Colorado Department of Health Care Policy and Financing

Rural Health Transformation Program

Project Narrative

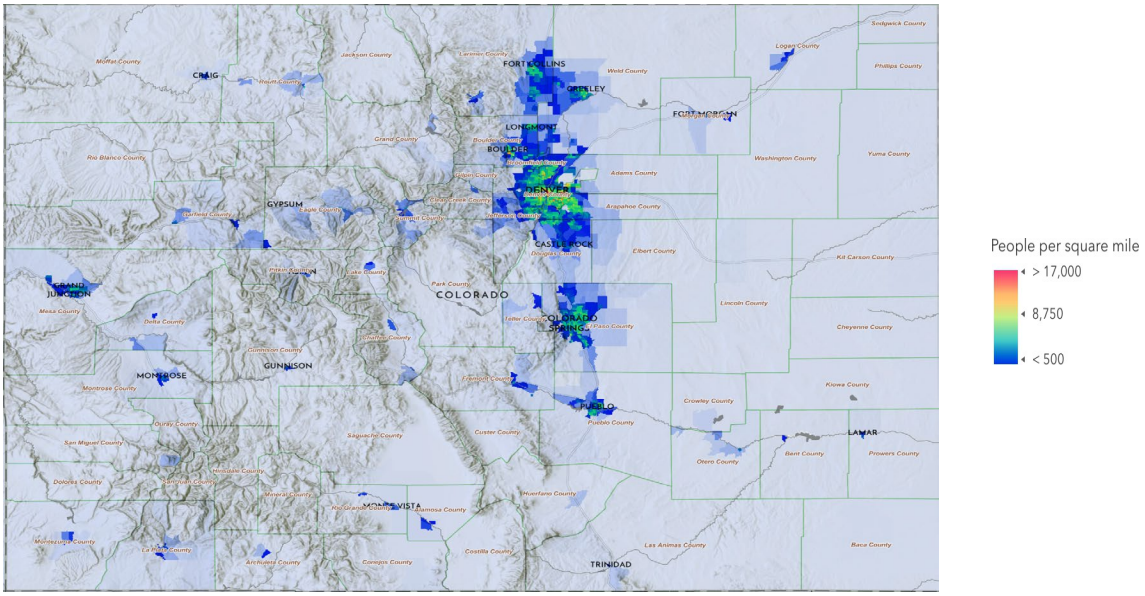
COLORADO
Department of Health Care Policy & Financing

Project Narrative

Colorado's Rural Landscape

Colorado is the 8th largest state in the nation[1], with 104,094 square miles of some of the most geographically diverse topography, ranging from the vast Eastern Plains, to the high desert mesas of the Western Slope, to the fertile San Luis Valley, to the rugged peaks of the Rocky Mountains. The size and composition of these rural areas is as unique as the approximately 800,000 (more than 13%) Colorado residents who live there[2]. Over **82% of the state's land mass (84,732 sq. miles) and 52 of Colorado's 64 counties are classified as** rural or frontier[4]. Some of these counties, such as Las Animas, are geographically larger than several U.S. states, which only serves to exacerbate the difficulty of accessing timely care.[5]

Colorado Population Density and Topography



Colorado's Tribes

There are two federally recognized tribes[12] in rural Colorado, as well as an Urban Indian Health Program[13], that serve tribal members across the state. The Southern Ute Indian Tribe is southeast of Durango, and is headquartered in rural La Plata County.[14] The Tribe runs its own clinics under Public Law 93-638[15]. The Ute Mountain Ute Tribe is in the southwest corner of state [6] and utilizes an Indian Health Services (IHS) clinic, along with other care access points[17]. Denver Indian Health and Family Services (DIHFS) is an Urban Indian Health Program,[18] primarily located in Denver but providing services across Colorado, including in rural locations[19].

Tribal members experience the same barriers to care and environmental factors as their geographical counterparts. Preventing and managing chronic health conditions (diabetes in particular) and addressing behavioral health needs, including access to crisis care and substance use treatment, are two areas that have been emphasized by the Colorado Tribes during formal consultation and quarterly meetings with the Colorado Commission on Indian Affairs (CCIA). **The implementation of RHTP will have a profound impact on our efforts to manage and prevent chronic disease, train and retain tribal Health Workers and improve access to care for this most vulnerable population.**

Care Access and Travel

Rural Coloradans travel significant distances to reach specialty or emergency care, sometimes driving hours over mountainous terrain. Navigating through winding

mountain roadways often blocked in inclement weather makes access to rural care that much more challenging. The result is delayed emergency response and treatment, creating higher-risk outcomes, limited access to specialty care and diagnostics, increased health risks during winter or severe weather, and lower routine and preventive care. Transportation options are scarce in rural communities where only 8% of rural older adults use public transit[6], and just 6% have access to rideshare services, compared to 36% of their urban counterparts[7]. Further, every rural and frontier county in Colorado contains areas classified as EMS deserts, meaning residents are more than 25 minutes from the nearest ambulance station[9]. These geographic gaps in emergency medical coverage pose serious risks to timely care, especially in counties with rugged terrain and limited infrastructure. In many rural counties, response and transport times often exceed 40 minutes for basic response and over 90 minutes[10] for total call time in high-acuity cases. **Colorado's RHTP directly addresses these challenges by expanding Emergency Medical Services (EMS) coverage, improving care coordination, and deploying telehealth and mobile health technologies to reduce travel burdens. These efforts improve the ability of rural Coloradans to access timely, coordinated care and therefore achieve better health outcomes, while also driving system efficiencies.**

Rural Health Needs and Target Population

Colorado's RHTP will serve all 52 rural and frontier counties and the two federally recognized tribes in Colorado. Across all provider types, 12.7% of health care facilities

are located in rural and frontier counties in Colorado[11] (574 out of 4,520). RHTP will address:

- Frontier counties (23) that lack critical specialty care access[11b], including behavioral health, obstetric and gynecology services;
- Rural counties (28) with the highest rates of chronic disease or preventable hospitalizations as identified by an assessment to be completed as part of RHTP;
- Providers such as Critical Access Hospitals (CAHs) and other rural hospitals, Rural Health Clinics (RHCs), behavioral health clinics, rural Federally Qualified Health Centers (FQHCs) and more, would strongly benefit from strategic partnerships that promote resource sharing to improve administrative efficiencies, affordability and health outcomes;
- Tribes (2), including addressing the unique needs of these valued partners.

These priority areas are most at risk of declining access, worsening health outcomes, and economic instability driven by geographic travel barriers, access challenges, workforce shortages, economic vulnerability, technology gaps, and health disparities. Colorado will apply a data-driven approach, using statewide health surveillance, hospital financial data, and workforce analyses to ensure that high-need populations receive transformative investment with sustainable impact and results. **The RHTP will enable the state to strengthen and modernize rural health systems, stabilize critical access hospitals, expand wellness, preventive and chronic disease programs, improve affordability, and grow the rural workforce.**

Colorado's Rural Health Care Landscape

Many rural providers struggle to overcome negative operating margins due to a variety of factors, such as low patient volume, high rates of public coverage, an aging population, uninsured residents, lack of critical partnerships, and inefficient legacy infrastructures. The challenges vary among the target rural providers outlined in the RHTP, including hospital-owned and operated certified RHCs, Emergency Preparedness/EMS, Long-Term Care and Nursing Homes/Skilled Nursing Facilities, Community Mental Health Centers (CMHCs), School-based Health Centers, and independent rural practices. **The injection of RHTP funding to address the unique needs of rural providers would create a multifaceted and sustainable solution that strengthens systems of care, expands and upskills the rural health care workforce, and pilots innovative care models and technology solutions to focus on affordability, chronic disease prevention and management.**

Rural Demographics

Rural Coloradans are more likely to be older than their urban counterparts[22], which makes them at higher risk for a number of chronic diseases. They also experience more barriers to accessing insurance coverage[23] and care than their urban counterparts because of a shortage of health care providers[24] and fewer insurance carriers[25]. Rural Colorado suffers from some of the highest health care costs and insurance premiums[26] in the nation. These factors contribute to poor rural health outcomes.

Colorado's RHTP addresses these population vulnerabilities by expanding

chronic disease prevention programs, connecting rural clinics through shared data systems, and strengthening the rural workforce to improve affordability and access to preventive services.

The Health Care Industry is a Significant Employer in Rural Communities

Health care provides more than just medical services for 809,253 rural Coloradans. It is an economic driver, creating jobs that are essential to the sustainability of small towns and tiny outposts across Colorado[27]. One in ten Colorado rural residents works in the Health Care and Social Assistance sector[28], the second-largest industry in rural areas, growing 21.8% since 2014[29]. In Colorado, rural hospitals are responsible for 4.5% of the jobs[30] in their communities. **Colorado's RHTP initiatives will not only improve care access and health outcomes for rural communities; it will create transformative financial sustainability through technology modernizations, operational efficiencies, provider recruitment and retention, and new care access points.**

Health Outcomes

Rural Coloradans experience a higher prevalence and mortality across nearly all major chronic diseases[32] compared to urban areas. In 2024, chronic conditions such as heart disease, hypertension, and chronic respiratory illness[33] were among the top four causes of death in rural areas. These are conditions that can be mitigated or prevented through early intervention and care coordination[34]. Rural health care gaps are compounded by limited preventive care infrastructure and workforce shortages[35] in rural communities.

Colorado's RHTP proposed initiatives (e.g., prevention programs, food as medicine, innovative and modernized technology, and improved access through e-consults and telehealth) will create a unified approach[36] for addressing these gaps to improve health outcomes across rural populations.

Chronic Disease (2024)[32]	Rural Rate	Urban Rate
Heart Attack	4.8%	3.6%
Heart Disease	4.4%	3.4%
High Blood Pressure	31%	26.8%
Stroke	3.5%	2.7%
Chronic Obstructive Pulmonary Disease	7.5%	5%
Diabetes	8.4%	8.4%

Maternal Care Access and Outcomes

The Colorado mountains and plains increase the risk of poor maternal outcomes for those living in these rural communities. A decline in maternity workforce and care has left more than half of our rural neighbors without access to a practicing OB-GYN in their counties; specifically, 57.4% of rural counties lack a practicing OBGYN[37] and 37.5% of counties in Colorado (and increasing with recent closures) are maternity care deserts[38]. A maternity care desert forces a pregnant or laboring woman to travel more than seven times farther[39] to access maternity care, with the highest travel averaging 68 miles and 75 minutes to reach their nearest birthing hospital[42]. Given this reality, Colorado's maternal mortality rate in frontier counties is almost four times the national average[43].

Colorado's RHTP will change this, with a targeted approach to expand access to specialists, sustain a workforce for essential services, drive innovative care models, while improving preventive and chronic care. As a result, the RHTP will increase patients' access to care, decrease travel times, and drive better maternal outcomes for our rural families.

