

On May 6, 2026, the Center for Rural Pennsylvania Board of Directors hosted a public hearing on *Rural Health Transformation in Pennsylvania: Access and Care Delivery* in Room 8EB of the Main Capitol Building in Harrisburg. The hearing examined Pennsylvania's Rural Health Transformation Plan (RHTP), awarded \$193 million in first-year federal funding through CMS, and explored how the Commonwealth is deploying those resources to improve health access and care delivery in rural communities. Testifiers from state government, academia, emergency medical services, and community health organizations addressed the RHTP's structure and implementation, funding alignment with rural health needs, EMS workforce and infrastructure, mobile integrated health models, and school-based health care. While testimony addressed a range of topics, testifiers consistently emphasized that improving rural health outcomes will require coordinated investments in workforce, reimbursement reform, transportation, and community-based care models that extend access beyond traditional healthcare settings.

Key Takeaways

- **Sustainable Funding and Reimbursement:** Multiple testifiers emphasized that expanding access to care in rural communities requires long-term reimbursement and financing models rather than short-term grant funding. Testifiers highlighted the need to align payment systems with care delivery models such as EMS readiness, Mobile Integrated Health, school-based health centers, and community-based preventive services.
- **Community-Based Care Delivery:** Testifiers highlighted the importance of delivering care through trusted community institutions and locally embedded models, including EMS agencies, schools, mobile integrated health teams, and transportation networks. These approaches were presented as strategies for overcoming provider shortages, transportation barriers, and fragmented care delivery systems in rural communities.
- **Val Arkoosh, MD, MPH, Secretary, Pennsylvania Department of Human Services:** Arkoosh testified that Pennsylvania's RHTP is the product of more than two years of stakeholder engagement and was built on eight Regional Rural Health Summits and more than 300 public concept submissions. The plan organizes delivery through eight Regional Care Collaboratives aligned with existing PREP regions, focuses on six initiative areas including aging and access, behavioral health, EMS and transportation, maternal health, technology, and workforce, and prioritizes sustainability over one-time funding infusions.
- **Paula Chatterjee, MD, MPH, Assistant Professor of Medicine, Perelman School of Medicine; Director of Innovation, Leonard Davis Institute of Health Economics, University of Pennsylvania:** Chatterjee testified that federal RHTP funding allocations do not align with measures of rural health need, with states experiencing higher rural mortality rates generally receiving less funding per resident than states with lower mortality rates, placing Pennsylvania at a disadvantage given its large rural population. She urged policymakers to target resources toward highest-need communities, measure success using access and local governance metrics, and coordinate RHTP investments with broader rural economic development efforts.
- **Alvin Wang, D.O., F.A.A.E.M., F.A.E.M.S., N.R.P., P.H.P., EMS Medical Director, Montgomery County; President, Pennsylvania Emergency Health Services Council:** Wang testified that EMS is not simply the frontline of rural care but the entry point into the healthcare system, and that community paramedicine and Mobile Integrated Health programs cannot be successfully expanded on top of already strained emergency response systems without first stabilizing the EMS workforce and reforming a fee-for-transport reimbursement model that fails to compensate agencies for readiness. He called on payers to evolve reimbursement policies to support clinically appropriate care delivered in the field.
- **Kevin Shutty, Executive Director, Economic Development Council of Mason County, Washington State:** Shutty testified that EDC Mason has led a multi-program regional approach to expanding healthcare access in Mason County, Washington, including a crisis co-responder program that reduced local cost share by roughly 50 percent through Medicaid reimbursement, a Linkages to Care transportation project connecting residents to outpatient and primary care, and a Mobile Integrated Health Program centered on nurse practitioners and peer navigators. He offered Mason County's model as a replicable framework for rural Pennsylvania.

