title: Rural Health Transformation Grant Guide — Pennsylvania version: 1.0 date: 2025-10-14 audience: State health agencies, Medicaid, rural providers, collaboratives

1. Executive Summary Pennsylvania has 48 rural counties and roughly 3.37 million rural residents (26% of the state) in 2023, underscoring the scale of transformation needed outside metropolitan areas. The CMS Rural Health Transformation (RHT) Program offers cooperative agreement funding totaling $50 billion across FY26–FY30, with awards expected by December 31, 2025. Half of funds are distributed equally to approved states and half by a points-based workload formula tied to rural/facility metrics and technical policy factors. Applications are due November 5, 2025. (rural.pa.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Pennsylvania in building an evidence-based, measurable portfolio that aligns cleanly to RHT use-of-funds categories and technical scoring factors. Capabilities include: 24/7 tele-emergency/ICU/hospitalist support for rural facilities (Avel eCare), continuous remote physiologic monitoring for chronic disease and post-acute care (BioIntelliSense), consumer-facing triage and health record tools (Humetrix), AI-enabled clinical pathways (Viz.ai), secure cloud, analytics, and cybersecurity (Microsoft), and implementation management and outcomes tracking (Accenture/KPMG/PwC/AVIA). These capabilities map to prevention and chronic disease, workforce and access stabilization, data infrastructure/interoperability, and innovative care/payment models.

Pennsylvania's current policy and program context—HealthChoices managed care, approved 1115 demonstrations (Keystones of Health; SUD/Former Foster Care Youth), BEAD-funded broadband expansion, and ongoing rural hospital payment initiatives—positions the Commonwealth to scale technology-enabled care models, expand access points, and strengthen rural provider solvency while meeting CMS's scoring factors and budget caps. (medicaid.gov)

Immediate high-leverage offerings for Pennsylvania's application include: (a) tele-ER/ICU and inpatient virtual hospital support to stabilize rural hospitals; (b) remote patient monitoring with exception-based workflows to reduce readmissions and ED use; (c) statewide data/interoperability stack with role-based access, analytics, and cyber hardening; and (d) rural provider High Value Networks (HVNs) to coordinate investments and catalyze payer-aligned, value-based arrangements.

One-page printable summary (for distribution)

- Program fit: CMS-RHT-26-001 funds state-led rural transformation (FY26–FY30). 50% equal baseline + 50% points-based workload; awards by 12/31/2025; app due 11/5/2025. Admin ≤10%; provider payments ≤15%; capital/infrastructure ≤20%. (files.simpler.grants.gov)
- Pennsylvania need snapshot (latest available):
  - Rural population: 3.37M (26%) in 2023. (rural.pa.gov)
  - CAHs: 17; rural hospital payment actions underway (2024–2025). (pa.gov)
  - Health centers: 42 awardees served 868k patients in 2024. (data.hrsa.gov)
  - Broadband: BEAD initial proposal Vol. I & II approved; $1.16B allocation (2023–2024 approvals; 2025 implementation). (broadband.pa.gov)
  - Maternal health: state initiatives and MMRC-led strategies scaling since 2024; 2016–2020 maternal mortality 10.6 per 100,000; ongoing investments continue (2024–2025). (pa.gov)
- Collaborative supports (examples, subject to contracting and integration):
  - 24/7 tele-ER/ICU/hospitalist and specialty backup (Avel eCare).
  - Remote monitoring with clinician dashboards (BioIntelliSense).
  - Consumer triage/PHR and analytics (Humetrix).
  - AI triage for time-sensitive conditions (Viz.ai).
  - Data/AI/cyber platforms and PMO (Microsoft + SIs).
  - Rural provider HVNs for joint governance (Cibolo Health).

2. Eligibility and RFP Fit 2.1 Summary of RHT NOFO requirements (CMS-RHT-26-001)

- Eligibility: Only the 50 U.S. states; DC and territories are ineligible. Governor-designated lead agency; single official application; no cost sharing. (files.simpler.grants.gov)
- Deadlines: Optional LOI 9/30/2025; application due 11/5/2025 (11:59 p.m. ET); awards and earliest start 12/31/2025; CMS information webinars in late September 2025. (files.simpler.grants.gov)
- Funds and distribution: Approx. $50B total FY26–FY30; 50% equal baseline; 50% workload via points (rural facility/population and technical factors). (files.simpler.grants.gov)
- Scoring: Table 3 weights—Rural facility/population factors (A1–A7) 50%, Technical factors (B1–F3) 50%. (files.simpler.grants.gov)
- Narrative and attachments—required contents, format, and page limits:
  - Project summary (1 page), Project narrative (≤60 pages; double-spaced), Budget narrative (≤20 pages; single-spaced). (files.simpler.grants.gov)
  - Attachments: Governor's endorsement (≤4 pages), Business assessment (≤12), Program duplication assessment (≤5), Indirect cost rate agreement (if used), Other supporting docs (≤35).