Behavioral Health Outcomes in Rural Locations

In 2024, Colorado's rural suicide rates were 56% higher than in urban areas[44], reflecting both behavioral health provider shortages and limited crisis response capacity. Many rural hospitals lack behavioral health providers, and community clinics are operating at or beyond capacity for their behavioral services[45]. Rural regions, particularly those located in the mountains, depend heavily on visiting providers[46] to provide on-premises services. **The Colorado RHTP will make an investment in rural workforce, eConsults, and telehealth[47] to improve access and health outcomes, while saving lives.**

Rural Health Care Access, Recruitment, and Retention

Rural Coloradans face a shortage of health care providers and are at an increasing risk of losing the limited resources currently available. Fully 17 of Colorado's rural counties do not have a hospital[48], 20 lack a RHC[49], and 15 lack a FQHC[49]. Colorado's rural provider shortfall is exemplified by the 325% more urban physician access points, or 0.8

physicians per 1,000 residents in rural regions, compared to 2.6 physicians per 1,000 residents[51] in Colorado's urban regions.

The majority of rural Coloradans are located more than 15 miles[53] away from their nearest hospital (through mountainous terrain) while many Coloradans live more than 50 miles from the nearest full-service hospital[54]. **Colorado's RHTP will address these rural challenges to improve health outcomes by providing greater access to care that is local, improving telehealth, and strengthening key strategic provider partnerships to create a hub and spoke approach to patient care.**

Rural areas also face challenges in recruitment and retention of health care providers, leading to limited access to primary care, specialty services, and preventive care. A goal of the RHTP is to retain these providers who serve in medically underserved[57] areas, while expanding new access points:

- 11 Rural Prospective Payment System Hospitals (PPS)[58]
- 32 Critical Access Hospitals (CAHs, which serve as large employers and economic anchors)[60]
- 15 Community Health Centers[62]
- 77 Federally Qualified Health Centers (FQHCs)[59]
- 21 School Based Health Centers (SBHCs)[61]
- 7 Certified Community Behavioral Health Clinics (CCBHCs)[76]
- 57 Rural Health Clinics (RHC)[63]

The RHTP will help recruit and retain rural providers by supporting credentialing and certification costs, training, continuing education, and other professional development opportunities, and advancing recruitment and retention strategies in rural communities.

Emergency Medical Services Access, Workforce, and Response Time

EMS staffing models also vary dramatically between urban and rural areas. In urban counties, EMS agencies are predominantly staffed by paid professionals, often with advanced certifications and access to robust training and equipment[64]. In contrast, rural and frontier counties rely heavily on volunteer EMS personnel[65], with some counties reporting over 70% of their EMS workforce as volunteers[66]. These volunteers often juggle EMS duties with full-time jobs, leading to limited availability and longer response times. This reliance on a volunteer workforce presents challenges in maintaining consistent service levels, especially during nights, weekends, or severe weather. In extreme emergencies, air ambulance services are used to overcome geographic barriers; however, flight times from remote areas to urban trauma centers can range from 30 to 90 minutes[67]. **The RHTP will improve EMS organizations' performance and response times in rural and frontier locations by training and certifying workers, expanding care capabilities, cross-training, developing sustainable solutions for paid staff, and connecting technology platforms for better communication among providers.**

Rural Hospital Financial Health

Sixty percent (60%) of Colorado's rural hospitals are operating with negative margins which average -1.27%[68], while 66% of Colorado's CAHs are operating with negative margins[69]. This is largely due to the payer mix: rural patients are more likely to be

uninsured, low income, and older, and therefore covered by public payers like Medicaid and Medicare[70]. Rural hospitals comprise 23.8 percent of the total number of hospitals receiving Disproportionate Share Hospital (DSH) payments (full details on DSH payments can be found in the supporting documents). Further, uncompensated care represents 3.83% of operating expenses for rural hospitals compared with 3.08% of urban hospitals and 3.19% for all hospitals in Colorado. In total, rural hospitals account for 16.6% of all uncompensated care[70b].

Colorado CAHs have seen a decrease in inpatient discharges and an increase in inpatient days[71] over the past five years, reflecting increased patient acuity, often because of postponed care due to cost and access challenges. CAHs are caring for patients who are more acutely ill, navigating workforce shortages,, and struggling with legacy infrastructure, systems, and technologies that impede capabilities and increase administrative costs. Additionally, Colorado CAHs have seen a 70.7% increase in outpatient visits since 2020[72], which drives lower reimbursements, further impacting the hospital's bottom line. **Colorado's RHTP provides multifaceted solutions to improve rural hospital sustainability, including: regional network development, infrastructure modernizations, and incentive programs that promote recruitment and retention of health care workers.**

Solution: The Rural Health Transformation Plan

Goals and Strategies

Colorado has organized its RHTP using the five strategic goals proposed by CMS for a total proposed investment of $1 billion over five years, scalable if additional RHTP resources become available.

Goals, Initiatives, and Outputs		
Goal	**Initiative**	**Primary Permissible Use of Funds and Activities**
Make Rural America Healthy Again *$229,950,000*	1 - Transforming rural care: Hospitals and Chronic Disease Prevention	A. Prevention & Chronic Disease: Chronic disease prevention, screenings, data tracking, community-based outreach.
	2 - Build Data and Evaluation Infrastructure for Chronic Disease Programs: Diabetes, Cardiovascular Disease, Hypertension, and Obesity	
Sustainable Access *$106,100,000*	3 - Build and Connect Colorado's Rural Health Networks	K. Access & Hospital Stabilization: EMS network support, hospital grants, regulatory readiness, rural referral networks.
	4 - Strengthen Rural Care Delivery Systems	
	5 - Sustain Rural Hospital Operations and Regulatory Readiness	
Workforce Development *$178,450,000*	6 - Strengthen and Expand the Rural Health Workforce	E. Workforce Development: Credentialing, Health Worker development programs, clinical training, recruitment, and retention.
	7 - Expand Clinical Capacity to Perform Preventive Care	
	8 - Strengthening State and Local Health Care Coordination	

Goals, Initiatives, and Outputs		
Innovative Care *$230,000,000*	9 - Design and Pilot Rural Value-based Care Model(s)	I. Innovation & Value-Based Care: Design, contract, and evaluate Alternative Payment Methodologies (APMs); shared savings and bundled-payment pilots.
Tech Innovation *$255,500,000*	10 - Expand Rural Telehealth & Technology Integration	C. Technology & Telehealth: Telehealth hardware grants, Health Information Exchange (HIE) integration, cybersecurity training, data dashboards.

Improving Access

To overcome geographic and facility gaps, Colorado will strengthen rural access through **Initiatives 3, 4, 5, and 10**.

- *Build and Connect Colorado's Rural Health Networks (Initiative 3)* will establish regional provider partnerships, networks, and shared service lines that reduce duplication, improve efficiencies, and maintain essential services.
- *Strengthen Rural Care Delivery Systems (Initiative 4)* will expand EMS coverage, coordinate emergency transport, and improve care integration between hospitals, clinics, and behavioral health providers.
- *Sustain Rural Hospital Operations (Initiative 5)* will launch a program for hospitals to modernize operations, ensure regulatory readiness, and transform maternal, emergency, and behavioral health services.

- *Expand Rural Telehealth and Technology Integration (Initiative 10)* will equip rural facilities with telehealth infrastructure (remote patient care), mobile health and monitoring tools, and cybersecurity training to extend specialty and preventive care to remote areas.

Expected Outcome: By FFY2031, Colorado will expand the number of rural hospitals with telehealth capability reaching 95%.

Improving Outcomes

Colorado will improve population health outcomes through **Initiatives 1 and 2**, targeting chronic disease, nutrition, and prevention.

- *Transforming Rural Care: Hospitals and Chronic Disease Prevention (Initiative 1)* expands evidence-based prevention and wellness programs, such as food-as-medicine interventions, growing and cooking food and nutrition programs and local care coordination.
- *Build Data and Evaluation Infrastructure (Initiative 2)* creates integrated dashboards linking Medicaid, data aggregated through Colorado's Rural Connectivity Program, and public health data to measure disease control, program reach, and return on investment.

Expected Outcome: By FFY2031, increase participation in evidence-based prevention programs by 30%.

Technology Use

RHTP will leverage emerging technologies through **Initiative 10** to enhance prevention and care management.

- Deploy remote patient monitoring and mobile health tools and units.
- Integrate COSHIE (Colorado Social Health Information Exchange) advanced technology into rural clinics to enable providers to connect patients to programs such as diabetes management, prenatal program, and local community programs to improve health outcomes and whole-person care.
- Telehealth enabled services can include: digital communication, video calls, and secure messaging capabilities to provide health care remotely.
- Provide cybersecurity and interoperability training to rural facilities.

Expected Outcome: To improve rural health care access, By FFY2031, we will reduce the percentage of rural residents that do not have access to telehealth-enabled services by 50%.

Partnerships

Colorado will expand regional and statewide partnerships through **Initiatives 3 and 8**.

- *Build and Connect Colorado's Rural Health Networks (Initiative 3)* will fund rural regional health alliances and rural cross-system governance structures to share data, staffing, and purchasing power.

- *Strengthening State and Local Health Coordination (Initiative 8)* will establish interagency leadership teams linking HCPF, CDPHE, and rural partners to align prevention and workforce efforts.

Expected Outcome: By FFY2031, Colorado will expand the number of formalized regional partnership agreements from 2 to 12 statewide, increasing efficiency through shared service arrangements and coordination amongst providers.

Workforce

Addressing rural workforce shortages is central to sustainability. Through **Initiatives 6, 7, and 8**, Colorado will:

- *Locally recruit, credential, and cross-train Health Workers (Initiative 6) to support* local capacity.
- *Expand Clinical Capacity to Perform Preventive Care (Initiative 7)* by training rural clinicians in advanced preventive procedures such as colorectal and hypertension screenings.
- *Strengthen interagency coordination (Initiative 8)* to streamline and align recruitment, credentialing, and continuing medical education (CME).

Expected Outcome: To improve rural health care access, by FFY2031, rural providers as a whole will offer 7% more services that drive better health outcomes.

Data-Driven Solutions

Through **Initiative 2**, Colorado will create a statewide data and evaluation infrastructure integrating Medicaid claims, public health surveillance, and provider data. This will allow for real-time quality monitoring, transparent reporting, and performance-based improvement across rural communities.

Expected Outcome: 85% of rural hospitals and eligible providers will have access to standardized dashboards to monitor chronic disease outcomes and track referrals to community-based programs

Financial Solvency Strategies

Colorado's financial solvency plan transforms rural health care through a sustainable and resilient rural health system; not just short-term balance, but long-term stability and adaptability. Colorado will help rural providers strengthen financial health through five coordinated strategies:

1. Strengthen Financial Resilience: Utilize existing financial data to identify at-risk facilities and target support by assisting rural hospitals streamlining their workflows, optimizing operations and aligning licensure to reduce costs and to better meet community care needs.
2. Diversify and Stabilize Revenue: Diversify revenue streams by expanding participation in value-based and preventive care programs such as Diabetes Self-Management Education Support (DSMES), Diabetes Prevention Program

(DPP), Family Health Weight Program (FHW), self-managed blood pressure (SMBP) and deploying strategies to reduce inappropriate denials.

