

INITIATIVE 5 OUTCOMES (BACK TO INITIATIVE 5 DESCRIPTION)

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Metric category
Average wait time for behavioral health bed placements across non-State facilities, all rural counties **and county specific**	Internal data on metric is not collected yet	By FY2028, electronic bed registry rolled out within HIE; by FY2029 internally sourced baselines and official target developed; by FY2031, target met	New bed registry analytics for non-State facilities within the HIE will be used to assess quarterly and annual trends	1. Access metrics

Metric definition	Baseline	Milestones / targets	Evaluation plan / source	Metric category
Percentage of rural facilities and clinics participating in HIE, all rural counties	73% of hospitals, 43% of other providers	By FY2029, HIE features rolled out; by FY2030, participation increases begin to manifest; by FY2031, participation of 95% for hospitals and 75% for other providers	Through HIE participation logs, this metric can be tracked annually.	5. Technology use
Percentage of rural sites connected with HITECH-certified EHRs, all rural counties	88% of hospitals currently have a HITECH-certified EHR	Connections incrementally grow year by year; by FY2031, 95% of hospitals connected; baseline and target for non-hospitals will be established once data is available to baseline	Baseline sourced through Definitive Healthcare. Exact evaluation plan to be determined and will be initially managed by administration team. Upon development, data will be tracked annually at a minimum	5. Technology use
Rural facility operating margin, all rural counties	Estimated -14.48% net operating profit margin based on *Definitive* data; to be validated and refined during FY2026 Q2	By FY2028, improvement in net operating margin; by FY2031 operating margin increases to 0% (i.e., breakeven). By FY2031, hospitals will have the foundation to become profitable in the following years.	Current baseline provided by Definitive Healthcare. Going forward, internal measures to determine financial performance will be implemented to ensure accurate representation of hospitals. The metric will be tracked yearly at a minimum	3. Financial metrics

Program Implementation Metrics

Metric	Milestones/ targets	Evaluation plan	Initiative connection
1.1 Rural service-commitment education awards / contracts executed (all disciplines)	By FY2027, 100 contracts executed; by FY2029, 200 executed; by FY2031, ≥250 executed (incl. ≥100 medical students + ≥150 other trainees)	Program records through DLI will provide annual tracking	Initiative 1; education awards with rural service commitments will increase the pipeline and place clinicians in high-need rural counties
1.2 New rural residency slots established in high-need specialties	By FY2027, 4 new slots filled; by FY2029, 8 slots filled; by FY2031, ≥10 new rural residency slots filled (at least one cohort in seat)	Program records through DLI will provide annual tracking	Initiative 1; residency expansion and rural training tracks will increase long-term rural retention and supply
1.3 Rural clinicians/staff completing upskilling/ resilience/ team-based care training	By FY2027, 150 clinicians/staff trained; by FY2029, 300 trained; by FY2031, ≥450 trained in the specified curricula	Program records through DLI will provide annual tracking	Initiative 1; upskilling and resilience programming will improve practice at top-of-license and reduce attrition
2.1 Number of facilities implementing CoE recommendations	By FY2027, 2 facilities implementing; by FY2028, additional 25; by FY2031,	CoE program records will provide annual tracking	Initiative 2; execution of CoE recommendations will right-size services, and