Forms: SF-424/424A, Site Location(s), SF-LLL. (files.simpler.grants.gov)
- Use of funds: States must address ≥3 categories; examples include prevention/chronic disease (A), provider payments (B; restricted), consumer-facing tech (C), training/TA (D), workforce (E), IT/cyber (F), right-sizing services (G), behavioral health (H), value-based models (I), capital/infrastructure (J), partnerships (K). (files.simpler.grants.gov)
- Funding limits (program-specific): provider payments ≤15% of period award (B); capital/infrastructure (J) ≤20%; administrative expenses (including indirects) ≤10% of amount allotted per budget period. (files.simpler.grants.gov)
- Compliance: Awards follow 2 CFR Part 200/HHS GPS; risk review per 2 CFR 200.206; post-award reporting; noncompliance may trigger payment withholding or recovery. (files.simpler.grants.gov)

2.2 Requirement-to-Capability mapping (illustrative)

- Requirement: ≥3 use-of-funds categories with measurable outcomes.
  - Collaborative capability: Tele-ER/ICU/Pharmacy support; RPM for chronic disease; behavioral tele-psychiatry; consumer screening/PHR. Evidence: Avel eCare, BioIntelliSense, Humetrix profiles and example outcomes.
- Requirement: Data infrastructure, interoperability, and cyber posture.
  - Capability: Secure cloud data platform; analytics; TEFCA-aligned exchange; cybersecurity hardening. Evidence: Collaborative overview of data/cyber stack and interoperability emphasis.
- Requirement: Governance, monitoring, evaluation, sustainability.
  - Capability: PMO toolkits; outcomes/value tracking; HVN governance; payer strategy support. Evidence: SI roles; Cibolo Health HVN model.
- Requirement: Funding policy limits (admin ≤10%; provider payments ≤15%; capital ≤20%).
  - Capability: Budget modeling and financial controls with tagged spend against NOFO categories and caps. Evidence: NOFO sections on limits; SI managed services for tracking. (files.simpler.grants.gov)

3. Pennsylvania Context Snapshot 3.1 Population and geography

- Rural residents: ~3.37M (26% of 13.0M) in 2023 across 48 rural counties; rural seniors ≥65 are 21% (2023). These demographics suggest elevated chronic disease risk and access challenges. (rural.pa.gov)

3.2 Facility mix and access points

- Hospitals/CAHs: Pennsylvania reports 17 federally designated CAHs in 2025; state actions in 2024–2025 increased Medicaid payments to rural hospitals (CAHs + PARHM + other rural) pending federal approvals. Collaborative tele-hospital services can support stabilization and keep patients local (subject to contracting). (pa.gov)
- FQHCs: 42 Health Center Program awardees served 867,867 patients in 2024; >300–400 care sites statewide. Collaborative primary care support and interoperability can extend care management. (data.hrsa.gov)
- RHCs (context): State resources maintain RHC listings and certification processes; CMS updated the CY2025 RHC AIR at $152/visit for most RHC types. (pa.gov)

3.3 Workforce/HPSA indicators

- Pennsylvania maintains extensive primary care, mental health, and dental HPSA designations; state Primary Care Office coordinates shortage designation and workforce programs (loan repayment, J-1 waivers). Collaborative workforce offerings (tele-mentoring, ambient documentation, pharmacist-enabled models) can support recruitment/retention and productivity. (pa.gov)

3.4 Medicaid and payment context

- Pennsylvania's approved Section 1115 demonstrations include Keystones of Health (HRSNs, pre-release coverage, continuous eligibility for children) effective 12/26/2024–12/31/2029, and an SUD/Former Foster Care Youth demonstration (renewed through 9/30/2027). Collaborative analytics and program design can align RHT initiatives with these authorities and HealthChoices managed care operations (subject to SPA/contracting). (medicaid.gov)