3. Right-Size and Regionalize Services: The State will map all rural providers to assess capacity, service mix, and referral patterns, then classify each as a hub, spoke, or telehealth node. This will guide the determination of which services are sustainable locally and which are best provided regionally or through telehealth.
4. Modernize Policy and Operations: Colorado is leading the way in terms of policy change to support the rural health systems and will continue to identify and implement policy as needed. Hospitals will receive technical assistance to improve operations and appropriately and responsibly strengthen revenue cycle performance.
5. Continuous Monitoring and Improvement: Colorado will develop a dashboard to track outcomes, identify improvement opportunities, and measure impact using program reported data, and leverage existing data sources, such as the Rural Financial Performance Dashboard, which details key indicators such as Reserves and Payer Mix indicators, to guide the development of the dashboard.

Expected Outcome: By FFY2031, rural hospitals will diversify revenue and strengthen operational capacity, resulting in a more stable, resilient rural health ecosystem.

Cause Identification

Independent rural hospitals are at risk due to low patient volumes, payer mix challenges, legacy infrastructure, and workforce shortages. Colorado's Rural Health Transformation Program addresses these causes by:

- Expanding or creating partnerships and regional networks, including Clinically Integrated Networks, to mitigate low-volume risk.
- Increasing data transparency.
- Establishing centers of excellence and stronger regional collaboration.
- Supporting payment reform to stabilize reimbursement and reduce uncompensated care.

Strategic Goals Alignment

Each initiative collectively advances the five CMS Rural Health Transformation goals:

- **Make America Healthy Again**: Enhancing prevention and care quality via evidence-based chronic disease management.
- **Sustainable Access**: Improving rural access through partnerships and telehealth.
- **Workforce development**: Expanding workforce capacity through interagency and localized academic partnerships.
- **Innovative care**: Ensuring sustainability via payment reform and data-driven planning.

- **Tech innovation**: Driving efficiency and innovation through technology-enabled care.

Together, these efforts create a unified, data-driven, and sustainable model for rural health transformation so every Coloradan has access to high-quality, affordable care.

Legislative or Regulatory Action

Colorado is leading the way in legislative and regulatory action to support rural providers and does not have a Certificate of Need[75] program, and will maintain this rural status. A few of Colorado's existing policies include:

Policies and Programs	Description
Hospital Transformation Program (HTP)	Improves the quality of hospital care provided to Health First Colorado (Colorado's Medicaid program) members by tying provider fee-funded hospital payments to quality-based initiatives. Key activities and quality measures for HTP are consistent statewide yet flexible enough to allow hospitals to collaborate on the most effective interventions and approaches.
Rural Support Program	Provides complementary funding to the HTP to prepare critical access and rural hospitals for future value-based payment environments.
Remote Patient Monitoring Program	Enables rural Coloradans to benefit from telehealth remote monitoring services. Access to these services results in better health outcomes while saving money, time, and energy spent on obtaining health care.
Supplemental Nutrition Assistance Program (SNAP)	Waiver to restrict the purchase of "soft drinks" with SNAP dollars, as approved by the USDA in August 2025 and is active in Spring 2026. More information can be found within the USDA approval letter.
Accountable Care Collaborative (ACC)	Primary delivery system for Health First Colorado. ACC Regional Accountable Entities (RAEs) are responsible for

	promoting member health and wellbeing by administering the capitated behavioral health benefit, establishing and supporting networks of providers, and coordinating medical and community-based services for members. As part of their role in supporting providers across the state, RAEs provide Accountable Care Organization (ACO)-like primary care infrastructure support for independent rural primary care providers and Rural Health Clinics.
Rural Connectivity and Access to Virtual Care	100% of rural safety net providers are now connected to state Health Information Exchange (HIE), with annual incentive payments to help them stay connected.
Improving Rural Access and Affordability	Resources and supports designed specifically to increase rural access and affordability.
Public Hospital Collaboration Agreements	Enables rural hospitals to collaborate/cooperate without merging or violating anti-competitive federal or state laws.
Continuing Medical Education (CME) Requirements	Colorado statute requires the state to set standards for physician CME; rule proposal envisions nutrition as a CME topic.
Short Term Limited Duration Insurance:	STLDI policies are required to provide coverage of the applicable benefits pursuant to Colorado law[77], and allows for an initial contract term of up to six months with a maximum total coverage period of 12 months. § 10-16-104, C.R.S. and § 10-16-102(22)(b), C.R.S.

Colorado will pursue additional state legislation as needs are identified pertaining to our goals for transformation and sustainability. Examples of types of legislation that might be pursued to optimize grant efficacy are:

- Updating Medicaid payment methodologies to support rural Alternative Payment Methodologies (APMs) and Health Worker billing

- Establishing telehealth parity standards across Medicaid and private payers.
- More interstate licensure reciprocity
- Further expanding scope of care.

Proposed Initiatives and Uses of Funds

Colorado has selected 10 initiatives for its Rural Health Transformation Program, as summarized in the table below. Each initiative is described in detail in the pages that follow.

Goals, Initiatives, and Initiative-Based Technical Score Factor		
Goal	**Initiative**	**Associated Initiative-Based Technical Score Factors**
Make Rural America Healthy Again	1 - Transforming Rural Care: Hospitals and Chronic Disease Prevention	B.1 Population health clinical infrastructure B.2 Health and lifestyle B.3 SNAP waivers B.4 Nutrition continuing medical education C.1 Rural provider strategic partnerships D.1 Talent recruitment E.1 Medicaid provider payment incentives E.2 Individuals dually eligible for Medicare and Medicaid F.1 Remote care services F.2 Data infrastructure F.3 Consumer-facing tech
	2 - Build Data and Evaluation Infrastructure for Chronic Disease Programs: Diabetes, Cardiovascular Disease, Hypertension, & Obesity	
Sustainable Access	3 - Build and Connect Colorado's Rural Health Networks	B.1 Population health clinical infrastructure C.1 Rural provider strategic partnerships C.2 EMS E.1 Medicaid provider payment incentives F.1 Remote care services
	4 - Strengthen Rural Care Delivery Systems	

Goals, Initiatives, and Initiative-Based Technical Score Factor		
	5 - Sustain Rural Hospital Operations and Regulatory Readiness	F.2 Data infrastructure F.3 Consumer-facing tech
Workforce Development	6 - Strengthen and Expand the Rural Health Workforce	B.1: Population health clinical infrastructure B.2 Health and lifestyle B.4 Nutrition continuing medical education C.1 Rural provider strategic partnerships D.1 Talent recruitment
	7 - Expand Clinical Capacity to Perform Preventive Care	
	8 - Strengthening State and Local Health Care Coordination	
Innovative Care	9 - Design and Pilot Rural Value-based Care Model(s)	B.1 Population health clinical infrastructure C.1 Rural provider strategic partnerships E.1 Medicaid provider payment incentives F.2 Data infrastructure
Tech Innovation	10 - Expand Rural Telehealth & Technology Integration	B.1 Population health clinical infrastructure B.2 Health and lifestyle C.1 Rural provider strategic partnerships E.1 Medicaid provider payment incentives F.1 Remote care services F.2 Data infrastructure F.3 Consumer-facing tech

Initiative 1: Transforming Rural Care: Hospitals and Chronic Disease Prevention

Description: This initiative will focus on providing educational, disease prevention, and care coordination services for cardiovascular disease, hypertension, obesity, and other high priority chronic conditions. Through targeted technical assistance, this initiative will support rural hospitals and will equip rural providers, local public health agencies, and

community organizations with the training, tools (e.g., consumer-facing technology solutions), and infrastructure needed to deliver high-quality prevention and chronic disease management services.

Chronic diseases such as cardiovascular disease, hypertension, and obesity account for a large proportion of the nation's health care burden. Approximately 90 percent of the nation's $4.3 trillion[75a] in annual health care expenditures are driven by individuals with chronic and mental health conditions. Further, evidence from various studies across different conditions and target populations indicate the opportunity to reduce chronic-disease based hospitalizations by 20% to 40%[75b]. Strengthening prevention and management efforts for these high-priority conditions could significantly reduce hospitalizations, emergency visits, and premature death by ultimately easing the strain on rural health systems and improving population wellbeing.

Funding for this initiative will enable hospitals and rural providers to hire and train staff dedicated to improving care coordination and integrating behavioral health and preventive care into rural delivery systems. These funds will not replace reimbursable services, and will instead be used for training and technical assistance. The funding will also expand chronic disease prevention and management programs (e.g., food as medicine, diabetes prevention, and many others), while also building rural training networks and funding regional collaborations and clinically integrated networks that strengthen shared services, staffing, and sustainability.

Colorado will use the funding to support efforts like:

- Implementation of pilot rural value based care models. For example, the CARPE DIEM model: a transformation framework emphasizing access, community, resilience, prevention, and efficiency in care delivery through improved care integration and emergency management.
- Coordinate a statewide rural-training network to support the training of health professionals and the implementation of prevention programs (such as, but not limited to, diabetes prevention, diabetes self-management education and support, self-measured blood pressure, family healthy weight, and nutrition or food as medicine).
- Fund regional collaborations that strengthen shared services, staffing, and sustainability for wellness and prevention programs.
- Support care coordination, including behavioral health and nutrition, and referral systems that link clinical providers with community-based prevention programs and social support resources.
- Colorado will continue to explore ways that SNAP waivers in addition to those already granted (to prevent SNAP from being used to purchase soda) and applied for (making it easier to use SNAP benefits at farmers markets and to purchase some prepared foods) as well as nutrition incentive programs can help rural Medicaid patients access healthy foods, nutrition counseling, and food as medicine as preventive health measures. Colorado will leverage existing efforts and build new supports and initiatives as identified.

Together, these efforts will transform the rural care system, equipping rural providers to develop the skills and partnerships needed, along with the data to identify at-risk patients, manage chronic diseases locally, and reduce avoidable hospitalizations.

Main Strategic Goal: Make Rural America Healthy Again

Use of Funds: A: Prevention and chronic disease, C: Consumer tech solutions, D: Training and technical assistance, E: Workforce, F: IT advances, G: Appropriate care delivery, H: Behavioral health, I: Innovative care, K: Fostering collaboration.

Technical Score Factors: B.1 Population health clinical infrastructure, B.2 Health and lifestyle, B.3 SNAP waivers, B.4 Nutrition continuing medical education, C.1 Rural provider strategic partnerships, D.1 Talent recruitment, D.3 Scope of practice, E.1 Medicaid provider payment incentives, E.2 Individuals dually eligible for Medicare and Medicaid, F.1 Remote care services, F.2 Data infrastructure, F.3 Consumer-facing tech.

Key Stakeholders: Rural and critical access hospitals, rural health clinics and providers (including behavioral health providers), FQHCs, community-based organizations, COSHIE hubs, regional health alliances, Colorado Department of Human Services (CDHS) for SNAP coordination, workforce development partners, and organizations offering training and technical assistance.