- **Beau Bakken, Fire Chief, North Mason Regional Fire Authority, Washington State:** Bakken testified that North Mason Regional Fire Authority’s Mobile Integrated Health Program has served 2,677 unique patients and logged 4,210 visits since 2023, with 62 percent of patients identified as high risk for hospitalization. The program achieved a 10 percent reduction in emergency calls in 2025 and an estimated \$12 million in avoided hospital and EMS-based health care costs, demonstrating that fire-based mobile health teams can meaningfully reduce emergency utilization and improve community health outcomes.
- **Julie Cousler, Executive Director, Pennsylvania School-Based Health Alliance:** Cousler testified that school-based health centers are a proven but underutilized strategy for expanding rural health access, noting that at least seven states included school-based health center expansion in their RHTP proposals to CMS. Pennsylvania research commissioned by DHS showed that 7,000 students served through school clinics had significantly fewer hospital visits — yielding approximately \$1 million in savings — and higher rates of well-child checkups compared to students receiving care through federally qualified health centers. Cousler called for sustainable state funding and standardized data collection to document and reinvest Medicaid savings.
- **Jenny Englerth, President and CEO, Family First Health:** Englerth testified that Family First Health operates two school-based health centers and a mobile school dentistry program serving more than 14 school districts across Adams, Lancaster, Lebanon, and York counties, integrating primary care, behavioral health, and dental services through a coordinated care model. She emphasized that rural communities can leverage schools — among the most trusted and stable institutions in any community — as hubs for care, and called for sustainable reimbursement, workforce flexibility, and state support for school-district health partnerships.

PANEL 1: RURAL HEALTH TRANSFORMATION PLAN – STRATEGY, FUNDING, AND TARGETING RESOURCES

Val Arkoosh, MD, MPH, Secretary, Pennsylvania Department of Human Services

Arkoosh testified that Pennsylvania’s RHTP reflects more than two years of stakeholder-driven planning rooted in eight Regional Rural Health Summits and more than 300 public concept submissions. The plan received \$193 million in first-year CMS funding and is organized around six initiative areas — aging and access, behavioral health, EMS and transportation, maternal health, technology and infrastructure, and workforce — to be implemented through eight Regional

Care Collaboratives aligned with Pennsylvania’s existing PREP regions. She highlighted the rapid response stabilization program as the first funding mechanism deployed, directing resources to hospitals and rural health facilities for equipment, renovations, and structural improvements, and noted that Year 1 focuses on establishing RCC governance structures ahead of Year 2 grant-making.

Paula Chatterjee, MD, MPH, Assistant Professor of Medicine, Perelman School of Medicine; Director of Innovation, Leonard Davis Institute of Health Economics, University of Pennsylvania

Chatterjee testified on three dimensions of RHTP implementation: federal funding alignment, local targeting, and impact measurement. Drawing on a 2026 JAMA analysis, she found that RHTP funding is inversely correlated with rural mortality — states with lower mortality received disproportionately more per-resident funding — and that Pennsylvania is disadvantaged by having more than one in four residents classified as rural. She recommended that Pennsylvania target RHTP resources toward highest-need communities, guard against concentration of funds in large intermediaries, and measure success using short-term access and governance metrics while linking health investments to broader rural economic development, noting that local economic decline often precedes rural hospital closures.

PANEL 2: EXPANDING ACCESS THROUGH EMS AND BEHAVIORAL HEALTH MODELS

Alvin Wang, D.O., F.A.A.E.M., F.A.E.M.S., N.R.P., P.H.P., EMS Medical Director, Montgomery County; President, Pennsylvania Emergency Health Services Council

Wang testified that EMS is the entry point into the healthcare system in rural Pennsylvania, not simply its frontline, and that Mobile Integrated Health and community paramedicine programs — while promising — cannot be sustained without first addressing the structural crisis in EMS workforce and funding. He described a reimbursement system that compensates agencies for transport rather than care or readiness, creating misalignment with expanded clinical roles. Wang called for readiness-based reimbursement, payer policy evolution to support field-based care, investment in telemedicine and health information exchange connectivity for EMS agencies, and continued engagement with the Pennsylvania Emergency Health Services Council as the plan moves to implementation.

Kevin Shutty, Executive Director, Economic Development Council of Mason County, Washington State

Shutty presented Mason County, Washington’s integrated approach to rural health access, framing

healthcare as a core economic development function. He described three interconnected programs: a crisis co-responder model embedding mental health clinicians and peer navigators in law enforcement that reduced local cost share by roughly 50 percent through Medicaid reimbursement; a Linkages to Care transportation program connecting residents to treatment, detox, and primary care; and a Mobile Integrated Health Program staffed by nurse practitioners, registered nurses, and peer navigators. He identified Washington State’s independent practice authority for nurse practitioners as a critical policy enabler and offered Mason County’s multi-sector approach as a model for rural Pennsylvania communities.

