Rural Health Transformation Program Plan

Maryland
DEPARTMENT OF HEALTH

Project Narrative

Maryland Rural Health Transformation Program

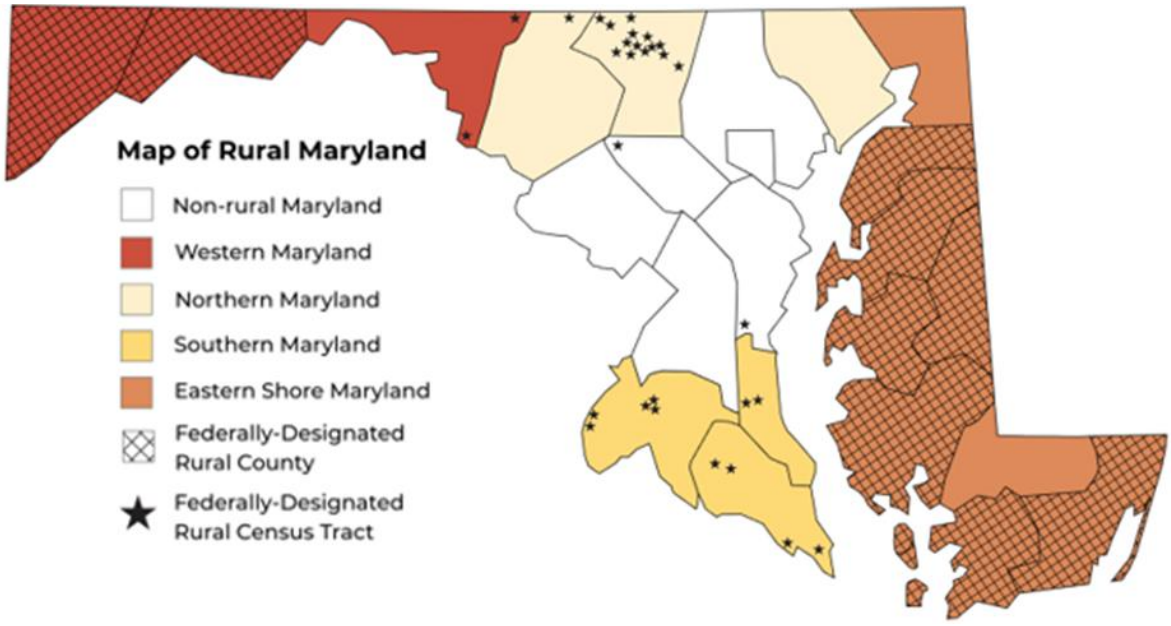
Rural Health Needs and Target Population

Maryland's Current Rural Health Landscape

Maryland is "America in miniature" in large part due to its rural areas. From the Appalachian mountains of Western Maryland to the Eastern Shore's coastal plains and wetlands, rural Marylanders have a long tradition of strength and resiliency. Our rural areas have deep historical roots, often tied to agriculture and aquaculture economies that helped shape Maryland's overall prosperity. Common characteristics – including geographic isolation and lack of proximity to healthcare – set rural jurisdictions apart from their suburban and urban counterparts.

Rural Maryland Demographics

Figure 1: Rural Maryland, by Federal and State Designation



Maryland law recognizes 18 of our 24 counties as rural, based on shared attributes including agricultural-based economies; challenges of persistent unemployment and poverty; aging

populations; out-migration of youth; inadequate access to quality housing, healthcare and other services; and inadequate transportation, communications, sanitation, and economic development infrastructure.[1] **Rural counties are home to 29% of the State's population**.[2] **Figure 1** shows federal and State definitions of rural areas. The Health Resources and Services Administration Federal Office of Rural Health Policy designates nine full and eight partial counties as rural, approximately 484,000 residents. Maryland's rural areas have low population density with small settlements. **Figure 2** shows key demographic indicators.

Figure 2: Maryland's Rural Population Demographics[3,4]

FEATURES	Population	% 65+ Years and Older	% Persons Under 150% of Poverty	Median Household Income	% Bachelor's Degree or Higher	% Medicaid Eligibility
DATA OBTAINED	2023 est.	2023 est.	2019-2023	2019-2023	2019-2023	2023
United States of America	334,914,895	17%	20%	$78,538	34%	N/A
State of Maryland (total)	6,180,253	17%	15%	$101,652	43%	31%
State-Designated Rural	1,833,824	18%	14%	$89,577	28%	28%
Western Maryland	251,509	20%	21%	$66,860	23%	39%
Northern Maryland	734,674	17%	10%	$115,884	41%	21%
Southern Maryland	381,982	15%	10%	$122,410	34%	25%
Eastern Shore Maryland	465,659	21%	19%	$77,435	29%	36%

Maryland's population is aging – almost a quarter of the statewide population is over 60 and those over 85 are the fastest growing segment of the population. Compared to the State overall,

[1] Maryland General Assembly. 2014 Regular Session. Senate Bill 137 Chapter 469. https://mgaleg.maryland.gov/2014RS/Chapters_noln/CH_469_sb0137t.pdf

[2] United States Census Bureau. Quick Facts Maryland. https://www.census.gov/quickfacts/fact/table/MD/PST045224

[3] Maryland Vital Statistics Administrative. Maryland Vital Statistics Annual Report 2023. https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2023_Annual%20Report_Final.pdf

[4] United States Census Bureau. Quick Facts Maryland. https://www.census.gov/quickfacts/fact/table/MD/PST045224

the rural Maryland population tends to be even older. Five of six counties predicted to have the largest percentage increases in older adults are rural.

Rural Marylanders have fewer economic resources with higher rates of poverty and lower educational attainment compared to the State overall. A larger proportion of rural Medicaid participants compared to urban Medicaid participants is eligible for partial dual (6% vs. 4% in CY 2024) or full dual (9% vs. 7% in CY 2024) Medicare and Medicaid coverage.[5]

Rural Maryland Health Outcomes

Rural health outcomes lag behind the rest of the State, with lower life expectancy, limited access to healthcare, and higher rates of conditions like obesity,[6] diabetes,[7] heart disease,[8] and behavioral health issues.[9] **Figure 3** shows that many rural areas have elevated death rates.

[5] September 2025 analysis by The Hilltop Institute.