Measurable Outcomes

- Number of rural/frontier-based chronic disease programs (SMBP, DPP, DSMES, FHW, etc.) seeded or supported.

- Number of people served through rural/frontier chronic disease programs.
- Number of clinics referring to chronic disease prevention and/or management programs.
- Number of clinics implementing evidence-based policies for chronic disease management.
- Number of facilities in ACO-like collaborative networks.

Impacted Counties: All rural counties in Colorado.

Estimated Required Funding: $230 - $250 Million over five years.

Initiative 2: Build Data and Evaluation Infrastructure for Chronic Disease Programs

Description: This initiative will strengthen data systems, performance monitoring, and evaluation to ensure chronic disease prevention and management programs are effective and sustainable. It will create a unified approach for collecting and analyzing data across programs and regions, enabling real-time feedback and continuous improvement. Potential uses of funding to support activities include:

- Designing and managing chronic disease dashboards to integrate Medicaid, public health, and program data.
- Aligning Community Resource Inventories (CRI) and digital referral infrastructure for rural COSHIE hubs to enable bidirectional information sharing between clinics and community partners.

- Providing technical assistance to ensure data interoperability, quality reporting, and alignment with state and federal data standards.
- Implementing a performance monitoring and evaluation framework to track reach, outcomes, and return on investment for rural prevention programs.

Main Strategic Goal: Make Rural America Healthy

Use of Funds: A: Prevention and chronic disease, C: Consumer tech solutions, D: Training and technical assistance, F: IT advances.

Technical Score Factors: B.1 Population health clinical infrastructure, F.2 Data infrastructure, F.3 Consumer-facing tech.

Key Stakeholders: Rural hospitals, rural health clinics and providers (including behavioral health providers), rural FQHCs, community-based organizations, COSHIE hubs, regional health alliances, and organizations offering training and technical assistance.

Measurable Outcomes:

- Number of people served through rural/frontier chronic disease programs.
- Number of rural programs engaging in COSHIE/HIE data sharing.
- Percent of facilities exchanging data via COSHIE, CAP, or HIE.

Impacted Counties: 52 rural and frontier counties in Colorado.

Estimated Required Funding: $7 Million - $15 Million over five years.

Initiative 3: Build and Connect Colorado's Rural Health Networks

Description: This initiative will strengthen coordination, collaboration, and sustainability across Colorado's rural health system by building regional health networks and developing a centralized data tracking system. Together, these components will connect hospitals, clinics, local public health agencies, and community partners to improve access, quality, and long-term system resilience.

Colorado will support activities such as:

- Building regional health networks.
- Developing rural or regional health-data dashboards.
- Supporting Tribal participation in creating their own rural health networks.

Main Strategic Goal: Sustainable Access

Use of Funds: F: IT advances K: Fostering collaboration.

Technical Score Factors: C.1 Rural provider strategic partnerships, F.2 Data infrastructure.

Key Stakeholders: Rural hospitals, rural providers, rural behavioral health providers, tribal health organizations, rural health associations, Colorado State Office of Rural Health, HCPF.

Measurable Outcomes:

- Number of new hospital collaborative agreements or service line expansions.
- Number of regional collaborations established for care access

- Number of regional partnership agreements executed.
- Number of collaborative workforce initiatives launched.

Impacted Counties: Rural counties in Colorado.

Estimated Required Funding: $25 - $30 Million over five years.

Initiative 4: Strengthen Rural Care Delivery Systems

Description: This initiative will strengthen, modernize, and transform rural-care delivery systems across Colorado by improving EMS coverage, expanding care coordination, and supporting clinical integration among hospitals, clinics, and local health partners. Through targeted efforts and support, HCPF will enhance the capacity of rural providers to deliver timely, coordinated, and sustainable high-quality care in rural communities. The initiative may include activities such as:

- Improving rural EMS transport and developing new coverage models to sustain and/or expand rural health emergency capacity.
- Funding regional coordination of EMS services, supporting shared dispatch systems, workforce coordination, and partnerships between rural providers, hospitals, behavioral health providers, and others.
- Supporting collaborative care networks that integrate rural hospitals, rural health clinics, and behavioral health providers with shared electronic medical record systems, referral management, care coordination positions, and joint protocols for acute-care transitions.

Main Strategic Goal: Sustainable Access

Use of Funds: B: Provider payments, D: Training and technical assistance, E: Workforce, F: IT advances, G: Appropriate care availability, H: Behavioral health, K: Fostering collaboration.

Technical Score Factors: B.1 Population health clinical infrastructure, C.1 Rural provider strategic partnerships, C.2 EMS, E.1 Medicaid provider payment incentives, F.1 Remote care services, F.2 Data infrastructure.

Key Stakeholders: Rural hospitals, rural clinics and providers, rural behavioral health, rural FQHCs, tribal health partners, rural EMS agencies and service providers, rural health associations, and other impacted entities.

Measurable Outcomes:

- EMS response time improvements or expansion of EMS programs.
- Number of new hospital collaborative agreements or service line expansions.
- Number of regional collaborations established for care access.
- Number of regional partnership agreements executed.

Impacted Counties: Rural counties in Colorado.

Estimated Required Funding: $45 - $55 Million over five years.

Initiative 5: Sustain Rural Hospital Operations and Regulatory Readiness

Description: This initiative will ensure the long-term stability, operational capacity, and regulatory readiness of rural hospitals across Colorado through a program that supports

expansion or coordination of essential services, modernization of operations, and compliance with emerging regulatory and payment reforms, without duplicating reimbursable services or providing direct funding of clinical services. Colorado will provide direct financial support to rural hospitals facing financial, operational and workforce challenges. Funds will enable hospitals to:

- Procure technical assistance and targeted operational support to help rural hospitals realign or sustain essential services lines (such as primary care, emergency, maternal and child health, and behavioral health).
- Enhance administrative and compliance capacity, including regulatory readiness for value-based care participation.
- Invest in small-scale infrastructure improvements, technology upgrades, and equipment necessary to maintain quality standards.
- Support strategic planning and implementation, financial modeling, support leadership education, and governance improvements to strengthen long-term sustainability.

Main Strategic Goal: Sustainable Access

Use of Funds: B: Provider payments, D: Training and technical assistance, E: Workforce, F: IT Advances, G: Appropriate care availability, H: Behavioral health.

Technical Score Factors: B.1: Population health clinical infrastructure, E.1: Medicaid Provider payment incentives, F.2: Data infrastructure, F.3: Consumer-facing tech.

Key Stakeholders: Rural hospitals, rural behavioral health, rural clinics, rural health care associations, rural health systems, and other rural organizations.

Measurable Outcomes:

- Number of service line expansions (e.g., OB, BH, post-acute).
- Number of facilities in ACO-like collaborative networks.
- Number of facilities engaged in quality improvement under HTP.
- Number of new APMs or value-based care models launched.

Impacted Counties: 52 Rural and Frontier counties in Colorado.

Estimated Required Funding: $20 - $25 Million over five years.

Initiative 6: Strengthen and Expand the Rural Health Workforce

Description: This initiative will strengthen Colorado's rural health workforce by expanding access to credentialing and continuing education opportunities for health professionals and other health workers serving in identified Health Professional Shortage Areas (HPSAs). Funding will be used to attract, train (including cross-training), and retain local essential providers (e.g., physicians, nurses, pharmacists, behavioral health clinicians, Health Worker, technicians, and others) who are critical to improving chronic disease prevention and management and sustaining rural care delivery. The focus on a homegrown workforce will support long-term sustainability.

Colorado may fund activities such as:

- Credentialing and certifications, paying for training, assessments, and/or application fees for rural residents seeking to become health workers..
- Support technology and training implementation for health workers, pharmacists, and other professions.
- Provide continuing education opportunities for health workers, pharmacists, and other providers to enhance their knowledge of prevention and chronic disease management programs and supports (e.g., food as medicine).

Main Strategic Goal: Workforce Development

Use of Funds: A: Prevention and chronic disease, D: Training and technical assistance, E: Workforce, G: Appropriate care availability, H: Behavioral health, I: Innovative care, K: Fostering collaboration.

Technical Score Factors: B.1: Population health clinical infrastructure, B.2 Health and lifestyle, B.4 Nutrition continuing medical education, C.1 Rural provider strategic partnerships, D.1 Talent recruitment, D.3 Scope of practice.

Key Stakeholders: Rural hospitals and clinics, rural behavioral health providers, FQHCs, academic institutions, training organizations, workforce development organizations, professional health care associations, CHRs, and pharmacists, and other regional health-related associations

Measurable Outcomes:

- Number of specialty service encounters in rural areas.

- Number of health workers, such as pharmacists, trained on chronic disease interventions.
- Number of collaborative workforce initiatives launched.
- Percent of clinics using remote monitoring for chronic disease.

Impacted Counties: Rural counties with an emphasis on areas with HPSA designations.

Estimated Required Funding: $145 Million - $150 Million over five years.

Initiative 7: Expanding Clinical Capacity to Perform Preventive Care

Description: This initiative will expand clinical workforce capacity to deliver preventive services and procedures in rural and frontier communities. By equipping rural clinicians with advanced procedural skills, Colorado will help local rural providers meet preventive screening needs in their regions.This initiative may support:

- Training rural providers to expand skills in the area of chronic diseases.
- Support curriculum development in partnership with rural hospitals, academic institutions, and professional associations.
- Provide continuing education scholarships for rural clinicians and care team members to participate in accredited chronic disease, wellness, and preventive care training.

Main Strategic Goal: Workforce Development

Use of Funds: A: Prevention and chronic disease, E: Workforce, G: Appropriate care availability, K: Fostering collaboration

Technical Score Factors: B.1. Population and health clinical infrastructure, C.1 Rural provider strategic partnerships

Key Stakeholders: Rural hospitals, rural medical providers, family medicine residency programs, primary care and family medicine associations, rural academic institutions

Measurable Outcomes:

- Number of rural health professionals trained in chronic disease topics.
- Number of rural/frontier-based chronic disease programs (SMBP, DPP, DSMES, FHW, etc.) seeded or supported.
- Number of people served through rural/frontier chronic disease programs.
- Number of clinics implementing evidence-based policies for chronic disease management.

Impacted Counties: Rural counties in Colorado.

Estimated Required Funding: $2.5 - $3 Million over five years.

Initiative 8: Strengthening State and Local Health Coordination

Description: This initiative will enhance coordination, communication, and alignment between state, regional, and local health entities to ensure effective implementation of prevention and workforce programs in rural Colorado. HCPF will invest in leadership

staffing, technical assistance, and training to strengthen collaborative governance and ensure sustained rural health infrastructure. Potential activities include:

- Developing and implementing interagency coordination among state departments, public health agencies, community organizations, and rural health care partners.
- Formalize collaboration practices and report network-level outcomes.