Metric	Milestones/ targets	Evaluation plan	Initiative connection
	around 50% of facilities implementing		improve rural financial sustainability
2.2 New tele-delivery systems deployed in rural hospitals	By FY2027, 20 hospitals live; by FY2029, 40 hospitals live; by FY2031, 60 hospitals live	Program governance and organization will work to track this metric annually	Initiative 2; increasing tele-stroke and tele-specialty partnerships will protect and increase access to critical specialty care in rural hospitals
2.3 Rural facilities enrolled in new shared service/GPO contracts	By FY2027, 10 facilities enrolled; by FY2029, 20 facilities; by FY2031, ≥30 facilities enrolled in at least one shared service/GPO contract	Program governance and organization will work to track this metric annually	Initiative 2; shared services and group purchasing will lower operating costs and improve rural financial sustainability
3.1 Rural practices enrolled in Medicaid value-based contracting (with TA completed)	By FY2027, 20 practices enrolled; by FY2028, 40 practices; by FY2031, impact and financial sustainability determined	Program governance and organization will work to track this metric annually	Initiative 3; technical assistance and contracting support will increase rural participation in Medicaid value-based models
3.2 Community paramedicine programs launched and operating	By FY2027, 4 programs launched; by FY2029, 7 programs operating; by FY2031, ≥10 programs sustained	Program governance and organization will work to track this metric annually	Initiative 3; modernization of EMS and treat-in-place models will enable community paramedicine in targeted rural counties
3.3 % of Rural pharmacists live with Medicaid-covered prescribing & point-of-care testing	By FY2028, 10% participation; by FY2030, 30% participation; by FY2031, 50% participation	Not currently tracked. Medicaid claims will track this, once policy change enacted, at least annually	Initiative 3; pharmacy-based prescribing and point-of-care testing will improve timely access for minor conditions and monitoring
3.4 Participating hospitals implementing ambulatory modernization projects	By FY2027, 10 facilities implementing; by FY2029, 20; by FY2031, ≥30 facilities	Program governance and organization will work to track this metric annually	Initiative 3; targeted outpatient upgrades will increase ambulatory capacity and shift care to appropriate lower-acuity settings
4.1 Community access points opened (school-based sites + mobile vans)	By FY2027, 70 access points opened; by FY2029, 140 open; by FY2031, ≥210 total (≥200 school-based sites and 10 mobile vans)	Program governance and organization will work to track this metric annually	Initiative 4; extension of school-based care and mobile services will increase preventive access for rural and Tribal communities
4.2 Community facilities receiving updates	By FY2027, 15 facilities receiving updates; by FY2029, 30 modernized; by FY2031, ≥40 facilities receiving updates	Program governance and organization will work to track this metric annually	Initiative 4; targeted repairs and crisis-space buildouts will increase capacity and stabilize community-based care
4.3 Community lifestyle projects completed (e.g., gardens)	By FY2028, 7 projects completed; by FY2029, 14 projects completed; by FY2031, ≥20 projects completed	Program governance and organization will work to track this metric annually	Initiative 4; one-time investments in healthy environments will encourage activity and nutrition, supporting chronic-disease prevention
5.1 Statewide BH bed registry live with facility reporting	By FY2027, live in 2 regions; by FY2029, 60% of facilities reporting; by	HIE and new bed registry analytics with provide annual tracking	Initiative 5; the electronic bed registry will improve coordination and reduce

Metric	Milestones/ targets	Evaluation plan	Initiative connection
	FY2031, ≥85% of relevant facilities reporting daily capacity		delays in behavioral-health placements
5.2 Community connect implementation and interoperability	By FY2026, 3 community connect region hubs implemented; by FY2029, achieve 95% interoperability throughout participating rural providers	Year-over-year trends from the EHR program records	Initiative 5; hub-and-spoke community-connect models will extend modern EHR capabilities and interoperability to rural providers

SUSTAINABILITY PLAN

Sustainability has been an absolute top priority as the State has constructed this plan and ensured that each proposed initiative does not create a "budget cliff" or unanticipated ongoing costs to the State or other stakeholders while ensuring lasting change to rural health. Program-specific sustainability is detailed within each initiative above. Initiatives fall into one of three categories:

1. **Time-limited initiatives with lasting impact:** These RHTP funds cover the costs of programs or activities that will only be in operation during the RHTP period of performance but will have a lasting impact beyond FY2031. Despite the limited time frame, these initiatives create lasting and sustainable impact by providing crucial resources (e.g., a larger workforce) that will last beyond RHTP funding, unlock transformation through features like network effects, and fill existing rural health gaps.
2. **Up-front investments intended to be self-sustaining**: These RHTP funds support for new systems that are hindered by initial costs. The return on investment (ROI) should cover ongoing expenses; if not, the programs will be phased out with no extra cost. These programs are pilots requiring impact demonstration through monitoring and evaluation to ensure they are self-sustaining beyond FY2031.
3. **Initiatives with a clear plan to transfer responsibility for operating/maintenance costs to a third party after the project period:** These RHTP funds provide necessary upfront investment for programs that require ongoing operating and/or maintenance

expenditures after the project period. These initiatives each have a designated organization that will be responsible for ongoing costs after FY2031.

INITIATIVE 1 SUSTAINABILITY PLAN (BACK TO INITIATIVE DESCRIPTION)

1.1. Increase recruitment of rural health care workers through education awards, tuition payments, and early exposure programs (Time-limited): This sub-initiative provides time-limited education awards, tuition support, and early-exposure/pre-apprenticeship programs executed during the five-year period. Funds will be disbursed only during RHTP funding period; participating health care trainees commit to practice in high-need rural areas for at least five years after training, creating durable workforce capacity with no ongoing State costs. Pipeline activities (e.g., HOSA/AHEC) transition to school and employer ownership. This is intended to increase rural provider supply and access beyond FY2031.

1.2. Increase rural clinical training capacity and opportunities, including additional residencies, preceptor incentives, and enhanced rural training tracks (Transfer responsibility): This sub-initiative covers start-up costs to add rural training capacity (residency slots, rural tracks, preceptor onboarding) and concludes within the award period. Ongoing operating costs are absorbed by sponsoring hospitals and academic partners via Medicare GME, institutional budgets, and commitments finalized during the funding window; preceptor incentives taper to employer/academic support. No State funding will be required after FY2031, as the additional slots and training infrastructure will persist.