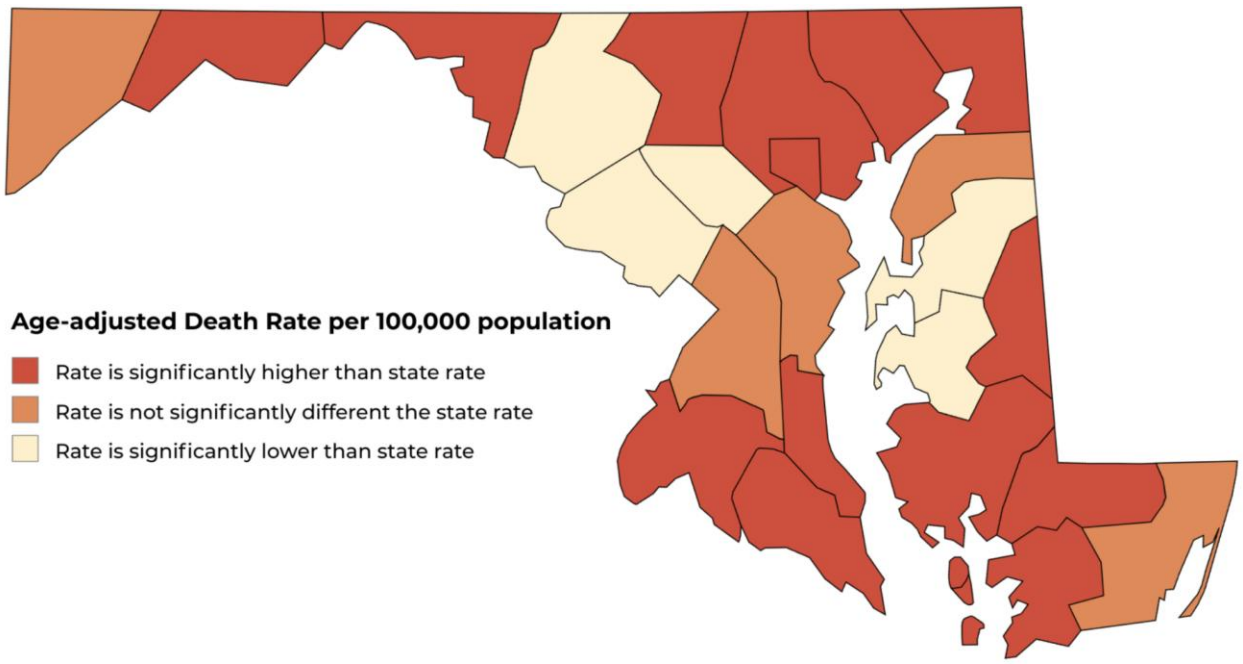
[6] Rural Health Information Hub, Map of Obesity Prevalence, 2021. https://www.ruralhealthinfo.org/charts/39

[7] Maryland BRFSS Surveillance Brief, Volume 4, Number 1. Diabetes in Maryland. February 2022. https://health.maryland.gov/phpa/ccdpc/Reports/Documents/Diabetes%20in%20Maryland%E2%80%94Maryland%20BRFSS%20Surveillance%20Brief%202022.pdf

[8] HD *Pulse*, Heart Disease Death Rates for Maryland by County, 2019-2023. https://hdpulse.nimhd.nih.gov/data-portal/mortality/table?age=001&age_options=age_11&cod=250&cod_options=cod_15&comparison=states_to_us&comparison_options=comparison_statename_to_us&race=00&race_options=race_6&ratetype=aa&ratetype_options=ratetype_2&ruralurban=0&ruralurban_options=ruralurban_3&sex=0&sex_options=sex_3&statefips=24&statefips_options=area_states&yeargroup=5&yeargroup_options=yearmort_2&ut

[9] Investing in Maryland's Behavioral Health Talent. October 2024. https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2024/md_bh_workforce_rpt_SB283.pdf

Figure 3: Age-Adjusted All-Cause Death Rates, 2023[10]



Despite these challenges, rural Maryland performs as well as or better than the State overall on important perinatal outcomes: early prenatal care is higher among Maryland's rural population (72.9% federally defined rural versus 65.7% State overall). The percentage of babies with low birthweight is similar (8.7% federally defined rural versus 8.6% State overall).[11]

Rural Maryland Healthcare Access

Like health outcomes, **rural healthcare access lags behind** more urban and suburban areas. Maryland has well-documented **rural provider shortages** with fewer primary care, specialty, and behavioral health providers. For example, some Eastern Shore rural counties have among the lowest provider-to-population ratios in the State. The federal government designates 14 rural

[10] 2025-2029 Maryland Rural Health Strategic Plan

[11] Maryland Vital Statistics Administration. Maryland Vital Statistics Annual Report 2023. https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2023_Annual%20Report_Final.pdf

Maryland jurisdictions in their entirety as health professional shortage areas for primary care. Rural behavioral health providers are only 3% of Maryland's total behavioral health providers. Many rural residents rely on hospitals as their main source of healthcare services. **Geographic isolation and transportation barriers** restrict timely care and preventive services. Communities face barriers managing chronic disease, with preventable hospitalizations and emergency department (ED) visits driving up costs and worsening outcomes. **Lack of healthcare access means delayed diagnosis, advanced disease at presentation, and higher burdens of chronic conditions** such as heart disease, diabetes, and kidney disease. Behavioral health needs, particularly among youth, are urgent and growing.

Rural Facility Financial Health

Hospitals and other healthcare facilities operating in rural areas face challenges that fundamentally differ from their counterparts in other parts of the State. These include acute workforce shortages and limited access to specialty services. Over many years, Maryland and the federal Centers for Medicare & Medicaid Services (CMS) have worked together to create a financing model that has **helped preserve access to care in rural areas**. Maryland's history of working with CMS and the CMS Innovation Center to implement a unique system of hospital global budgets has made rural hospital funding relatively more stable and predictable. Hospitals have been able to innovate with hub and spoke models for specialty care and community-based services. Maryland is actively engaged with CMS/CMMI to build on this experience with a model that will further advance efficient, accountable, and sustainable value-based care.

Target Population

Maryland will target Rural Health Transformation Program (RHTP) resources to rural residents and healthcare providers in **all 18 counties recognized as rural by Maryland law**. This includes **Western Maryland** (Allegany, Garrett, and Washington Counties), **Eastern Shore** (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties), **Southern Maryland** (Calvert, Charles, and St. Mary's Counties) and **Northern Maryland** (Carroll, Frederick, and Harford Counties).

Need for Transformation

As described below in *Governance and Project Management*, the M**aryland Department of Health (MDH) is the lead agency for the RHTP**. Maryland's **State Office of Rural Health (SORH)** is the designated office within MDH **responsible for overall implementation, management, and assessment of RHTP initiatives**. Through our *Rural Health Transformation Plan (Transformation Plan*) and proposed initiatives, Maryland will tackle longstanding challenges to improve the well-being of the one- third of residents who call rural Maryland home. Our strategies include **strengthening the rural health workforce**; **expanding access** to primary care, chronic disease management, and specialty care including behavioral health; **reshaping care access points through technology**; and increasing access to **nutritious food to address root causes** of chronic disease.

Rural Health Transformation Plan: Goals and Strategies

Maryland Context

Maryland's *Transformation Plan* builds on the experience of our hospital global budgeting system. Maryland's next phase of transformation will invest in **continued adoption of value-based care models** to ensure residents in every part of the State have access to high-quality, sustainable healthcare. Maryland's additional strengths include a **culture of cross-sector collaboration** and a track record of **creative, community-led solutions** to empower rural stakeholders to design the solutions they need for transformation.

Vision and Goals for Rural Health Transformation

Our vision is to **enable all rural Marylanders to achieve optimal health and well-being**. Our goals are to (1) Transform the Rural Health Workforce, (2) Promote Sustainable Access and Innovative Care for Rural Marylanders, and (3) Empower Rural Marylanders to Eat for Health.