Main Strategic Goal: Workforce Development

Use of Funds: A: Prevention and chronic disease, D: Training and technical assistance, E: Workforce, K: Fostering collaboration

Technical Score Factors: C.1 Rural provider strategic partnerships, D.1 Talent recruitment

Key Stakeholders: HCPF, CDPHE, State Office of Rural Health, rural hospitals, rural providers and clinics, rural health associations, and other relevant local and community-based organizations

Measurable Outcomes:

- Number of collaborative workforce initiatives launched.
- Number of new hospital collaborative agreements or service line expansions.
- Number of regional collaborations established for care access.
- Number of regional partnership agreements executed.

Impacted Counties: All 52 rural and frontier counties in Colorado.

Estimated Required Funding: $4.5 - $5 Million over five years.

Initiative 9: Design and Pilot Rural Value-Based Care Model(s)

Description: This initiative will research, design, pilot, and ultimately scale value-based care model(s) tailored for rural providers and hospitals. This initiative will assess the feasibility of shared savings, bundled payments, and other approaches that reward prevention, care coordination, and improved health outcomes. HCPF will collaborate with rural health clinics, hospitals, and Regional Accountable Entities (RAEs) to implement scalable, value-based frameworks that are aligned with Colorado's ACO and Clinically Integrated Networks (CIN). These efforts will support rural population health priorities and community health needs (CHNA) assessment action plans through an ACO-like infrastructure facilitated by HCPF under Phase III of the Accountable Care Collaborative, effective July 1, 2025.

Main Strategic Goal: Innovative care

Use of Funds: A: Prevention and chronic disease, D: Training and technical assistance, F: IT advances, H: Behavioral health, I: Innovative care, K: Fostering collaboration

Technical Score Factors: B.1 Population health clinical infrastructure, C.1 Rural provider strategic partnerships, E.1 Medicaid provider payment incentives, F.2 Data infrastructure.

Key Stakeholders: Rural hospitals, rural health clinics, behavioral health clinics, community-based organizations, and other approved rural health providers.

Measurable Outcomes:

- Number of new APMs or value-based care models launched.

- Number of facilities in ACO-like collaborative networks.
- Number of facilities engaged in quality improvement under the Hospital Transformation Program (HTP).
- Number of new rural payment arrangements or shared savings programs.

Impacted Counties: All Colorado rural counties participating in Medicaid.

Estimated Required Funding: $200 - $250 Million over five years.

Initiative 10: Expand Rural Telehealth and Technology Integration

Description: This initiative will strengthen and expand rural health system participation in the use of technology-enabled prevention, monitoring, and care delivery. Through telehealth (eConsults) and remote-patient monitoring, this initiative will equip rural providers and other agencies with the tools and technical support necessary to engage in data-driven, integrated care (clinically integrated networks). Funding may support projects such as:

- Conduct statewide technology readiness assessment.
- Support to local health organizations to expand mobile health programs across rural regions by allowing the scaling, staffing, and compensation of the workforce.
- Integrated dashboards and networks that maintain data tools to access rural population health data and program outcomes (e.g.Clinically Integrated Networks).

Main Strategic Goal: Tech innovation

Use of Funds: B: Provider payments, C: Consumer tech solutions, D: Training and technical assistance, F: IT advanced

Technical Score Factors: B.1 Population health clinical infrastructure, B.2 Health and lifestyle, C.1 Rural provider strategic partnerships, E.1 Medicaid provider payment incentives, F.1 Remote care services, F.2 Data infrastructure, F. 3 Consumer-facing tech

Key Stakeholders: Rural FQHCs, community-based organizations, rural health clinics, behavioral health providers, rural hospitals, local public health organizations, and other health-focused community organizations.

Measurable Outcomes:

- Percentage of rural patients with access to telehealth or virtual-enabled services.
- Percentage of rural facilities exchanging data via Community Analytics Platform (CAP) or Health Information Exchange (HIE).
- Percentage of facilities completing cybersecurity readiness training.
- Percentage of clinics using remote monitoring for chronic disease.
- Number of technology grants or regional platforms launched.

Impacted Counties: All rural counties, with priority given to those designated as having limited virtual infrastructure.

Estimated Required Funding: $250 - $275 Million over five years, with subgrants provided to rural providers and technology vendors.

Implementation Plan and Timeline

A detailed implementation plan for each goal and associated initiative, along with aligned milestones, is contained in the following tables.

Goal: Make Rural America Healthy Again **Related Initiatives:** 1 - Transforming Rural Care: Hospitals and Chronic Disease Prevention 2 - Build Data and Evaluation Infrastructure for Chronic Disease Programs	
Fiscal Year, Stage, & Activities	**Milestones & Measures of Progress**
FFY26 (Stage 0–1): Planning & early launch of rural chronic disease prevention programs; establish training network; select lead organizations; initiate vendor contract.	• Rural prevention network designed and vendors onboarded. • Initial training programs begin statewide.
FFY27 (Stage 2): Expand training and referral networks linking clinics to community programs; launch CAP dashboards; begin program participation tracking.	• # of rural/frontier programs seeded. • # of clinics referring patients to prevention and food as medicine programs.
FFY28 (Stage 3): Broaden participation and link CAP data with chronic disease metrics; visible outcomes emerge.	• Early CAP reporting of # of people served. • Percent of clinics using remote monitoring for chronic disease.
FFY29 (Stage 4): Full implementation of data-sharing and care coordination; refine SNAP/nutrition incentive programs.	• # of programs using COSHIE/HIE data exchange. • Midterm evaluation of referral and outcome data.
FFY30-31 (Stage 5): Formalization of prevention systems; statewide integration and outcome reporting.	• # of clinics implementing evidence-based policies for chronic care. • Chronic disease rates demonstrate improvement statewide.

Initiative 1 – Transforming Rural Care: Hospitals and Chronic Disease Prevention	
FFY26 (Stage 0)	• Design statewide prevention training network and select lead organizations.
FFY27 (Stage 1)	• Launch initial training cohorts; award regional prevention grants.
FFY28 (Stage 2)	• Implement referral systems linking clinics with community programs. • Support SNAP and nutrition incentive collaborations.
FFY29 (Stage 3)	• Mid-course evaluation; expand participation across additional counties.
FFY30 (Stage 4)	• Integrate prevention data with CAP dashboards; finalize network standards.
FFY31 (Stage 5)	• Fully functional statewide chronic disease prevention and coordination system.

Initiative 2 – Build Data and Evaluation Infrastructure for Chronic Disease Programs	
FFY26 (Stage 0-1)	• Contract data vendor; begin CAP dashboard design.
FFY27 (Stage 2)	• Launch pilot data systems; establish data-sharing agreements.
FFY28 (Stage 3)	• Expand dashboards statewide; implement performance monitoring framework.
FFY29 (Stage 4)	• Conduct comprehensive data validation; align with federal standards.
FFY30-31 (Stage 5)	• Routine data reporting and evaluation integration into HCPF operations.

Goal: Sustainable Access **Related Initiatives:** 3 - Build and Connect Colorado's Rural Health Networks 4 - Strengthen Rural Care Delivery Systems 5 - Sustain Rural Hospital Operations and Regulatory Readiness	
Fiscal Year, Stage, & Activities	**Milestones & Measures of Progress**
FFY26 (Stage 0–1): Conduct rural network survey; design EMS and hospital readiness programs.	• # of new hospital collaborative agreements signed. • Initial regional engagement sessions.
FFY27 (Stage 2): Launch pilot networks and grant programs; begin EMS coordination models; establish regional advisory boards.	• # of partnership agreements executed. • Service-line expansions planned (OB, BH, post-acute).
FFY 28 (Stage 3): Implement shared dispatch and coordination systems; connect rural partners via data dashboards.	• # of regional collaborations established. • EMS pilots operational and early response data collected.
FFY29 (Stage 4): Evaluate EMS performance; refine hospital collaboration frameworks.	• Measurable EMS response improvements. • Midterm hospital service expansion progress.
FFY30-31 (Stage 5): Fully connected rural health networks and modernized EMS systems; hospitals financially and operationally stable.	• # of sustained service-line expansions. • Operational readiness and regulatory compliance confirmed.

Initiative 3 – Build and Connect Colorado's Rural Health Networks	
FFY26 (Stage 0)	• Conduct statewide survey of existing networks.
FFY27 (Stage 1)	• Establish advisory boards; initiate data dashboard design.
FFY28 (Stage 2)	• Launch pilot regional networks and tracking systems.

FFY29 (Stage 3)	• Evaluate network performance; expand tribal and frontier participation.
FFY30 (Stage 4)	• Finalize network governance and sustainability models.
FFY31 (Stage 5)	• Fully connected statewide rural health network operating with shared data systems.

Initiative 4 – Strengthen Rural Care Delivery Systems	
FFY26 (Stage 0-1)	• Engage vendors for EMS and care coordination model design. • Award pilot regional coordination grants.
FFY27-28 (Stage 2)	• Implement EMS coverage pilots; expand shared dispatch systems.
FFY29 (Stage 3)	• Assess response time and coordination improvements; refine models.
FFY30 (Stage 4)	• Scale collaborative care networks statewide.
FFY31 (Stage 5)	• Fully integrated rural EMS and care coordination systems operational.

Initiative 5 – Sustain Rural Hospital Operations and Regulatory Readiness	
FFY26 (Stage 0)	• Develop funding program framework and eligibility criteria.
FFY27 (Stage 1)	• Launch first grant cycle; award to priority hospitals.
FFY28-29 (Stage 2-3)	• Support operational improvements, compliance upgrades, and service expansions.
FFY30 (Stage 4)	• Evaluate program outcomes; document regulatory readiness gains.
FFY31 (Stage 5)	• Ongoing sustainability reporting and integration with value-based payment initiatives.

Goal: Workforce Development **Related Initiatives:** 6 - Strengthen and Expand the Rural Health Workforce 7 - Expanding Clinical Capacity to Perform Preventive Care 8 - Strengthening State and Local Health Coordination	
Fiscal Year, Stage, & Activities	**Milestones & Measures of Progress**
FFY26 (Stage 0–1): Health worker workforce needs assessment; curriculum planning for rural training; establish interagency consortium.	• Workforce registry and governance structures developed. • # of services offered by rural providers baseline established. • Early coordination meetings initiated.
FFY27 (Stage 2): Launch health worker certification program and training for clinicians; begin first residency and CME cohorts.	• # of health workers credentialed. • # of medical providers and pharmacists trained.
FFY28-29 (Stage 3): Expand trainings statewide; implement continuing education; coordinate workforce alignment across agencies.	• # of health workers trained in chronic disease interventions. • Midterm evaluation of workforce participation.
FFY30 (Stage 4): Implement retention incentives and professional development supports; finalize sustainability plan.	• # of services offered by rural providers that drive better health outcomes. • Workforce proportionality index shows an upward trend.
FFY31 (Stage 5): Fully integrated and sustainable rural workforce ecosystem operational across all rural regions.	• # of collaborative workforce initiatives institutionalized. • Long-term retention and career progression documented.