3.5 Broadband and telehealth readiness

- PBDA BEAD Initial Proposals Vol I & II approved; allocation >$1.16B for universal coverage in un/underserved areas. Collaborative platforms can ride these investments to expand remote care, HIE, and cyber protections. (broadband.pa.gov)

3.6 Maternal and behavioral health signals

- Maternal health: Pennsylvania continues maternal health investments and coalition building; DOH reports a 2016–2020 maternal mortality ratio of 10.6 per 100,000; additional funding and MMRC initiatives are in progress (2024–2025). Collaborative maternal tele-consults, RPM, and community engagement are applicable. (pa.gov)

Table 1. Key metrics and fit to Collaborative capability (selected)

- Rural residents (2023): 3.37M (26%); source: Center for Rural PA; fit: networked access + RPM + tele-specialty. (rural.pa.gov)
- CAHs (2025): 17; state rural hospital payment actions; fit: tele-ICU, tele-ER, ops redesign. (pa.gov)
- FQHC patients (2024): 867,867; 42 awardees; fit: chronic care/RPM, digital front door, analytics. (data.hrsa.gov)
- BEAD status (2024–2025): Vol I & II approved; $1.16B; fit: video/remote care reliability and cyber. (broadband.pa.gov)
- Maternal care (2016–2020 ratio 10.6); fit: maternal tele-consults/RPM, perinatal pathways. (pa.gov)

4. Strategy Aligned to RFP Pennsylvania can structure its Rural Health Transformation Plan around three pillars that directly mirror NOFO scoring and use-of-funds categories.

4.1 Access stabilization and clinical support (A, H, G; factors C.1, C.2, F.1)

- Virtual hospital coverage (tele-ER/ICU/hospitalist), behavioral crisis support, and specialty e-consults to match local capacity and reduce avoidable transfers. Evidence and roles: Avel eCare; Cibolo-enabled HVNs to share services.

4.2 Chronic disease and consumer engagement (A, C, D, F; factors B.1, B.2, F.3)

- RPM with exception-based workflows (e.g., BioButton), multi-language triage/PHR, retail-adjacent screening, and community paramedicine linkages.

4.3 Data, interoperability, and cybersecurity (F; factors F.2, E.1)

- HIPAA/FHIR platforms, TEFCA-aligned exchange, and cyber hardening that support claims/payment integrity, prior authorization automation, and value-based measure tracking. SI partners supply PMO/value tracking.

Equity strategy

- Prioritize high-need rural geographies (HPSAs, maternity care deserts) with culturally and linguistically appropriate consumer tools; integrate Tribal/IHS partners where relevant; leverage BEAD to mitigate digital barriers. (pa.gov)

Data use and privacy

- Role-based access, minimum necessary, and audit trails within cloud platforms; alignment with CMS Health Technology Ecosystem and ONC interoperability criteria; TEFCA participation to support continuity across referral pathways.

5. Program Design Options (Pennsylvania-tuned; non-exhaustive) Option A. Rural Hospital Virtual Coverage and Transfer Optimization

- Target: 17 CAHs and other rural PPS hospitals; reduce avoidable transfers, LOS, and readmissions.
- Problem framing (2024–2025): Payment pressure and staffing gaps; maternal and behavioral access variability. (pa.gov)
- Components: Tele-ER/ICU/hospitalist, tele-pharmacy, systemwide escalation protocols, community paramedicine pilots; Viz.ai for time-sensitive conditions; RPM for post-discharge.
- Payment logic: Within NOFO caps, direct support for tech/TA (F, D), prevention/chronic (A), limited provider payments (B ≤15%) for clearly non-reimbursable gap-fill, with sustainability via payer-aligned shared savings or global budget extensions (subject to CMS/Medicaid actuarial review). (files.simpler.grants.gov)
- Pros/risks: Rapid coverage; dependency on telestaff; mitigate via HVN governance and service-level agreements.

Option B. Statewide Chronic Disease/RPM Collaborative

- Target: Rural Medicare/Medicaid high-risk adults (e.g., HF, COPD, diabetes).
- Components: BioIntelliSense RPM + CHC/FQHC primary care follow-up; Humetrix patient-facing tools; pharmacist-enabled HTN/lipid management at rural pharmacies (scope subject to PA law/regulation).
- Payment logic: Category A/C/D/F investments; value-based incentives with MCOs/ACOs over time.

(files.simpler.grants.gov)
- Pros/risks: Outcome measurability; device logistics—mitigate via digital navigator training and inventory management.