Strategies for Rural Health Transformation

Achieving true rural health transformation requires an array of interconnected strategies, initiatives, and actions. These strategies are not discrete – they will **interact with and reinforce one another** by design.

Improving Access, Technology Use, and Data Driven Solutions

One of Maryland's pillars for transformation is promoting sustainable access and innovative care to improve access via technology use and data-driven Solutions (*Initiative Two*). This aligns with the **RHTP strategic goals of Sustainable Access, Innovative Care, and Tech Innovation**. Maryland will fund a range of initiatives, including to:

- Improve health information technology **(HIT) connectivity and telehealth infrastructure**.
- Create sustainable access through clinical care service expansions and HIT advances, including **advanced artificial intelligence (AI) models, telehealth, and technology-enabled chronic disease management**.
- Bring healthcare into rural communities by **expanding mobile health services**.
- Advance **innovative value-based care models**, including geographic-based approaches.
- Launch **new primary care** practices and expand specialty practices.
- Strengthen **emergency response** for trauma care.
- Expand **School-Based Health Center** (SBHC) capacity.
- Provide focused support to expand **behavioral health** across the care continuum.

We will support data-driven workforce solutions through immediate funding for a health workforce data strategy under *Initiative One: Transform the Rural Health Workforce.*

Improving Outcomes

Maryland will improve health outcomes through all three of our pillars, aligning with the **RHTP strategic goal to Make Rural America Healthy Again.** *Initiative One: Transform the Rural Health Workforce* will expand the professionals who can help rural Marylanders prevent and manage chronic disease. *Initiative Two: Promote Sustainable Access and Innovative Care for Rural Marylanders* will expand services for primary care, specialty care, and behavioral health across the continuum and bring healthcare directly to rural Marylanders to help prevent and manage chronic disease. *Initiative Three: Empower Rural Marylanders to Eat for Health* will expand supply and demand for local, nutritious, unprocessed foods to reverse chronic disease by confronting food as a root cause of health.

Partnerships

Our RHTP funding method fosters partnerships by supporting **strategic, cohesive proposals and delivering resources to rural providers and organizations working together**. We will award partnerships that align around common resources for cohesive solutions. Our *Transformation Plan* is consistent with our **long-standing commitment to partnership**, community engagement, coalition-building, and addressing service gaps. As described in *Stakeholder Engagement* below, we heard directly from rural communities about their needs and strengths when developing this proposal.

Workforce

Workforce is a foundational issue to promote population health; ensure effective, trusted, high-value care; and improve access and outcomes. Technology alone cannot close care gaps – **people are the core of a world-class healthcare system**. *Initiative One* will address the persistent health workforce shortages that have been a critical deficiency. This directly aligns with the **RHTP Workforce Development strategic goal**. We will grow a well-trained and supported workforce across a broad range of healthcare fields and different levels of professions. We include **career ladder advancement** and "**grow your own**" initiatives to foster community expertise and opportunities for healthcare careers close to home.

Financial Solvency Strategies

Initiative Two promotes innovative care models such as a **geographic-based model** to create payment mechanisms that **incentivize reduced healthcare costs while promoting population health and improving quality**. In Maryland's experience, hospital global budgets provided relatively stable financial solvency for rural hospitals.

Cause Identification

Hospitals and other healthcare facilities in rural areas face challenges such as especially acute workforce shortages and limited access to specialty services. Maryland will continue working with CMS to understand and address the risks our rural hospitals face to advance efficient and accountable care. *Initiatives One and Two* provide **flexibility for hospitals to propose solutions to meet their needs.**

Program Key Performance Objectives

Maryland's *Transformation Plan* will improve the health of rural Marylanders by **(1) strengthening the rural health workforce, (2) connecting them to primary care, chronic disease management, specialty care, and behavioral health,** and **(3) addressing chronic disease with increased demand for and supply of nutritious food**. Per our *Metrics and Evaluation Plan,* we will assess our success with initiative-specific metrics. SORH staff will measure our **overall success** by tracking rural performance on: **potentially avoidable hospital utilization**; **diabetes control**; and follow-up for acute **behavioral health needs**. We will build on this effort to **define specific rural performance targets**, in alignment with stated strategic goals.

Strategic Goals Alignment

- *Initiative One: Transform the Rural Health Workforce* aligns with the **RHTP strategic goal Workforce Development.**
- *Initiative Two: Promote Sustainable Access and Innovative Care for Rural Marylanders* aligns with the **RHTP strategic goals Sustainable Access, Innovative Care, and Tech Innovation**.

- *Initiative Three: Empower Rural Marylanders to Eat for Health* aligns with the **RHTP strategic goal Make Rural America Healthy Again.**

State Policies

Figure 4 shows Maryland's current status regarding state policy actions as outlined in the NOFO. Maryland is engaged with CMS/CMMI to pursue additional policies to support the delivery of high-quality, cost-effective care.

Figure 4: Maryland's Current State Policy Action Status

State Policy Action	Maryland Status
B.2. Health and Lifestyle	No statewide mandated reinstatement of Presidential Fitness Test.
B.3. SNAP Waivers	No pending or approved USDA SNAP food restriction waiver.
B.4. Nutrition Continuing Medical Education	Physicians applying for renewal of their license must earn at least 50 Category I or II CME credits in the two-year period preceding the license expiration date, with at least 25 of those CME credits being Category I. Physicians are exempt from the continuing education requirement for the first license renewal. Accredited Nutrition Continuing Medical Education courses are included in Category I.
C.3. Certificate of Need	MD ranks 41st with a total score of 95 from the Cicero Institute's *A Policymaking Playbook for Certificate of Need Repeal Ranking* (2024). Maryland has modernized and streamlined CON provisions in recent years. The state will consider further work in the policy area.
D.2. Licensure Compacts	MD participates in the: Interstate Medical Licensure Compact (IMLC) and serves as SPL; Nurse Licensure Compact (NLC); and Psychology Interjurisdictional Compact (PSYPACT). The state is not currently a member of the EMS compact or the PA Compact but will consider further work in the policy area.
D.3. Scope of Practice	Based on data sources provided on pages 87-88 of the NOFO - MD's PA Scope of Practice scored as Moderate; NP Scope is considered Full Practice; and Dental Hygienist Scope is considered semi-restrictive with 4 of 8 allowable tasks. The state will consider further work in the policy area.
E.3. Short-term, limited-duration insurance	MD does offer STLDI plans. *Restrictions in place to limit STLDI plans beyond latest federal guidance* - Maryland law defines short-term limited duration insurance as health coverage that 1) has a policy term that is less than 3 months after the original effective date of the policy or contract; 2) may not be extended or renewed; 3) applies the same underwriting standards to all applicants regardless of whether they have previously been covered by short-term limited duration insurance; and 4) contains the notice required by federal law prominently displayed in the contract and any application materials. *State's maximum allowable initiative contract term is:* 3 months *State's maximum allowable coverage period is*: 3 months

F.1. Remote Care Services	The recently enacted Preserve Telehealth Access Act of 2025 permanently extends telehealth coverage and reimbursement in Maryland, making permanent the inclusion of audio-only visits and requiring payment parity. Medicaid insurers must reimburse for telehealth services on the same basis and at the same rate as in-person visits. The state will explore whether additional work is needed in this policy area.