Initiative 6 – Strengthen and Expand the Rural Health Workforce	
FFY26 (Stage 0)	• Conduct health worker workforce and services needs assessment.
FFY27 (Stage 1)	• Launch health worker certification support program; begin training cohorts.

FFY28-29 (Stage 2-3)	• Expand training statewide; establish continuing education offerings. • Implement tech and reporting tools.
FFY30 (Stage 4)	• Evaluate workforce retention and regional coverage.
FFY31 (Stage 5)	• Sustain health worker programs through ongoing funding and integration with rural providers.

Initiative 7 – Expanding Clinical Capacity to Perform Preventive Care	
FFY26 (Stage 0-1)	• Develop curriculum with academic partners; identify training hubs.
FFY27 (Stage 2)	• Begin first training cohort of rural providers.
FFY28-29 (Stage 3)	• Expand trainings to additional regions; assess preventive service rates.
FFY30 (Stage 4)	• Integrate training into continuing medical education for rural providers.
FFY31 (Stage 5)	• Training and credentialing programs to be fully operational statewide.

Initiative 8 – Strengthening State and Local Health Coordination	
FFY26 (Stage 0)	• Develop interagency coordination framework; define governance structure.
FFY27 (Stage 1)	• Assign staff and technical assistance teams; initiate coordination meetings.
FFY28 (Stage 2)	• Implement cross-agency data sharing and workforce initiatives.
FFY29 (Stage 3)	• Evaluate collaboration effectiveness; refine governance processes.
FFY30-31 (Stage 4-5)	• Formalize collaboration practices and report system-level outcomes.

Goal: Innovative Care **Related Initiatives:** 9 - Design and Pilot Rural Value-Based Care Model(s)	
Stage & Activities	**Milestones & Measures of Progress**
FFY26 (Stage 0): Vendor engagement for VBC design; develop CARPE DIEM training content; select pilot hospitals.	• # of facilities engaged in HTP baseline reporting.
FFY27 (Stage 1–2): Launch pilot APM design; implement early hospital transformation activities.	• # of new APM/value-based models initiated. • Hospitals begin workflow redesign.
FFY28-29 (Stage 3): Expand pilots; evaluate ROI and QI progress; foster ACO-like networks.	• # of facilities in ACO-style collaboratives. • # of new rural payment arrangements executed.
FFY30 (Stage 4): Scale successful models statewide; refine training and hospital metrics.	• HTP improvement measures achieved by most participants.
FFY31 (Stage 5): Full implementation of value-based and transformed hospital systems; sustained performance monitoring.	• Statewide reporting of financial and quality outcomes.

Initiative 9 – Design and Pilot Rural Value-Based Care Models	
FFY26 (Stage 0)	• Engage design vendor; complete environmental scan of rural payment models.
FFY27 (Stage 1)	• Draft value-based care frameworks; recruit pilot sites. • Identify eligible hospitals; develop CARPE DIEM training modules. • Award initial transformation grants.

FFY28 (Stage 2)	• Begin pilot implementation with selected hospitals and clinics. • Hire transformation staff; begin workflow redesign. • Integrate behavioral health and emergency management plans.
FFY29 (Stage 3)	• Evaluate financial and quality performance; refine model parameters. • Midpoint progress—half of participating hospitals achieving performance metrics. • Conduct peer learning sessions.
FFY30 (Stage 4)	• Prepare scale-up strategy; finalize contracts for broader adoption. • Finalize deliverables; assess hospital financial and quality indicators.
FFY31 (Stage 5)	• Fully operational value-based care model producing savings and quality data statewide. • Report measurable outcomes and sustainability plans; CARPE DIEM model institutionalized.

Goal: Tech Innovation
Related Initiatives:
10 - Expand Rural Telehealth and Technology Integration

Stage & Activities	Milestones & Measures of Progress
FFY26 (Stage 0–1): Develop project plan; select vendors; award pilot telehealth and technology grants.	• % of rural patients with telehealth access baseline established. • # of technology grants awarded.
FFY27 (Stage 2): Launch CAP dashboards; begin provider onboarding and cybersecurity training.	• % of facilities completing cybersecurity readiness. • # of facilities using CAP/HIE data exchange.
FFY28-29 (Stage 3): Expand mobile health; refine digital capability and platform integration.	• % of clinics using RPM for chronic care. • # of digital platforms launched statewide.

FFY30 (Stage 4): Integrate systems and finalize data interoperability with HIE.	• Statewide telehealth utilization metrics published.
FFY31 (Stage 5): Fully implemented telehealth ecosystem with measurable outcomes.	• Continuous CAP-based reporting and evaluation of telehealth use.

Initiative 10 – Expand Rural Telehealth and Technology Integration	
FFY26 (Stage 0–1)	• Develop project plan; identify vendor(s) for telehealth equipment and CAP dashboard design. • Conduct statewide technology readiness assessment. • Begin issuing pilot grants to a limited number of rural providers.
FFY27 (Stage 2)	• Expand grant availability statewide. • Launch initial CAP data dashboards and begin provider onboarding. • Initiate mobile health program expansion in two rural regions.
FFY28 (Stage 3)	• Midpoint evaluation of telehealth usage and capability metrics. • Refine grant criteria and adjust funding allocations. • Continue scaling mobile health services
FFY29 (Stage 4)	• Integrate CAP dashboards with HIE; finalize technology vendor support. • Document measurable increases in telehealth access and remote monitoring use.
FFY30–FFY31 (Stage 5)	• Achieve full statewide implementation and reporting. • CAP dashboards in routine use; measurable outcomes reported publicly.

Governance and Project Management Structure

HCPF serves as the lead agency for the Rural Health Transformation Program (RHTP).

The program will operate within HCPF's Special Financing Division, with strong

collaboration across HCPF's Finance Office divisions, including accounting, procurement, budgeting, rates, value based payment (VBP) sections, and more. HCPF expects to hire 18 new FTE to manage the grant and provide oversight and optimization of fund use, with all hires expected to be complete in the first half of calendar year 2026. Our overall administrative budget will not exceed 2.98% of the overall 10% allowable funds. A complete list of staff and their roles is included in the supporting documents. Together, these roles ensure effective coordination across funding, contracting, and implementation activities.

Advisory Committees and Workgroups

HCPF will work closely with stakeholders to develop robust and clearly-defined decision-making structures and communication channels, including the following groups:

- Rural Health Transformation Advisory Committee: Includes representatives from HCPF, CDPHE, rural hospitals, behavioral health providers, local public health agencies (LPHAs), RHC, hospital association, and community-based organizations. Meets monthly to review progress, guide policy alignment, and advise on priorities. Oversees the development of the RFP process to distribute funding across rural Colorado.
- Technical Advisory Workgroups: Formed as needed around topics such as telehealth, workforce development, and hospital sustainability. These groups include rural provider representatives, subject matter experts, and state staff.

- Tribal Consultation Forum: Facilitated by the Tribal Liaison, ensuring continuous engagement and alignment with Tribal priorities.
- Bi-weekly internal RHTP team meetings across divisions (Special Financing, Finance, HIO, HPO, OeHi, CDPHE).
- Monthly cross-agency coordination meetings with CDPHE and other partners.
- Quarterly stakeholder updates and progress dashboards shared publicly.

Decision-making will follow a tiered approach:

1. Program-level operational decisions made by RHTP Supervisor.
2. Strategic decisions escalated to the RHTP Lead and Advisory Committee with advice and recommendations from technical advisory workgroups and Tribal consultation forum, as relevant.
3. Fiscal and contract approvals coordinated with the Finance Division.

External Contractors

To enhance implementation capacity, HCPF will contract with external consultants to support key activities:

- Stakeholder/Advisory Committee Engagement: The contractor will form and run regularly occurring meetings for the Rural Hospital Transformation Stakeholder Advisory Committee.

- Research and Analysis: The RHT consultant to perform research and analysis to manage long-term financial solvency and identify causes driving rural hospitals to be at risk of closure, conversion, or service reduction.
- eHealth Innovation Analysis: The eHealth Innovation Analysis contractor will be used to track metrics and make enhancements to the eHealth platform.
- Grant Financial Vendor: The Grant Financial Vendor will help establish the proposed grantees. The vendor will solicit grantees, establish agreements, pay invoices, track payments, and perform other grant management duties.
- Rural Provider Administrative Support: Rural hospitals and rural health centers will need technical and administrative support to manage funds. CRHC has the expertise and would be the best entity to support the providers.

Stakeholder Engagement

The stakeholder engagement framework is designed to keep rural health subject matter experts, provider representatives, and other key stakeholders meaningfully involved throughout the program's lifecycle.This framework follows a structured, multi-phase approach emphasizing collaboration, transparency, and feedback loops with HCPF.

Planning and needs assessment stakeholder meetings were conducted in this calendar year on July 23, August 1, September 23,and October 2. Outcomes from these sessions directly informed this application.

Beginning in late 2025, an Advisory Committee will convene as a consultative body of rural health subject matter experts supporting Colorado's RHTP. After the RHTP application has been submitted, the Advisory Committee will convene to support implementation and management of the program. The meetings will ensure inclusive, well-structured discussions on rural health challenges, funding distribution, program design, and review of Request for Application (RFA) materials. Colorado will also conduct joint program evaluations and integrate stakeholder recommendations into program modifications.Moving forward, the State of Colorado will continue to obtain stakeholder input by:

- Convening an Advisory Committee representing rural providers, community leaders, and tribal partners.
- Hosting community listening sessions and public forums.
- Incorporating feedback into policy, payment, and regulatory decisions.
- Maintaining a dedicated webpage and weekly newsletters that provide updates.
- Monitoring a dedicated inbox for submission of comments, suggestions, and questions.

Metrics and Evaluation Plan

Colorado is committed to a robust performance metric and evaluation plan to ensure meaningful progress toward rural health transformation goals. Accordingly, metrics have been designed with implementation across several key measurable categories,

including: access, quality and health outcomes, financial and workforce metrics, and technology use. Detailed metrics, timing, and program evaluation is critical to achieve intended impact. Thus, Colorado will work internally across divisions to ensure utilization of all relevant, existing data, as well as partner with an evaluation vendor to design a robust monitoring and evaluation plan. The vendor will design a reporting system for maximizing existing data, collection of necessary new data, and a cadence that allows HCPF to recognize improvement opportunities. Grantees will enter into a grant agreement with metrics compliance and reporting as part of the agreement. HCPF will work with vendors, stakeholders, and other key partners to set performance goals to show outcomes and gather baseline data.