Option C. Maternal and Behavioral Health Integration

- Target: Rural obstetric and perinatal pathways; behavioral health access via tele-BH and crisis supports.
- Components: Tele-MFM consults, RPM for high-risk pregnancy; 24/7 tele-behavioral coverage; linkage with CCBHCs; BH 1115 and Keystones of Health alignment for HRSNs. (medicaid.gov)
- Pros/risks: Addresses high-impact outcomes; requires strong referral management—mitigate with TEFCA exchange and closed-loop e-referrals.

Option D. Rural Data & Cyber Modernization + HVN Shared Services

- Target: Multi-county clusters; elevate data exchange, analytics, cyber readiness, and group purchasing.
- Components: Cloud data platform; identity and access management; HVN-coordinated shared services; dashboards for RHT reporting.
- Pros/risks: Cross-facility leverage; change management—mitigate with SI-led adoption playbooks.

6. Governance and Collaborative Roles 6.1 Structure (illustrative)

- State lead agency (Governor-designated) sets priorities; Medicaid agency aligns managed care/SPA as needed.
- HVNs (facilitated by Cibolo Health) coordinate rural providers for joint investments, value-based models, and transparent fund stewardship.
- SI partners (Accenture/KPMG/PwC/AVIA) support PMO, procurement, systems integration, analytics, and value tracking.
- Technology/clinical vendors deliver services under State-approved contracts and data-sharing agreements.

6.2 RACI (selected)

- Strategy and policy alignment: Responsible—State lead; Accountable—Governor's office; Consulted—Medicaid, Hospital Association, PACHC, HVNs; Informed—stakeholders.
- Data/cyber platform: R—SI + platform vendor; A—State CIO/lead agency; C—providers/HIE; I—CMS.
- RPM/tele-services: R—providers/vendors; A—lead agency; C—MCOs/PACHC; I—community orgs.

7. Payment and Funding

- Funding categories and caps (per NOFO): provider payments ≤15%; capital/infrastructure ≤20%; admin (incl. indirect) ≤10%; no pre-award costs; 2 CFR Part 200/HHS GPS apply. (files.simpler.grants.gov)
- Medicaid alignment: Coordinate with HealthChoices and 1115 demonstrations (Keystones of Health; SUD) for sustainability—e.g., value-based add-ons, directed payments, or SPA amendments for RPM coverage and tele-care modalities (subject to CMS approval). (medicaid.gov)

Table 2. Illustrative cost/workplan alignment (rough-order)

- Clinical virtual coverage (Avel eCare): Services fees, training (A,D,F); funding: RHT + MCO pilots; deliverables: uptime SLAs, transfer KPIs.
- RPM kits + hub: Devices/services (A,C,D,F); funding within caps; deliverables: adherence, alerts, outcomes.
- Data/cyber stack: Cloud tenancy, identity/security, interfaces (F); funding: RHT + BEAD synergies; deliverables: HIE utilization, cyber controls. (broadband.pa.gov)
- HVN shared services: Governance, analytics, procurement (K); deliverables: joint investment plan, value tracking.

8. Data, Measurement, and Evaluation Core measures (examples; align to narrative outcomes table and CMS evaluation):

- Access: ED transfer rates, tele-consult response times, behavioral tele-visit availability.
- Quality: Readmissions, avoidable ED utilization, BP/HbA1c control, maternal complications.
- Financial: Cost per beneficiary, total cost vs. baselines, revenue cycle timeliness.
- Workforce: Vacancy/turnover, time on documentation (ambient AI impact).
- Technology: HIE query rates, T-MSIS completeness, cyber incidents averted. Data sources/integrations: Medicaid claims/T-MSIS; hospital EHRs; FQHC UDS extracts; EMS data; HIE; consumer app telemetry; public health registries.

Evaluation approach: Learning system with quarterly run-charts and annual counterfactual analyses; SI partners

provide outcomes/value tracking under standard evaluation frameworks; cooperate with CMS third-party evaluators.