Certified Community Behavioral Health Clinic (CCBHC) Entities (Factor A.2.)

Maryland is working with stakeholders to address requirements of our **Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC Planning Grant**, awarded December 2024. There are no CCBHCs certified by the State in Maryland. Five SAMHSA CCBHC Expansion Grantees self-attest to meeting criteria (see Attachments). One of the five – Lower Shore Clinic (doing business as Healthport) – serves several rural counties including Caroline, Dorchester, Somerset, Wicomico and Worcester.

Maryland is **committed to increasing sustainable access to the full behavioral health continuum** of care for holistic, whole-system transformation for rural communities. Beyond CCBHCs, MDH's Behavioral Health Administration (BHA) and Maryland Medicaid are partnering to **identify behavioral health service expansions**, including revising the 1915(i) Intensive Home and Community-Based Services State Plan Amendment for youth and families. Efforts include outreach to partners and family caregivers, streamlining the referral process, and enhanced provider training. Revisions to the 1915(i) State Plan Amendment and associated regulations will **streamline enrollment and strengthen referrals**. A new reimbursement code supports the inclusion of Youth Peer Support Service, enhancing the comprehensive suite of services offered by Medicaid. We will use RHTP funds to expand and not supplant these efforts.

Medicaid Disproportionate Share Hospital (DSH) Payment (Factor A.7.)

Because of Maryland's unique hospital payment system, **Maryland hospitals do not receive DSH** payments like their counterparts in other states.

Proposed Initiatives and Use of Funds

Proposed Initiatives

Our *Transformation Plan* centers on three initiatives, as shown in **Figure 5**.

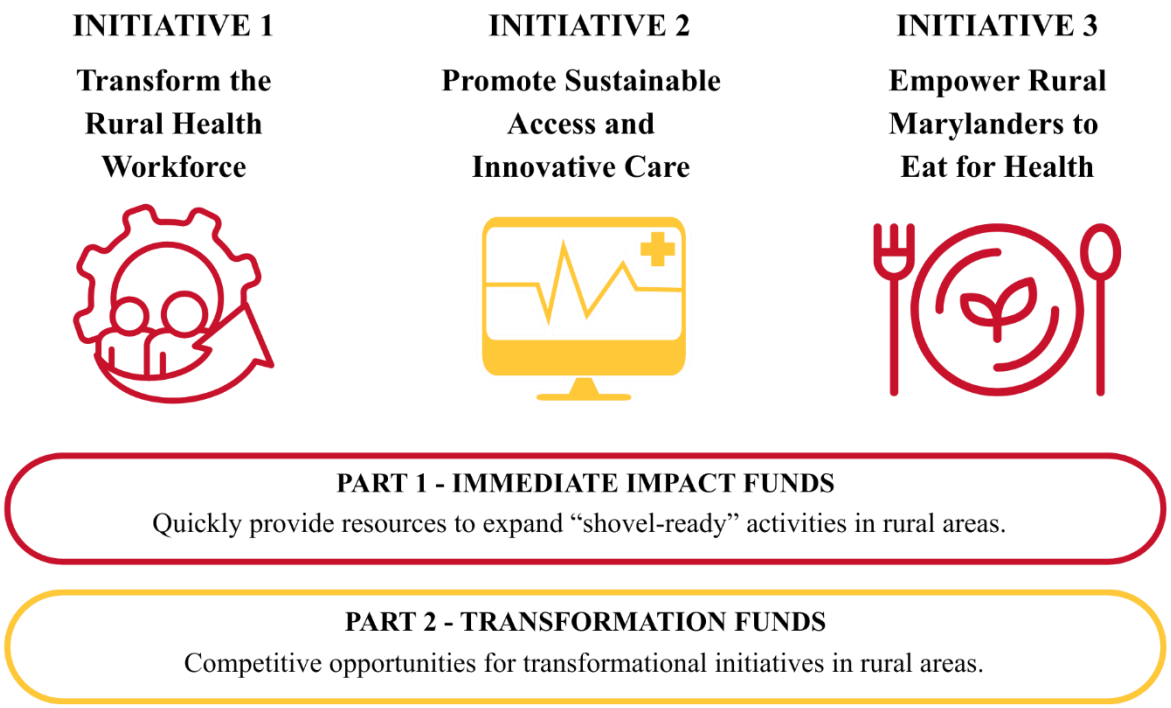
Figure 5: Proposed Initiatives and Activities

Initiative	Activities	Estimated Required Funding
Initiative One: Transform the Rural Health Workforce	**Immediate Impact Funding:** - Pathways to Health Careers - Area Health Education Centers - Health Workforce Infrastructure **Transformation Funding Opportunities:** - Workforce Pipeline Training Programs - Provider Training, Recruitment, and Retention Strategies	$139,118,329 over all five years
Initiative Two: Promote Sustainable Access and Innovative Care for Rural Marylanders	**Immediate Impact Funding:** - Expand Primary Care and Specialty Practice Capacity - Increase Efficiency of Local Agency Operations - Strengthen Emergency Trauma Response - Expand School-Based Health Center Capacity - Optimize HIT Connectivity and Use of CRISP Tools - Centralize Telehealth Infrastructure **Transformation Funding Opportunities:** - Sustainable Access through Service Expansions and IT Advances - Mobile Health Transformation Fund - Innovative Care Transformation Fund - Behavioral Health Transformation Fund	$765,310,876 over all five years
Initiative Three: Empower Rural	**Immediate Impact Funding:** - Post-Harvest Infrastructure	$88,017,624 over all five years

Marylanders to Eat for Health	- Expand Grocers and Mobile Markets - Create Demand for Healthy Foods - Support Food Planning and Coordination **Transformation Funding Opportunities:** - Increase Local Healthy Food Access: Aggregation - Increase Local Healthy Food Access: Purchasing Strategy	

Funding Methods

Maryland proposes two funding methods to transform rural health:



- **Immediate impact funding** will target resources to projects that are ready for implementation and have a clear entity to carry out the project.
- **Transformation fund opportunities** through grant subawards will enable Maryland to select the most promising projects from a pool of applicants.

This directs resources to impactful projects as soon as possible while creating flexibility to distribute resources to projects that will benefit from a longer planning process. It builds on Maryland's key strengths identified by stakeholders: (1) history of **creative, community-led solutions**, and (2) **robust partnerships and collaboration** across sectors and organizations.

Immediate Impact Funding

The immediate impact funding approach allows us to quickly provide resources to **expand "shovel-ready" activities that do not currently exist in rural areas**. The RHTP planning process provided sufficient opportunity for us to deliberate on and select programs for funding.

Transformation Fund Opportunities

Transformation fund opportunities provide for a **longer planning process that leverages rural expertise and empowers local ecosystems**. Rural residents and leaders possess deep knowledge of their communities' needs and opportunities. MDH and its transformation fund partners will issue requests for proposals (RFPs)/requests for applications (RFAs). RFPs/RFAs will define proposal requirements such as required partnerships; target population/geography served; proposed activities; measurement and outcomes; scalability and sustainability; implementation plan; budget; and evaluation criteria. Maryland will appoint committees to review applications and make award recommendations.