1.3. Retain and upskill rural health care workforce through additional supportive services and enhanced training (including BH) (Self-sustaining): This sub-initiative provides retention support and upskilling (e.g., resilience programs, team-based care, BH training) as pilots with explicit ROI targets (reduced turnover and vacancy costs, improved productivity, quality gains). The State will fund design and initial deployment with required monitoring;

programs meeting ROI benchmarks transition to provider financing using realized savings, while non-performing programs sunset at period end. Curricula, protocols, and train-the-trainer assets remain reusable with minimal maintenance costs. This is expected to lower avoidable staffing costs and sustain higher-quality rural care post-FY2031.

INITIATIVE 2 SUSTAINABILITY PLAN (BACK TO INITIATIVE DESCRIPTION)

2.1. Launch the Montana Rural Health Center of Excellence to develop and oversee implementation of data-backed financial sustainability recommendations (Time-limited): The State will establish a time-limited CoE that will involve at least one third-party organization and a stakeholder board. Incentive payments to providers to implement recommended changes specific to the needs of each participating facility will be provided during the funding period and will cease at the end of the period. No ongoing program costs will continue after the RHTP period. This initiative will support long-term financial sustainability for participating providers.

2.2. Protect and increase access through clinical partnerships (Transfer responsibility /Self-sustaining): This sub-initiative involves upfront investment in virtual care equipment and training and upfront investment in an interfacility patient transport coordination system. These programs will be implemented with the upfront agreement that providers receiving funding will cover ongoing costs after the funding period (including through projected reimbursement revenues), with no funding commitment by the State. One program involves leveraging the existing 1915(c) Home and Community-Based Services (HCBS) Waiver to cover reimbursement for scaling the IDD virtual care statewide and will be self-sustaining by preventing utilization of higher cost services (e.g., ED, hospitalization).

2.3. Facilitate vendors and shared services for rural facility cost efficiency (Self-sustaining): This involves upfront investment by the State to facilitate rural providers to join or with other providers to obtain improved GPO pricing for supplies, devices, and pharmaceuticals.

Once the State facilitates the initial GPO, coalitions of providers will continue to purchase together without State intervention.

INITIATIVE 3 SUSTAINABILITY PLAN (BACK TO INITIATIVE DESCRIPTION)

3.1. Implement innovative payment models (Self-sustaining): Technical assistance for innovative payment participation is time-limited and front-loaded; models for duals/LTC and other value-based arrangements are identified and evaluated based on savings and quality thresholds. Programs meeting ROI targets transition to payer/provider financing and formal contracts (e.g., APMs/ACOs). This ensures sustainability via payment mechanisms that reduce costs and shift care to lower-cost settings.

3.2. Modernize Emergency Medical Service (EMS) care model (Transfer responsibility /Self-sustaining): Upfront funds cover dispatch upgrades, vehicles/equipment, and initial rollout of community paramedicine to expand access. Ongoing costs associated with infrastructure investments and a pre-hospital blood program are absorbed by EMS organizations and hospital partners via agreements, including fee-share agreements. Community paramedicine will be sustained through the adoption of Medicaid and private payor coverage of treat-in-place CPT codes. This approach is designed for long-term sustainability while improving access to care.

3.3. Extend access to lower cost care through pharmacists (Self-sustaining): Start-up funding would be used to enable point-of-care testing and prescribing workflows through purchasing of medical equipment and initial supply costs. Funds will also be used for minor pharmacy infrastructure improvements. The State will evaluate utilization and cost offsets during the funding window. If outcome targets are met and Medicaid coverage is finalized, pharmacists continue services under existing fee schedules; if not, pilots phase out at the end of the period.

3.4. Increase needed outpatient services (Time-limited): Time-limited funding is used to increase outpatient services across rural providers as needed and as determined by the CoE. No

State operating support continues after the period. Providers maintain the upgraded footprint with ongoing operating budgets and participation agreements tied to care-delivery restructuring centered on long-term financial sustainability. This will create durable access improvements.

INITIATIVE 4 SUSTAINABILITY PLAN (BACK TO INITIATIVE DESCRIPTION)

4.1. Implement community-based care (Transfer responsibility): Upfront funds cover site buildouts for school-based care and the purchase of mobile vans. Provider partners absorb ongoing operating costs with reimbursement revenue and through commitments to post-award staffing, routing, and maintenance; no State operating funds continue after FY2031. The footprint remains locally owned and sustained to preserve access.