9. Implementation Plan Gantt-style 12–24 month plan (illustrative; subject to procurement)

- Workstream; Start; End; Owner; Outputs
- Program mobilization; Jan 2026; Mar 2026; State PMO + SI; Charter, governance, RHT reporting plan.
- Data/cyber platform; Feb 2026; Oct 2026; SI + platform vendor; Tenant, interfaces, security baselines.
- Tele-ER/ICU rollout (wave 1–2); Apr 2026; Dec 2026; Hospitals + Avel eCare; Go-lives, KPIs.
- RPM cohort deployment; May 2026; Feb 2027; FQHC/RHC + BioIntelliSense; Enrollment, alerting, outcomes.
- Maternal/BH integration pilots; Jun 2026; Mar 2027; Providers + BH partners; Tele-MFM + BH coverage metrics.
- HVN formation and value model design; Jan 2026; Jun 2026; Cibolo + State + payers; HVN charter, payer engagement.
- Reporting and continuation apps; Recurring; Recurring; PMO; Annual NCC package, CMS KPIs. (files.simpler.grants.gov)

Procurement/legal gating items (indicative): master services agreements, BAAs/data use agreements, payer MOUs for value models, and alignment to NOFO spending caps with line-item tagging. (files.simpler.grants.gov)

10. Risk Register (selected)

- Cyber incident at a rural facility; Mitigation: hardening, MFA, 24/7 SOC, tabletop exercises; Owner: CIO + vendor.
- Insufficient broadband for video care; Mitigation: prioritize BEAD-served areas, adaptive bitrate, store-and-forward; Owner: State/PBDA + providers. (broadband.pa.gov)
- RPM adherence drop-off; Mitigation: digital navigators, patient segmentation, pharmacy touchpoints; Owner: FQHC/RHC.
- Workforce fatigue with new tools; Mitigation: phased rollout, ambient documentation, CME; Owner: facility leadership.
- Data-sharing delays; Mitigation: TEFCA/QHIN participation, standardized interfaces; Owner: HIE/vendor.
- Value arrangements not finalized; Mitigation: parallel payer engagement, scenario analytics; Owner: Medicaid + HVN.
- Budget cap overruns; Mitigation: category tagging with cap alerts; Owner: PMO/finance. (files.simpler.grants.gov)
- Rural hospital transfer pathways not adopted; Mitigation: shared protocols + tele-coaching; Owner: HVN/medical directors.
- Privacy concerns with consumer apps; Mitigation: minimum necessary, opt-in consent, audits; Owner: vendor + compliance.
- Procurement lag; Mitigation: pre-negotiated riders, cooperative purchasing; Owner: State procurement + SI.

11. Draft RFP Response Language (Pennsylvania-tailored; copy-ready) 11.1 Rural health needs and target population (excerpt) “Pennsylvania’s rural population numbered approximately 3.37 million in 2023 (26% of the state), concentrated in 48 rural counties with higher shares of older adults than urban areas. Barriers include hospital service reductions, long travel times, broadband gaps, and workforce shortages. The proposed program targets rural residents in CAH/PPS hospital service areas, rural FQHC/RHC catchments, and HPSA-designated communities, prioritizing geographies with unmet maternity and behavioral health needs.” (rural.pa.gov)

11.2 Goals, strategies, and policy actions (excerpt) “Our goals are to (1) strengthen sustainable access by providing virtual hospital and emergency coverage statewide; (2) improve outcomes in chronic disease and maternal health through connected care models; (3) modernize rural data, interoperability, and cybersecurity; and (4) build durable rural provider networks to support value-based arrangements. We intend to pursue policy updates aligned to NOFO technical factors (e.g., remote care coverage, licensure processes, data infrastructure milestones) and report progress consistent with CMS timelines.” (files.simpler.grants.gov)

11.3 Proposed initiatives and use of funds (illustrative language) “Initiative 1: Rural Virtual Coverage. Use-of-funds A, D, F, G. Outcomes: 10% reduction in transfers; 8% reduction in 30-day readmissions; 90% clinician satisfaction with tele-support; county-level ED transfer rate improvement within 12 months.”

“Initiative 2: Chronic Disease RPM. Use-of-funds A, C, D, F. Outcomes: 10-mmHg average SBP reduction among uncontrolled HTN cohort; 0.5% absolute HbA1c reduction at 6 months; 15% fewer all-cause 30-day readmissions among RPM enrollees.”

“Initiative 3: Maternal/BH Integration. Use-of-funds H, A, F. Outcomes: 10% reduction in severe maternal morbidity events among participating sites; 24/7 tele-BH coverage in pilot counties; reduced time-to-psychiatric

consult by 30%."

"Initiative 4: Data/Cyber Modernization + HVN. Use-of-funds F, K. Outcomes: 80% of partner sites exchanging CCDAs/USCDI via HIE or TEFCA endpoints; zero critical cyber findings by month 12; HVN joint investment plan executed."