Transformation fund opportunities will **foster innovation and accelerate progress** while reflecting federal RHTP goals and amplifying investment impact. MDH and its transformation fund partners will award funds to compelling proposals with clear potential impact. We will distribute funding only to the most promising and innovative projects, **advancing CMS core principles of choice and competition**.

Maryland Will Not Use RHTP Funds For Any Prohibited Spending

Maryland will comply with all RHTP policies and limitations, including all applicable provisions of 2 CFR Part 200 and 2 CFR Part 300. We will not use RHTP funding for any unallowable costs as described in the RHTP Notice of Funding Opportunity (NOFO).

Description of Initiative One: Transform the Rural Health Workforce

Figure 6: Overview of Initiative One

Initiative	Transform the Rural Health Workforce
Main Strategic Goal	Workforce Development
Use of Funds	E. Workforce F. IT Advances
Technical Score Factors	D.1. Talent recruitment F.2. Data infrastructure
Key Stakeholders	MDH Office of Health Care Access and Workforce Development, MD Labor, employers and industry intermediaries, AHECs, Maryland occupational boards, Maryland Longitudinal Data System Center, MHCC, community colleges, school districts, colleges and universities, academic medical centers, healthcare providers, LHDs, and community-based organizations. See Acronym List Attachment.
Outcomes	See *Metrics and Evaluation Plan* for detail. (1) Student participants in pipeline programs across medical and behavioral health, # with percentage increase, as available (**workforce and program implementation metric**) (2) Participants in training and education programming related to medical, behavioral, and dental health, # with percentage increase, as available (**workforce and program implementation metric**) (3) Participants providing professional services to meet Maryland's health needs for the first time (as a student or new employee) or in a promoted role due to newly earned credentials (#) (**workforce and program implementation metric**) (4) Sustainable infrastructure improvements related to workforce transformation efforts, # (**workforce and program implementation metric**)
Impacted Counties	Maryland law recognizes 18 counties as rural. The initiative will impact residents in all 18 counties. The Federal Information Processing Series (FIPS) codes for these counties are: 24001, 24009, 24011, 24013, 24015, 24017, 24019, 24021, 24023, 24025, 24029, 24035, 24037, 24039, 24041, 24043, 24045, and 24047.
Estimated Required Funding	$139,118,329 over all five years Please see detailed information in the Budget Narrative.

Under *Initiative One: Transform the Rural Health Workforce* Maryland will **expand existing and implement new efforts to develop, recruit, and retain a strong health workforce** in rural communities, addressing multiple types of healthcare clinicians and allied health professionals. **Figure 7 s**hows *Initiative One* elements. See the *Budget Narrative* for budget information.

Figure 7: Initiative One Proposed Elements

Initiative One: Transform the Rural Health Workforce	
Immediate Impact Funding	
Investments: - Pathways to Health Careers (Technical Score Factor D.1.) - Area Health Education Centers (Technical Score Factor D.1.) - Health Workforce Infrastructure (Technical Score Factor D.1., F.2.)	**Key Uses of Funds:** Workforce IT advances
Transformation Funding	
Funding Opportunities: - Workforce Pipeline Training Programs (Technical Score Factor D.1.) - Provider Training, Recruitment, and Retention Strategies (Technical Score Factor D.1.)	**Key Uses of Funds:** Workforce

Immediate Impact Funding

Pathways to Health Careers

Maryland operates effective apprenticeships with an estimated $1.47 return on every $1 invested and a reported one-year retention rate exceeding 90%. We propose allocating RHTP funds to the **Maryland Department of Labor** (MD Labor) to expand its Registered Apprenticeship program to **focus on healthcare apprenticeships not currently available in rural parts of the State**. We will expand annual placements, including for community health workers (CHWs), certified nursing assistants, licensed practical nurses, medical assistants, alcohol and drug counselors, and Certified Peer Recovery Specialists (Peers). MD Labor will use funds to **support employer costs** for items such as apprentice instruction and preceptor pay, as well as **infrastructure costs** of developing and scaling the program of apprenticeships in new healthcare fields and new geographic areas.

MD Labor's Rural Advancement for Maryland Peers (RAMP) program provides a career pathway for Peers. RAMP funds rural organizations that (1) **Train individuals** to become certified in Maryland; (2) **Provide supportive services** to participants to ensure their successful

completion of training for certification and employment; and (3) Prepare participants for **upskilling and supervisor training** for advancement to mid-level behavioral health roles.

We propose allocating RHTP funds to **MD Labor** to expand the RAMP model to **additional health occupation tracks** including CHWs, patient navigators, direct support professionals, and other healthcare support occupations as determined by labor market analysis. The expansion will emphasize training for unemployed and underemployed individuals and upskilling post-certification with ongoing training, education, and support services. Notably, the expanded RAMP program is a **pathway for employment for Maryland Medicaid participants** in rural areas to meet new Working Families Tax Cut Act community engagement requirements starting in 2027. Maryland will refer adult Medicaid participants to RAMP. We anticipate the RAMP model's expansion will result in **1,100 additional Marylanders participating in training and upskilling pathways, with 900 reporting an increase in skills, 750 earning an industry-recognized credential, and 500 obtaining employment**.

MD Labor will competitively grant funds to non-profit organizations, institutions of higher education, local workforce development boards, and Registered Apprenticeship sponsors. Employers will help identify skills gaps and training needs and will hire participants upon successful completion of the program. The track record of success and MD Labor's experience engaging employers will lead to sustainability beyond RHTP.

Area Health Education Centers

Maryland's Area Health Education Centers (AHECs) work across rural Maryland to recruit, train, and retain a qualified health workforce. Programs address pre-college students, health professional students, and current professionals from the fields of medicine, nursing, dentistry, pharmacy, psychology, and social work. We will allocate RHTP funds to the Maryland Area

Health Education Center at the **University of Maryland** to **expand the capacity of existing AHEC work** in rural Maryland, as well as **open a new AHEC** in rural Southern Maryland. Within the existing AHECs, RHTP funds will expand programs that (1) connect rural students to healthcare careers with **hands-on experience in healthcare settings** and (2) support **health profession clinical education rotations** that include housing, preceptorships, interprofessional training, and continuing education. The AHEC Scholars Program is a longitudinal two-year program that exposes students to interdisciplinary didactic and community-based clinical or experiential training in rural Maryland. RHTP funds will **support new infrastructure** including data management and analysis technology tools to capture return on investment.

RHTP funds will **support start-up operations of a new AHEC in Southern Maryland**, including execution of five formal partnerships with health systems, preceptor pool development, and K-12 and health professions program initiation. We will track a number of performance indicators including AHEC Scholars enrolled/completing interprofessional training and employer placements. Infrastructure investments will have sustained use. The new Southern AHEC will build sustainability through in-kind support, partnerships and diverse funding opportunities.