Metric	Timeline	Evaluation Milestone
Make Rural America Healthy Again		
Metric 1: Number of rural/frontier-based chronic disease programs (SMBP, DPP, DSMES, FHW, etc.) seeded or supported.	**FFY26–FFY28**	Training and program seeding statewide; early visible outcomes
Metric 2: Number of people served through rural/frontier chronic disease programs.	**FFY27–FFY31**	Participation tracking and CAP reporting; continuous growth
Metric 3: Number of clinics referring to chronic disease prevention and/or management programs.	**FFY27–FFY30**	Referral networks and Community Resource Inventories (CRI) development; midterm evaluation
Metric 4: Number of programs engaging in COSHIE/HIE data sharing.	**FFY27–FFY29**	Data-sharing expansion and technology support
Metric 5: Number of clinics implementing evidence-based	**FFY27–FFY31**	Policy adoption grants and TA; institutionalized by FFY31

Metric	Timeline	Evaluation Milestone
policies for chronic disease management.		
Sustainable Access		
Metric 1: Number of new hospital collaborative agreements or new service lines.	**FFY26–FFY28**	Early deliverable; initial agreements signed and tracked
Metric 2: Number of regional collaborations established for care access.	**FFY27–FFY30**	Launch regional advisory boards and funding pilots
Metric 3: Number of regional partnership agreements executed.	**FFY27–FFY29**	Legal and data MOUs executed; CAP reporting live
Metric 4: EMS response time improvements or expansion of EMS programs.	**FFY28–FFY31**	EMS pilots launched; measurable outcomes by FFY30
Metric 5: Number of service line expansions (OB, BH, post-acute).	**FFY27–FFY31**	Hospital service expansion; final reporting by FFY31
Workforce Development		
Metric 1: Number of health workers credentialed and practicing in rural/frontier areas.	**FFY26–FFY30**	Early-start workforce pipeline; registry operational
Metric 2: Number of pharmacists and health workers trained on chronic disease interventions.	**FFY27–FFY29**	Training cycles; midterm evaluation by FFY29
Metric 3: Number of medical providers trained and offering services for chronic disease topics.	**FFY27–FFY30**	Residency program integration; ongoing evaluation
Metric 4: Number of collaborative workforce initiatives launched.	**FFY26–FFY30**	Interagency consortium setup; sustainability plan FFY30
Innovative Care		
Metric 1: Number of new APM or value-based models launched.	**FFY27–FFY30**	APM design and rollout; ROI evaluation FFY29

Metric	Timeline	Evaluation Milestone
Metric 2: Number of facilities in ACO-like collaborative networks.	**FFY27–FFY30**	Launch pilots; scale-up by FFY30
Metric 3: Number of facilities engaged in quality improvement under HTP.	**FFY26–FFY31**	Continuous measure using HTP baseline
Metric 4: Number of new rural payment arrangements or shared savings programs.	**FFY27–FFY30**	Medicaid alignment and pilot testing
Tech Innovation		
Metric 1: Percent of rural patients with access to telehealth or virtual-enabled services.	**FFY26–FFY28**	Virtual accessibility programs and telehealth expansion; early metric
Metric 2: Percent of facilities exchanging data via CAP or HIE.	**FFY27–FFY30**	HIE interoperability; full statewide reporting FFY30
Metric 3: Percent of facilities completing cybersecurity readiness training.	**FFY27–FFY29**	Security audits and TA training completed
Metric 4: Percent of clinics using remote monitoring for chronic disease.	**FFY27–FFY31**	RPM adoption tracked in CAP; long-term metric
Metric 5: Number of technology grants or regional platforms launched.	**FFY26–FFY29**	CAP dashboard and digital tools; completion FFY29

Self-Perpetuating Sustainability Plan

Colorado's sustainability strategy for RHTP recognizes transformational change will become part of the state's ongoing health policy, payment, workforce and overall infrastructure rather than creating a dependency on temporary federal or grant funding.

Sustaining Health Network Expansions

The health network expansion models piloted under RHTP, which link hospitals, local public health agencies (LPHAs), primary care providers, and behavioral health organizations, will transition from grant-funded operations to self-sustaining collaboratives. These collaboratives will:

- Utilize shared service agreements, pooled administrative functions, and joint staffing models that reduce overhead costs and improve efficiencies.
- Partner with Medicaid Regional Accountable Entities (RAEs) to align population health management, Accountable Care Organization infrastructure resources, and data-sharing strategies.
- Leverage value-based payment (VBP) incentives under Medicaid, Medicare and commercial payers to sustain ACO infrastructure, related cost control and quality improvement resources, and network functions.

Maintaining Technology and Technology Integration

RHTP-supported investments in telehealth platforms, ACO infrastructure resources and tools, and shared data systems will be maintained through integration with the Office of eHealth Innovation, HCPF's Medicaid Accountable Care Collaborative innovation initiatives, and the Colorado Social Health Information Exchange (COSHIE). These technologies will also result in cost savings and better health outcomes, increased prevention and management of chronic disease.

Sustainability will be achieved through:

- Ongoing support from HCPF via Medicaid Accountable Care Collaborative existing RAE contracts that require the provision of ACO-like infrastructure to RHCs and independent rural PCPs. Partnerships among providers will support cost-sharing.
- Alignment with the state's Health IT Roadmap, ensuring that technology upgrades and maintenance are supported through existing interoperability and data-governance frameworks.

Workforce Development and Retention

Colorado will work closely with partners, including the CDPHE, the Colorado Rural Health Center (CRHC) and the Colorado Department of Higher Education to embed RHTP-supported workforce programs within a collective health workforce strategy. Key strategies include:

- Transitioning rural training and recruitment initiatives to ongoing funding streams, such as the State Loan Repayment Program (SLRP), HRSA grants, partnerships with higher education, and Care Forward programs.
- Investing in recruitment and retention opportunities identified through the Community Apgar Program, a nationally renowned, research-driven program designed to assess readiness for recruitment of providers. Expanding clinical and non-clinical career pathways through collaboration with community colleges and workforce job boards, e.g. CRHC job board.

- Aligning local rural workforce investments strategies that promote retention like those identified as part of the Colorado Provider Recruitment and Retention Program along with cost containment and access goals.

Innovative Payment Models

Colorado will use the RHTP funding to pilot and evaluate new models. Rural health centers will be able to leverage the Medicaid RAE supported ACO-like infrastructure to participate in these models, which will allow them to continue well past the grant period. In addition, robust evaluation will allow Colorado to develop the business case for continuation of the models. Examples of how these models may be sustained include:

- Expand and increase rural provider adoption of existing Alternative Payment Models (APMs) that reward value and outcomes, including shared savings, bundled payments, and per-member-per-month models for rural practices, ex. ACO attribution.
- Pilot and scale innovative payment models that have sustainable capabilities, such as stand by payments to rural hospitals, clinically integrated networks which share similar cost savings by allowing rural facilities to work together to negotiate contracts, participate in shared savings, and more.
- Independent PCPs and RHCs can leverage Medicaid RAE ACO-like infrastructure to establish or engage in Accountable Care Organizations (ACOs) to bear upside and downside risk.

- Use existing 1115 waiver opportunities like funding for health related social needs, child and prenatal care, and hospital transformation activities to sustain rural hospitals.
- Embed VBP requirements into RFPs and contracts with Medicaid RAEs, ensuring the continued alignment of incentives beyond the RHTP funding period.

Integration Into State Policy and Planning

Lessons from the RHTP will be incorporated into Colorado's long-term policy and planning frameworks:

- State Health Improvement Plan (SHIP): Rural health transformation goals and metrics will be embedded into the next SHIP cycle, coordinated through CDPHE and the Colorado Health Improvement Coalition.
- Public Health Modernization: Rural collaboration models will inform implementation of the Public Health Transformation Act (Senate Bill 21-154), ensuring integrated service delivery between state, regional, and local partners.
- Financing Transition: RHTP-supported payment models will help Colorado reduce reliance on Medicaid financing mechanisms being phased out federally, ensuring compliance and long-term fiscal health.

Colorado's sustainability strategy ensures that RHTP investments yield enduring benefits for all rural communities. Colorado will carry forward the program's vision of improved access, efficient systems, and resilient rural health infrastructure to improve sustainability well beyond FFY31

Endnotes Table

Endnote #	Indicator / Statistic	Source (Citation)
1	Colorado ranking as the 8th largest U.S. state by area	U.S. Census Bureau. 2020 Census Geographic Area Size and Rankings Tables. Washington, DC: U.S. Department of Commerce; 2021.
2	Estimated rural population (809,253 residents)	U.S. Census Bureau, American Community Survey (ACS) 5-Year Estimates (2024). Table B01003: Total Population; Colorado Rural Health Center (CRHC), Colorado Rural Health Snapshot 2025.
3	Percent of state land area classified as rural or frontier (82%)	U.S. Department of Agriculture (USDA), Economic Research Service, Frontier and Remote Area Codes, 2024 Update; Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy Rural Classification Data (2024).
4	Number of counties classified as rural or frontier (52 of 64). (12 urban, 28 rural, 24 frontier). 82% (81.76%) of Colorado's landmass is considered rural or frontier. 13.6% of the population (809,253 people) lives in rural Colorado. 2.2% of the population (130,538 people) lives in frontier counties, and 11.4% of the population (678,715 people) lives in rural counties	Federal Office of Rural Health Policy County and Census Tract (2023). U.S. Census Bureau, 2020 Census County Geographic Profiles.
5	Las Animas County geographic size comparison	U.S. Census Bureau, 2020 Census County Geographic Profiles (Area in Square Miles), Washington, DC: U.S. Department of Commerce; 2021.
6	Percentage of rural older adults using public transit (8%)	U.S. Department of Transportation, National Household Travel Survey (NHTS), Rural and Urban Transit Use by Age and Geography, 2023.
7	Percentage of rural older adults using public transit (8%)	U.S. Department of Transportation, National Household Travel Survey (NHTS), Rural and Urban Transit Use by Age and Geography, 2023.
8	Percentage of rural older adults using public transit (8%)	U.S. Department of Transportation, National Household Travel Survey (NHTS), Rural and Urban Transit Use by Age and Geography, 2023.
9	Regions located more than 25 minutes from nearest ambulance station	CDPHE, Emergency Medical Services NEMSIS v3.5 Data Repository (2023–2024).