4.2. Make critical repairs to community infrastructure (Time-limited/Self-sustaining): One-time capital funds complete priority repairs, minor modernization, and crisis safe-space buildouts during the award period; all grants conclude by FY2031. No State operating funds continue thereafter; facilities fold the upgraded space into routine operations or, for crisis services, use alternate reimbursement (e.g., CCBHC PPS) or local funds. The improvements create durable capacity and reliability gains beyond FY2031 with no ongoing State costs.

4.3 Invest in healthy lifestyles (Transfer responsibility): One-time grants to pilot and scale community-driven programs with no State operating commitment beyond the award. Projects proceed only with upkeep commitments by municipalities, schools, or community partners (e.g., food banks, local health departments). The assets continue to deliver preventative health benefits in accordance with Make rural America healthy again principles well past FY2031.

INITIATIVE 5 SUSTAINABILITY PLAN (BACK TO INITIATIVE DESCRIPTION)

5.1. Improve data usability and population health interventions by utilizing HIE data to drive decisions (Self-sustaining): Upfront funds cover buildout and initial deployment of targeted analytics-driven interventions and tools that drive value for providers. Continuation after

FY2031 is contingent on demonstrated ROI (e.g., measurable reductions in avoidable utilization and costs); programs meeting benchmarks transition to financing via realized savings and partner cost-sharing. No ongoing State operating funds are assumed beyond the award period.

5.2. Modernize EHRs for rural providers, activate consumer-facing modules, and enable interoperability, telehealth capabilities, data sharing, and chronic disease management (Transfer responsibility): Time-limited subsidies and implementation support end by FY2031; ongoing license, hosting, and support costs are assumed by hub systems and participating providers under executed agreements. Any consumer-facing modules and RPM activated through this effort continue only where providers elect to fund them based on documented value. No State funds are committed beyond the award period, while interoperability and capabilities remain in place.

Endnote 1: Citations

[i] Definitive Healthcare. Accessed Nov. 2025.
[ii] U.S. Department of Health and Human Services — Health Resources & Services Administration. "How We Define Rural." Accessed Nov. 2025.
[iii] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, Rockville, MD. "Area Health Resources Files (AHRF) 2023-2024." Accessed Nov. 2025.
[iv] The impact of Urban Indian Organizations extends to tribal members in rural areas
[v] U.S. Department of Health and Human Services — Health Resources & Services Administration. "How We Define Rural." Accessed Nov. 2025.
[vi] Montana State Library. "Area of Montana Counties." Accessed Nov. 2025. https://msl.mt.gov/geoinfo/geography/geography_facts/area_of_montana_counties.
[vii] Montana Department of Labor & Industry. Local Area Profiles. https://lmi.mt.gov/LocalAreaProfiles . Accessed Nov. 2025.
[viii] U.S. Census Bureau. "QuickFacts: Montana." Accessed Nov. 2025.
[ix] Centers for Disease Control and Prevention. "PLACES: Local Data for Better Health." Accessed Nov. 2025.
[x] In order, Centers for Disease Control and Prevention. "Trends in the Prevalence of Chronic Obstructive Pulmonary Disease Among Adults Aged ≥18 Years — United States, 2011–2021." Accessed Nov. 2025. https://www.cdc.gov/mmwr/volumes/72/wr/mm7246a1.htm; Centers for Disease Control and Prevention. "National Diabetes Statistics Report." Accessed Nov. 2025. https://www.cdc.gov/diabetes/php/data-research/index.html; Centers for Disease Control and Prevention. "Heart Disease Facts." Accessed Nov. 2025. https://www.cdc.gov/heart-disease/data-research/facts-stats/index.html; World Health Organization. "Hypertension." Accessed Nov. 2025. https://www.who.int/news-room/fact-sheets/detail/hypertension
[xi] America's Health Ranking. "Child Mortality in Montana." Accessed Nov. 2025.
[xii] Georgetown Institute for Women, Peace and Security. "Montana — U.S. Women, Peace and Security Index." Accessed Nov. 2025. https://giwps.georgetown.edu/usa-index/state/montana/.
[xiii] OpenStreetMap contributors. "OpenStreetMap." Accessed Nov. 2025.
[xiv] Definitive Healthcare. Accessed Nov. 2025.
[xv] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, Rockville, MD. "Area Health Resources Files (AHRF) 2023-2024." Accessed Nov. 2025.
[xvi] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, Rockville, MD. "Area Health Resources Files (AHRF) 2023-2024." Accessed Nov. 2025.
[xvii] Montana Department of Labor and Industry 2025 Labor Day Report
[xviii] Centers for Disease Control and Prevention. "PLACES: Local Data for Better Health." Accessed Nov. 2025.
[xix] Definitive Healthcare. Accessed Nov. 2025.
[xx] American Hospital Association. Accessed Nov. 2025.
[xxi] Definitive Healthcare. "Atlas Dataset." Accessed Nov. 2025