Health Workforce Infrastructure

Considerable technical infrastructure is necessary to effectively support workforce investments throughout rural Maryland. **We need better insight into the capacity and characteristics of our current health workforce**. Like all states, Maryland collects licensure data via occupational boards. However, there are significant gaps between active licensure and actual provision of healthcare services. Data are often incomplete and outdated. To determine the needs of rural Maryland, we need to know who practitioners are, what services they provide, in what geographies and settings they practice, hours worked per week, and number of hours providing

clinical care versus performing administrative, teaching, or managerial responsibilities. **Better data will enable us to effectively focus our rural workforce investments.**

We propose allocating RHTP funds to the **MDH Office of Population Health Improvement** to implement a **Maryland Health Workforce Data Clearinghouse** (Clearinghouse). MDH has engaged stakeholders in planning and drafting a Clearinghouse blueprint, identifying the following potential data sources: all-payer claims data, health plan network adequacy, licensing boards, hospital staff vacancy rates, and community insights. Key partners are the Maryland occupational boards, Maryland Longitudinal Data System Center, and Maryland Health Care Commission (MHCC). A task force will help develop initial use cases for key professions and inform inaugural data collection, analysis, and reporting on patient need and healthcare professional supply. This work is foundational to determine need for primary and specialty care providers, promote the recruitment and retention of healthcare providers to help meet identified needs, and help reduce shortages of healthcare providers in rural Maryland.

In addition, a proposed **Data System will improve efficiency and the experience of rural health professionals** in their interactions with MDH workforce development programs such as the Maryland Loan Repayment Programs and CHW Program. The **Maryland Department of Information Technology** will use RHTP funds to enhance existing workforce development opportunities by **managing data to ensure appropriate healthcare delivery throughout rural Maryland**. Current manual processes create inefficiencies, security challenges, and delays for health professionals. We need an automated, cloud-based system to streamline and expedite operations, enhance security, improve customer service, and strengthen reporting and auditing capabilities while adapting to significantly increased health professional applicant numbers.

Thousands of current and prospective healthcare professionals across rural Maryland will benefit from more efficient MDH programming.

Transformation Fund Opportunities

Workforce Pipeline Training Programs

This transformation fund will **increase recruitment and training opportunities for healthcare and public health professionals** in rural Maryland and build the bench strength of the rural health workforce. In compliance with RHTP requirements, there will be a five-year rural service commitment where applicable. **MD Labor** will administer the fund.

Background: Awards to local and/or regional entities will help eligible individuals find, train for, and obtain employment, paving the way to long term health careers serving rural Marylanders. The fund will support three categories of opportunities:

- **Career exploration and work-based learning programs** that provide hands-on, skills-based training for students (ranging from from middle school to those as institutions of higher education) to connect classroom learning to real-world careers. This can include but is not limited to **career and technical education, internships, and apprenticeships.**
- **Upskilling opportunities for incumbent workers** to **gain new skills, credentials,** and/or **access advancement opportunities.** This investment will boost earning potential of workers while also cultivating a more highly skilled workforce and increasing the quality of care received in rural Maryland.
- Programs to **support innovation and public health**, including the creation of a public health service corps, community-level health promotion and chronic disease prevention, and health data analytics.

Objectives: This transformation fund will **build a pipeline of future health professionals** for rural communities, while providing advancement opportunities to existing workers. This fund will focus on **direct care, administrative, and HIT** careers. It will help individuals complete educational and training opportunities and obtain certifications and degrees. The fund will spur partnerships across K-12 and postsecondary education, workforce systems, and training infrastructure.

Potential Applicants: Potential applicants to this transformation fund include community colleges, school districts, universities, and other education providers in partnership with hospitals/health systems, healthcare providers, community-based social service providers, and local health departments (LHDs). Applicants will have the flexibility to define how to form partnerships across geographies that make sense for their proposals.

Activities: **Figure 8** shows the types of activities eligible for funding to develop rural professionals.

Figure 8: Potential Workforce Pipeline Training Programs Activities

Domain	Examples
Recruitment and Training	- Partner with middle and high schools, community colleges, training programs to identify students interested in healthcare/public health. - "Grow your own" recruitment, including career and technical education (CTE) programs reflective of rural communities. - Deploy participants (trainees, interns, apprentices, early-careers) to skill building pathways. - Match recruits with experienced mentors in public health or healthcare practice.
Placement/ Partnerships	- Full-time roles, college summer internships, and junior fellowships for high school students. - Strengthen and formalize partnerships with employers - Deploy participants to partner sites, e.g., local health departments, FQHCs, hospitals, schools, EMS/community paramedicine programs. - Training in place to bridge training and full-time employment. - Structure tiers for different education/experience levels.
Incentives and Support	- Earn while you learn models with stipends, support for transportation, and other potential training obstacles to reduce participation barriers. - Training cost reductions tied to service commitments. - Career advancement with preferential hiring.
Outcomes Tracking	- Data-sharing partnerships with education institutions and health systems to track outcomes and workforce retention.

Provider Training, Recruitment, and Retention Strategies

The Provider Training, Recruitment, and Retention Transformation Fund will expand **training, recruitment, and retention** strategies for rural Maryland physicians and advanced practice professionals (e.g.,**physician assistants, advanced practice nurses, behavioral health providers, and dentists)**. In compliance with RHTP requirements, there will be a five-year rural service commitment. **MD Labor** will administer the fund.

Background: The transformation fund will enable Maryland's **education and health systems to develop cohesive strategies** across provider types and rural areas. The increase in workforce resulting from five years of RHTP funding will produce a positive cycle – a larger workforce will reduce burnout and professional isolation, creating a more appealing environment for new and established providers. This will continue to attract additional healthcare providers, **sustaining workforce gains** even after the RHTP period.

Objectives: This transformation fund will increase the number of healthcare trainees and practitioners in rural areas.

Potential Applicants: Potential applicants include health professional schools and healthcare provider organizations.

Activities: **Figure 9** shows examples of activities eligible for funding across training, recruitment, and retention.

Figure 9: Potential Provider Training, Recruitment, and Retention Activities

Domain	Examples
Training	- Build rural-relevant education pathways to expose students early to rural practice and community-based training. - Rural track programs within health professional schools to place students in rural settings early and often, offering immersive experiences via longitudinal curriculum, mentoring, and clinical experiences in rural areas. - Training cost reductions tied to service commitments. - Community-based education partnerships to deliver training in local hospitals, FQHCs, or health departments and build familiarity with the community. - Interprofessional rural training hubs to combine nursing, medical, behavioral health, EMS, and public health students for team-based, interprofessional training. - Simulation and telehealth training to allow rural providers to practice high-acuity skills and integrate technology (tele-emergency, tele-ICU, telepsychiatry).
Recruitment and Retention	- Attract and match clinicians to rural practices. - Flexible work and lifestyle incentives, e.g., flexible scheduling, spousal employment assistance, childcare assistance. - Community integration initiatives, e.g., "Welcome Teams" to help new clinicians connect with schools, faith communities, and civic groups. - Relocation incentives. - Professional development funding, e.g., CME stipends, leadership training, and tele-mentoring to keep rural clinicians connected and advancing. - Wellness, team-based practice models and peer support networks to reduce professional isolation.