Endnote #	Indicator / Statistic	Source (Citation)
10	Average rural EMS response time (40 minutes for basic response; >90 minutes total call time)	CDPHE, Emergency Medical Services NEMSIS v3.5 Data Repository (2023–2024).
11	12.70% of health care facilities are located in rural and frontier counties in Colorado (574 / 4520 = 12.70%)	CDPHE All Facilities list by Facility ID including: Assisted Living residence, Community Clinic, Home Care Agency, Home Health Agency, Hospital, Nursing Facilities, All other Fac Types. Federal Office of Rural Health Policy County and CensusTract (2023).
11b	23 frontier counties lacking access to specialty care	Health Resource and Services Administration. Area Health Resource Files, 2023. Annual Estimates of the Resident Population for Counties in Colorado: April 1, 2020 to July 1, 2023 (CO-EST2023-POP-08). Source: U.S. Census Bureau, Population Division. Release Date: March 2024.
12	Federally recognized tribes in Colorado (two)	U.S. Department of the Interior, Bureau of Indian Affairs (BIA). Federal Register List of Federally Recognized Tribes, 2024.
13	Presence of Urban Indian Health Program in Colorado	Indian Health Service (IHS). Directory of Urban Indian Organizations and Programs, 2024.
14	Southern Ute Indian Tribe headquartered in La Plata County	Southern Ute Indian Tribe. Official Tribal Government Website (https://www.southernute-nsn.gov); U.S. Census Bureau, County Geographic Profiles (2024).
15	Southern Ute clinics operating under Public Law 93-638 (Self-Determination and Education Assistance Act)	Indian Health Service (IHS). Self-Determination Contracts and Compacts Directory, FY 2024.
16	Ute Mountain Ute Tribe location in southwest Colorado	Ute Mountain Ute Tribe. Tribal Government Website (https://www.utemountainute.com); BIA Geographic Service Areas Map (2024).
17	Use of IHS clinic and associated tribal clinics for care	Indian Health Service (IHS). IHS Facility Locator and Service Directory, 2024.
18	Denver Indian Health and Family Services (DIHFS) designation as Urban Indian Health Program	Indian Health Service (IHS). Urban Indian Health Program Designation List, 2024.
19	Availability of DIHFS services across Colorado, including rural locations	Denver Indian Health and Family Services (DIHFS). Annual Service Area Report 2024.
20	Financial vulnerability of rural health facilities	Colorado Rural Health Center (CRHC). Colorado Rural Health Snapshot 2025. Denver, CO.
21	Rural hospital negative operating margins	Colorado Hospital Association. Hospital Financial Performance Report, FY 2024.
22	Higher proportion of residents age 65+ in rural Colorado (22% rural vs. 14% urban)	U.S. Census Bureau, American Community Survey (ACS) 5-Year Estimates (2024).

Endnote #	Indicator / Statistic	Source (Citation)
23	Higher uninsured rate in rural areas (8.4% vs. 6.2% urban)	U.S. Census Bureau, ACS Table S2701: Health Insurance Coverage Status, 2024.
24	Shortage of rural health care providers (32 PCPs per 100,000 rural vs. 68 urban)	Health Resources and Services Administration (HRSA). Area Health Resource File (AHRF), 2023.
25	Fewer insurance carriers available in rural regions	Colorado Division of Insurance (DOI). Health Insurance Market Report, 2024.
26	Higher average insurance premiums in rural counties	Colorado Division of Insurance (DOI). Health Coverage Affordability Dashboard, 2024.
27	Historic presence of rural towns for 200 years	History Colorado. Colorado Rural Settlement Historical Summary, 2024.
28	One in ten rural residents employed in health care	U.S. Bureau of Labor Statistics (BLS). Quarterly Census of Employment and Wages (QCEW), Rural Colorado Employment Tables, 2024.
29	Growth of Health Care and Social Assistance sector (21.8% since 2014)	BLS QCEW, Industry Employment by County Dataset, 2014–2024.
30	Rural hospitals responsible for 4.5% of local jobs	Colorado Hospital Association. Economic Impact of Hospitals Report, 2024.
32	Higher prevalence and mortality from chronic diseases in rural areas	Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System (BRFSS), 2024; Colorado Department of Public Health and Environment (CDPHE). Vital Statistics, 2024.
33	Leading causes of death: heart disease, hypertension, chronic respiratory illness	CDC WONDER, Multiple Cause of Death Files, 2024; CDPHE Vital Statistics Program, 2024.
34	Preventability of chronic disease mortality through early intervention	CDC, Chronic Disease Prevention and Health Promotion Reports, 2024.
35	Preventive care infrastructure and workforce shortages	HRSA, AHRF 2023; Colorado Health Institute (CHI). Primary Care Workforce Report, 2024.
36	Integration of preventive care and telehealth strategies	Colorado Department of Health Care Policy and Financing (HCPF). Rural Health Transformation Plan Working Draft, 2025.
37	Rural counties lacking a practicing OB-GYN (57.4%)	Colorado Rural Health Center (CRHC). Colorado Rural Health Snapshot 2025. Denver, CO.
38	Counties classified as maternity care deserts (37.5%)	March of Dimes. Nowhere to Go: Maternity Care Deserts Report 2023. Washington, DC.
39	Rural women traveling more than seven times farther to maternity care	March of Dimes. Maternity Care Deserts Report 2023.
40	Average rural drive time to birthing hospital (30 minutes)	Colorado Department of Public Health and Environment (CDPHE). Perinatal Care Access Report 2024.
41	Percent of urban residents traveling comparable distances (3.3%)	CDPHE. Perinatal Care Access Report 2024.
42	Highest travel times: 68 miles and 75 minutes to nearest birthing hospital	CDPHE. Maternal Health Access and Travel Burden Analysis 2024.

Endnote #	Indicator / Statistic	Source (Citation)
43	Maternal mortality rate in frontier counties four times the national average	CDPHE. Maternal Mortality Review Board Annual Report 2024.
44	Rural suicide rates 56% higher than urban rates	CDC. National Vital Statistics System: Mortality Data 2024.; CDPHE. Behavioral Health Outcomes Dashboard 2024.
45	Rural behavioral health provider shortages and clinic capacity issues	Health Resources and Services Administration (HRSA). Area Health Resources File (AHRF) 2023.; Colorado Health Institute (CHI). Behavioral Health Workforce Analysis 2025.
46	Dependence on visiting behavioral health providers in rural regions	Colorado Behavioral Health care Council (CBHC). Rural Provider Staffing and Access Report 2024.
47	Telehealth and eConsult behavioral health access improvements	Colorado Office of eHealth Innovation (OeHI). Telebehavioral Health Expansion Evaluation 2024.
48	Counties without a hospital (17)	Colorado Rural Health Center (CRHC). Colorado Rural Health Snapshot 2025.
49	Counties without a certified Rural Health Clinic (20)	Health Resources and Services Administration (HRSA). Rural Health Clinic Locator Data, 2024.
50	Counties without a Federally Qualified Health Center (15)	HRSA. Health Center Program Data Portal, 2024.
51	Physician ratio 0.8 per 1,000 rural vs. 2.6 per 1,000 urban	HRSA. Area Health Resource File (AHRF) 2023.
52	Average rural resident distance to nearest hospital (10.5 miles)	Colorado Hospital Association (CHA). Access to Hospital Services Report 2024.
53	Majority of rural residents living >15 miles from nearest CAH	HRSA. Critical Access Hospital Distance and Access Dataset 2024.
54	Many rural residents >50 miles from nearest full-service hospital	CHA. Hospital Access and Service Area Analysis 2024.
55	Impact of distance and weather on access to preventive care	Colorado Health Institute (CHI). Barriers to Care in Rural Colorado Report 2024.
56	Rural facilities comprising ~34% of total licensed facilities	Colorado Department of Public Health and Environment (CDPHE). Health Facilities Licensing Database, 2024.
57	Distribution of medically underserved rural areas	Health Resources and Services Administration (HRSA). Medically Underserved Areas/Populations (MUA/P) Dataset, 2024.
58	Number of Rural Prospective Payment System (PPS) Hospitals (11)	Colorado Hospital Association (CHA). Hospital Directory 2025.
59	Number of Federally Qualified Health Centers (77)	HRSA. Health Center Program Data Portal, 2024.
60	Number of Critical Access Hospitals (32)	HRSA. Critical Access Hospital Database, 2024.
61	Number of School-Based Health Centers (21)	Colorado Department of Public Health and Environment (CDPHE). School-Based Health Center Annual Report 2024.

Endnote #	Indicator / Statistic	Source (Citation)
62	Number of Community Health Centers (15)	HRSA. Health Center Program Data Portal, 2024.
63	Number of certified Rural Health Clinics (57)	HRSA. Rural Health Clinic Locator Database, 2024.
64	Urban EMS agencies staffed by paid professionals with advanced certifications	Colorado Department of Public Health and Environment (CDPHE). Emergency Medical and Trauma Services Workforce Report, 2024.
65	Rural and frontier counties' reliance on volunteer EMS personnel	CDPHE. Emergency Medical Services NEMSIS v3.5 Data Repository, 2023–2024.
66	Counties with 70% of EMS workforce serving as volunteers	CDPHE. Emergency Medical Services NEMSIS v3.5 Data Repository, 2023–2024.
67	Air ambulance transport times (30–90 minutes from rural to urban trauma centers)	Association of Air Medical Services (AAMS). Air Medical Transport Response Time Report, 2024.
68	Rural hospitals operating with negative margins (60%; average -1.27%)	Colorado Hospital Association (CHA). Hospital Financial Performance Dashboard, FY2024.
69	Critical Access Hospitals operating with negative margins (66%)	CHA. Critical Access Hospital Financial Performance Survey, 2024.
70	Higher uninsured and low-income populations among rural patients	U.S. Census Bureau. American Community Survey (ACS), 5-Year Estimates, 2024.
70b	Uncompensated care plus bad debt for rural hospitals 16.6%. Uncompensated care represents 3.83% of operating expenses for rural hospitals compared with 3.08% of urban hospitals and 3.19% for all hospitals in Colorado.	Medicare Cost report (2023): Uncompensated Care. Fields used for uncompensated care % of operating expenses: Charity Care (S-10, line 23) + Cost of non-reimbursed Medicare bad debt amounts (S-10, line 29), then divide by hospital-only operating expenses. Fields used for % of rural uncompensated care: Charity Care (S-10, line 23 for rural/frontier hospitals only) + Cost of non-reimbursed Medicare bad debt amounts (S-10, line 29 for rural frontier hospitals only), then divide by the of charity care + cost of non-reimbursable Medicare bad debt amounts (all hospitals).
71	Decline in inpatient discharges and increase in inpatient days (2019–2024)	CHA. Hospital Utilization and Efficiency Report, 2024.
72	70.7% increase in outpatient visits since 2020	CHA. Hospital Outpatient Utilization Report, 2024.
73	52 Colorado rural and frontier counties	Colorado Rural Health Center (CRHC). Colorado Rural Health Snapshot 2025. Denver, CO.
74	Identification of high-need populations through statewide health and workforce analyses	Health Resources and Services Administration (HRSA). Health Workforce Analysis Dashboard, 2024; Colorado Hospital Association (CHA). Rural Financial Performance Database, 2024.

Endnote #	Indicator / Statistic	Source (Citation)
75	Certificate of Need	Cicero Institute. A Policymaking Playbook for Certificate of Need Repeal: Ranking Certificate of Needs Laws in All 50 States. 2024.
75a	90 percent of the nation's $4.3 trillion in annual health care expenditures are driven by individuals with chronic and mental health conditions	Centers for Disease Control. Health and Economic Costs of Chronic Conditions. August 2025.
75b	20-40% reduction in hospitalizations for chronic-disease related conditions across various populations and conditions.	Georgetown University Health Policy Institute. CDC Fast Facts.
76	7 Certified Community Behavioral Health Clinics in Colorado with 30 total actives sites of care	Behavioral Health Administration (BHA) and HCPF. July 2025.
77	Short Term Limited Duration Insurance	Colorado Revised Statutes § 10-16-102(32), C.R.S. and § 10-16-102(60), C.R.S.