11.4 Budget narrative (compliance language) "The budget tags each line to NOFO categories, maintains administrative costs at or below 10% of the award for each budget period, limits provider payments to ≤15%, and caps capital/infrastructure at ≤20%. We will use the CMS-recommended annual planning placeholder for tables, with updates through annual continuation applications." (files.simpler.grants.gov)

12. Assumptions and Open Questions

- CCBHC inventory: The application must include a list of CCBHCs and sites as of September 1, 2025; Pennsylvania to confirm the authoritative list for attachment. (files.simpler.grants.gov)
- Hospitals receiving Medicaid DSH (latest SPRY): Pennsylvania to confirm the most recent count from DHS DSH schedules for NOFO reporting. (files.simpler.grants.gov)
- Broadband location-level priorities: PBDA BEAD subgrantee awards and timelines will shape telehealth rollout phasing; align initiative waves to BEAD build schedule. (broadband.pa.gov)
- Licensure/scope: Pharmacist-enabled chronic disease protocols and tele-licensure processes to be validated against current Pennsylvania law/regulation before inclusion in scoring.

13. Checklists Application compliance (extract)

- Single application from Governor-designated lead; AOR signature; SF-424/424A; SF-LLL; Project/Performance Site form. (files.simpler.grants.gov)
- Narratives within page limits (1/60/20) and formatting; required attachments (Governor letter ≤4; Business assessment ≤12; Program duplication assessment ≤5; other ≤35). (files.simpler.grants.gov)
- Budget caps (admin ≤10%; provider payments ≤15%; capital ≤20%); no pre-award costs; 2 CFR/HHS GPS compliance. (files.simpler.grants.gov)

14. Gantt-style Table (summary)

- Q1–Q2 2026: PMO mobilization; data/cyber platform setup; HVN governance launch.
- Q2–Q3 2026: Tele-ER/ICU wave 1; RPM wave 1; maternal/BH pilots begin.
- Q4 2026–Q2 2027: Tele-ER/ICU wave 2; RPM wave 2; data exchange expansion; payer model tests.
- Reporting: Quarterly to CMS; annual NCC ~60 days before period end. (files.simpler.grants.gov)

15. References Internal sources

1. Rural Health Transformation Collaborative. R1. 10-11-25 (internal consensus document). Accessed 2025-10-14.

External sources 2) CMS. Rural Health Transformation (RHT) Program — Overview page. https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview. Accessed 2025-10-14. (cms.gov) 3) CMS. Rural Health Transformation Program — NOFO (CMS-RHT-26-001). https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf. Accessed 2025-10-14. (files.simpler.grants.gov) 4) CMS. Current CMS Grants — listing showing CMS-RHT-26-001. https://www.cms.gov/about-cms/grants-cooperative-agreements/currentnts-funding-opportunities. Accessed 2025-10-14. (cms.gov) 5) Center for Rural Pennsylvania. Rural Quick Facts (2023 updates). https://www.rural.pa.gov/data/rural-quick-facts. Accessed 2025-10-14. (rural.pa.gov) 6) Pennsylvania DHS. Rural Health (highlights for rural hospitals and CAHs). https://www.pa.gov/agencies/dhs/programs-services/healthcare/rural-health.html. Accessed 2025-10-14. (pa.gov) 7) HRSA UDS Data (Pennsylvania, 2024). https://data.hrsa.gov/tools/data-reporting/program-data/state/PA. Accessed 2025-10-14. (data.hrsa.gov) 8) PBDA. BEAD Program approvals and 5-year plan. https://broadband.pa.gov/funding/broadband-equity-access-and-deployment-bead-program/. Accessed 2025-10-14. (broadband.pa.gov) 9) Pennsylvania DOH. Maternal Mortality (program page; selected metrics and initiatives). https://www.pa.gov/agencies/health/programs/maternal-health-and-infant-care/maternal-mortality. Accessed 2025-10-14. (pa.gov) 10) Medicaid.gov. Pennsylvania Keystones of Health (1115). https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/159451. Accessed 2025-10-14. (medicaid.gov) 11) Medicaid.gov. Pennsylvania Former Foster Care Youth & SUD Demonstration (1115). https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83081. Accessed 2025-10-14. (medicaid.gov) 12) CMS. HPSA Bonus Payment (ZIP lists and guidance). https://www.cms.gov/medicare/payment/fee-for-service-providers/physician-bonuses-health-professional-shortage-areas-hpsas. Accessed 2025-10-14. (cms.gov)

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