Note the Budget Narrative combines the two *Initiative One* transformation fund opportunities.

This reflects an efficient staffing approach across the two transformation funds.

Description of Initiative Two: Promote Sustainable Access and Innovative Care for Rural Marylanders

Figure 10: Overview of Initiative Two

Initiative	Promote Sustainable Access and Innovative Care for Rural Marylanders
Main Strategic Goal	Sustainable Access Innovative Care Tech Innovation
Use of Funds	F. IT advances G. Appropriate care delivery H. Behavioral health I. Innovative care
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 F.3. Consumer-facing tech
Key Stakeholders	SORH, HSCRC, MHCC, CRISP, MIEMSS, MACHO, LHDs, AAAs, healthcare providers (hospitals, primary and specialty care practices, behavioral health providers, FHQCs, SBHCs), community-based organizations, technology vendors, and universities. See Acronym List Attachment.
Outcomes	See *Metrics and Evaluation Plan* for detail. (1) Increase in primary care capacity in rural counties (**access metric**) (2) Increase in behavioral health capacity in rural counties (**access metric**) (3) New connectivity points to HIE benefiting rural Marylanders, # connections, with percentage increase (**technology use, quality and health outcomes metric**) (4) New rural provider participation in advanced care models, # with percentage increase, as available (**quality and health outcomes metric**)
Impacted Counties	Maryland law recognizes 18 counties as rural. The initiative will impact residents in all 18 counties. The Federal Information Processing Series (FIPS) codes for these counties are: 24001, 24009, 24011, 24013, 24015, 24017, 24019, 24021, 24023, 24025, 24029, 24035, 24037, 24039, 24041, 24043, 24045, and 24047.
Estimated Required Funding	$765,310,876 over all five years Please see detailed information in the Budget Narrative.

To achieve a **world-class health system** for rural Marylanders, we will **expand existing and implement new** efforts to bring healthcare services into rural communities. **Figure 11** shows the elements of *Initiative Two*. See the *Budget Narrative* for budget information.

Figure 11: Initiative Two Proposed Elements

Initiative Two: Promote Sustainable Access and Innovative Care for Rural Marylanders	
Immediate Impact Funding	
Investments: - Expand Primary Care and Specialty Practice Capacity (Technical Score Factors B.1., C.1., E.1.) - Increase Efficiency of Local Agency Operations (Technical Score Factor F.2.) - Strengthen Emergency Trauma Response (Technical Score Factor C.2) - Expand School-Based Health Center Capacity (Technical Score Factors B.1., F.1., F.2.) - Optimize HIT Connectivity and Use of CRISP Tools (Technical Score Factors B.1., C.2., F.1., F.2.) - Centralize Telehealth Infrastructure (Technical Score Factors F.1., F.2.)	**Key Uses of Funds:** - Appropriate Care Delivery - IT Advances
Transformation Funding	
Funding Opportunities: - Sustainable Access through Service Expansions and IT Advances (Technical Score Factors B.1., F.1., F.2., F.3.) - Mobile Health Transformation Fund (Technical Score Factors B.1., C.1., F.2.) - Innovative Care Transformation Fund (Technical Score Factors B.1., C.1., E.1.) - Behavioral Health Transformation Fund Technical Score Factors B.1., C.1., F.1.)	**Key Uses of Funds:** - Innovative Care - IT Advances - Behavioral Health - Appropriate Care Delivery

Immediate Impact Funding

Expand Primary Care and Specialty Practice Capacity

Maryland has used savings from value-based care models to increase access to advanced primary care and help specialty physician practices participate in value-based care arrangements. To date, eleven new primary care practice sites are serving communities and specialty practices generated more than $50 million in savings in the first two years of an episode-based value-based care arrangement. We propose allocating RHTP funds to the **Health Services Cost Review Commission** (HSCRC) to **expand these efforts, supporting more primary care and specialty practices in rural communities**. This builds on existing HSCRC and MDH initiatives to expand rural primary care access and transform more rural specialty practices. Funding will support primary care start-up costs and specialty practice transformation. Efforts **promote patient-centered care** and help **avoid high cost, unnecessary health care utilization**. As providers fill

patient panels and advance their practices they will sustain costs through billing and earned savings through value-based care arrangements.

Increase Efficiency of Local Agency Operations

Maryland's LHDs and local Area Agencies on Aging (AAAs) provide critical clinical services and/or care coordination in rural areas. However, contracting with and billing Medicare, Medicaid, and other insurers is an administrative hurdle to reimbursement for currently covered services. Maryland proposes allocating RHTP funding to **strengthen rural LHD and AAA revenue capture and self-sufficiency**. MDH would fund a lead LHD to hire a contractor with **expertise in coding, billing, and revenue cycle management**. The contractor will help LHDs and AAAs streamline processes for empaneling with insurance companies, enabling rural residents to access covered services locally. This can translate to earlier disease detection, better chronic disease management, and avoidance of high-cost health crises. Increased revenue will sustain ongoing service delivery.

Strengthen Emergency Trauma Response

The **Maryland Institute for Emergency Medical Services Systems** (MIEMSS) has a sophisticated pre-hospital system, with a single statewide integrated emergency medical services (EMS) and trauma system, plus two Level 1 adult trauma centers. For severely injured trauma patients, providing blood within 35 minutes of the injury increases survival. This is particularly valuable in rural areas where travel distance to trauma centers is significant. With RHTP funds, we will **pilot pre-hospital whole blood transfusion in rural regions to reduce mortality**. MIEMSS recently worked with a central Maryland county's fire and rescue services and local hospital to pilot a pre-hospital blood transfusion program. We will **fund a pilot and assess effectiveness** in our rural jurisdictions to inform the role of whole blood programs in increasing

survival and reducing hospital lengths of stay. MIEMSS and MHCC will assess results to determine sustainability, for example through Maryland's recently expanded trauma fund grant program.

Expand School-Based Health Center Capacity

Maryland has 37 rural SBHCs in 12 counties. Our rural SBHCs address residents' needs holistically by offering physical, behavioral, and oral healthcare. **Demand for rural SBHC services currently exceeds supply** due to limits on operational capacity. Compared to their urban counterparts, rural SBHCs have higher utilization despite being open fewer overall hours due to provider staffing shortages. **Investment in SBHCs expands access to integrated primary care, chronic disease management, behavioral health, and oral health for students, teachers, school staff, and the rural community**. We propose allocating RHTP funding to the **Maryland School-Based Health Center Program within MDH** to immediately impact rural communities by:

- Expanding service delivery to new geographic areas currently lacking services.
- Expanding primary care, chronic disease management (e.g. asthma action plan support), oral health, behavioral health, and social work to integrate care and ensure more rural youth can access preventive and therapeutic care within their communities.
- Investing in start-up costs of increased clinical provider staffing to extend operating hours.
- Piloting alternative service delivery models and partnerships with Federally Qualified Health Centers (FQHCs) to increase access, including mobile clinic capacity and telehealth/HIT infrastructure.
- Building long-term capacity through minor alternations and facility upgrades and equipment.