Beau Bakken, Fire Chief, North Mason Regional Fire Authority, Washington State

Bakken detailed the operational model and outcomes of North Mason Regional Fire Authority’s Mobile Integrated Health Program, which serves 132 rural square miles in Mason County, Washington with two fire-based MIH teams staffed by advanced nurse practitioners, registered nurses, psychiatric nurse practitioners, and peer support specialists. Since launching in 2023, the program has served 2,677 unique patients across 4,210 visits — 62 percent of whom were identified as high risk for hospitalization — achieved an estimated \$12 million in avoided health care costs, and contributed to a 10 percent reduction in emergency calls in 2025. Funding draws on a diverse mix of sources including accountable community of health contracts, opioid settlement funds, insurance billing, and public health districts.

PANEL 3: EXPANDING ACCESS THROUGH COMMUNITY-BASED CARE MODELS

Julie Cousler, Executive Director, Pennsylvania School-Based Health Alliance

Cousler testified that school-based health centers integrate medical, behavioral, dental, and vision care directly into schools — the most stable and trusted institutions in many communities — and are particularly well-suited to rural settings where transportation barriers and provider shortages amplify access gaps. She cited a 2023 Cornell University study showing that students with school-based clinic access made two additional health care visits per year, were significantly less likely to seek emergency care, and missed less school. Pennsylvania research commissioned by DHS found that 7,000 students served through school-based centers had significantly fewer hospital visits and approximately \$1 million in savings compared to peers served by FQHCs. Cousler called for state investment, standardized data collection, and reinvestment of documented Medicaid savings to expand school-based health center capacity across Pennsylvania.

Jenny Englerth, President and CEO, Family First Health

Englerth testified that Family First Health’s school-based model — two health centers in the School District of the City of York and a mobile school dentistry program serving more than 14 districts — demonstrates how FQHCs can leverage schools as care hubs to extend reach, improve continuity, and support whole-family engagement. She described embedded behavioral health consultants, behavioral health associates providing real-time in-school support, and “reset rooms” as elements of a coordinated care ecosystem that reduces emergency escalation and connects students to higher levels of care when needed. For rural Pennsylvania, Englerth highlighted the importance of sustainable reimbursement across service types, interdisciplinary workforce flexibility, strong school-district partnerships, and mobile care infrastructure investments.

WRITTEN TESTIMONY SUBMISSION

Andrea Berry-Brown, Ed.D., Superintendent, School District of the City of York

Berry-Brown submitted written testimony describing the impact of Family First Health’s school-based health centers on the School District of the City of York, where two centers — one at Hannah Penn serving pre-K through grade 8, and one at William Penn serving grades 9 through 12 — provide primary medical and behavioral health services to students and families. She emphasized that access to health care directly improves attendance, academic engagement, and long-term outcomes, and credited the deep integration of the Family First Health team into district culture as a model of how school-health partnerships can be both responsive and sustainable.

ISSUES FOR FURTHER EXAMINATION

The hearing identified several issues that warrant additional examination:

- Long-term sustainability of Rural Health Transformation Plan investments.
- Rural EMS workforce recruitment and retention.
- Reimbursement reform for EMS and Mobile Integrated Health services.
- School-based health center expansion and financing.
- Behavioral health integration in rural communities.
- Transportation barriers to healthcare access.
- Workforce shortages across rural healthcare professions.
- Measuring outcomes and accountability within the Regional Care Collaboratives.

Thank You

Thank you to the hearing participants who presented testimony:

- Val Arkoosh, MD, MPH, Secretary, Pennsylvania Department of Human Services
- Paula Chatterjee, MD, MPH, Assistant Professor of Medicine, Perelman School of Medicine; Director of Innovation, Leonard Davis Institute of Health Economics, University of Pennsylvania
- Alvin Wang, D.O., F.A.A.E.M., F.A.E.M.S., N.R.P., P.H.P., EMS Medical Director, Montgomery County; President, Pennsylvania Emergency Health Services Council
- Kevin Shutty, Executive Director, Economic Development Council of Mason County (Washington State)
- Beau Bakken, Fire Chief, North Mason Regional Fire Authority (Washington State)
- Julie Cousler, Executive Director, Pennsylvania School-Based Health Alliance
- Jenny Englerth, President and CEO, Family First Health

Written testimony submissions:

- Andrea Berry-Brown, Ed.D., Superintendent, School District of the City of York

Scan the QR code for the public hearing agenda, testimony, and recording.



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