SBHC start-up and infrastructure investments will be sustainable through ongoing Medicaid coverage for existing benefits covered under the Maryland Medicaid State Plan and billing of other insurance types.

Optimize HIT Connectivity and Use of CRISP Tools

We propose allocating RHTP funds to enable the Chesapeake Regional Information System for our Patients (**CRISP)**, Maryland's State-Designated Health Information Exchange (HIE) and Health Data Utility (HDU), to **expand HIT connectivity and optimize the use of CRISP tools** in rural Maryland. **Figure 12** summarizes proposed activities. CRISP has long supported **interoperability and data exchange** across multiple systems, partners, and domains to improve quality of care, create a holistic view of patient care, and reduce healthcare costs. CRISP integrates health and other data across sectors to support clinical treatment, care coordination, and public health. The comprehensive and longitudinal data available through CRISP enables Maryland to **develop advanced AI models to improve care**. CRISP's ability to manage granular consent for 42 CFR Part 2 data creates a unique opportunity for Maryland to **address rural behavioral health challenges through improved data sharing**. To realize the full benefits of HIE and HDU infrastructure, we need interoperability across all care touchpoints. However, many rural health providers lack connectivity and/or interoperability, resulting in system fragmentation. CRISP will **connect new rural providers to HIE tools,** support their use, and develop new offerings for rural communities. MHCC will implement needed regulatory changes and oversight.

Figure 12: Proposed Activities for HIT Connectivity and Use of CRISP Tools

Domain	Examples
Pilot AI technology to improve clinical workflows	- Implement AI search functionality to allow providers to search the HIE for specific encounters, diagnoses, and medications. Develop with provider input and pilot in select rural areas. - Develop predictive alerts that notify care teams when a patient's risk level changes based on HIE data.
Increase rural provider connectivity and HIT optimization	- Increase provider data sharing and data quality with CRISP through outreach, integrations, automating manual feeds and targeted technical assistance for new rural providers, including primary care, specialists, behavioral health providers and others. - Offset provider integration costs for newly connected rural providers. - Improve behavioral health HIT and connectivity as well as data sharing through a central registry for methadone dosage information among Opioid Treatment Programs, EMS, and hospitals and share EMS and hospital overdose data with LHDs to facilitate more rapid outreach and treatment initiation. - Enable access to the HIE from EMS EMR platforms to emergency providers with patient clinical and care management information. - Extract Mobile Integrated Health reporting from community paramedicine to incorporate in the HIE.
Connect closed-loop referral tools	- Significantly scale the number of new rural community-based organizations (CBOs) CBOs onboarded onto a closed-loop screening and referral platform for upstream drivers of health free of charge through outreach and integrations. This work will focus on non-food CBOs. Work to connect food CBOs to the referral platform is supported outside of RHTP. - Develop new interoperability capabilities for commercial and CRISP tools through standards or FHIR APIs that allow screening and referral platforms to exchange electronic health data efficiently and securely, and integrate screening data with EHR vendors.
Support CBO Billing	- Support rural CBO billing for non-clinical needs, integrated with CRISP's screening and referral tools. Billing capacity will expand to CBOs that address other needs identified by rural communities. - Develop reporting tools and resources to inform community planning efforts through Local Health Departments and funding under the Food Is Health work (see Initiative Three for information about this fund).

Centralize Telehealth Infrastructure

Telehealth enables patients to overcome transportation barriers and allows rural providers to link to specialty knowledge. Maryland lacks the technical infrastructure to realize telehealth at scale in rural communities. A **centralized telehealth technical infrastructur**e will help create a **virtual continuum of care** across local clinics, hospitals, and distant tertiary care centers and **spur adoption among rural providers and residents**. We propose allocating RHTP funding to **CRISP** for a centralized telehealth infrastructure. **Figure 13** shows examples of activities.

As Maryland's backbone of interoperability, CRISP will enable telehealth to operate as part of an **integrated healthcare ecosystem** by connecting telehealth platforms with electronic health

records (EHRs) and supporting standardized data exchange for real-time information sharing. MDH and MHCC will review and develop any necessary policy to support broad adoption of interoperable telehealth.

Figure 13: Proposed Activities to Centralize Telehealth Infrastructure

Domain	Example
Needs Assessment and Strategy Implementation Plan	- Conduct a needs assessment and develop an implementation plan to advance the adoption of telehealth and teleconsults in rural communities, e.g., making grants to offset provider costs for telehealth system adoption and maintenance, and/or conducting provider outreach for telehealth adoption.
Integration of Existing Telehealth	- Integrate existing telehealth platforms with CRISP, ensuring seamless interoperability with local EHRs and across the care continuum of health care, public health, and social services. - Oversee data security, encryption, and patient privacy.
Workforce Support/Technical Assistance	- Provide guidance and training to providers on assessing technology infrastructure needs for telehealth and understanding vendor offerings. - Develop telehealth training and technical assistance for technology use, legal and regulatory issues, and contracting billing and coding, and patient engagement.
Patient Support	- Develop tools for patients and health workers (e.g., CHWs) to support patient reception to/use of telehealth.
Data Analytics	- Track real-time metrics to optimize operations and inform telehealth strategy.
Policy and Reimbursement	- Work with MHCC, MDH, and other regulatory authorities to align telehealth with Maryland's priorities and vision for rural health as needed. - Track and disseminate federal, state, and payer telehealth regulations and reimbursement rules. - Provide guidance for specialized areas such as school telehealth and tele-behavioral health.

RHTP funds will cover **outreach and integrations with new rural providers** and the **development of new technical solutions**. Some of these activities are one-time start-up costs. To sustain activities that require ongoing funding, we will consider CRISP's revenue model of hospital assessments and provider user fees.

Transformation Fund Opportunities

Sustainable Access Through Service Expansions and HIT Advances

The Sustainable Access Transformation Fund will provide strategic investments to: (1) **Expand services** to meet current demand and build long-term capacity to improve health outcomes; and (2) Deploy **technology-enabled chronic disease management** including remote patient

monitoring and wearable devices such as continuous glucose monitors. **MDH** will administer the fund and issue a competitive RFP/RFA.

Service Expansions for Appropriate Care Delivery

Background: The advanced age of rural Maryland residents means higher chronic disease prevalence. Maryland's rural residents need better access to **primary care** and **specialists**. RHTP funds will support **initial service expansion start-up costs**. As patient volumes grow, providers will bill public and private payers for ongoing sustainability. Additional sources for future sustainability include hospital contracts for readmission reduction and ED diversion, MCO partnerships for chronic care management, and integration into Accountable Care Organization (ACO) shared savings programs and other value-based care arrangements. Behavioral health is also a major need. We elevate behavioral health to its own transformation fund described below.

Objectives: This fund will increase access to a range of priority healthcare services in rural areas. We will **create net-new access points** and promote **efficient, effective management** for individuals at increased risk for hospital readmissions, such as older adults and those with multiple chronic conditions including co-occurring behavioral and somatic needs.

Potential applicants: (1) Partnerships of providers/institutions across the delivery system, and (2) Individual healthcare providers, including hospitals/health systems, FQHCs, pharmacies, post-acute providers, and home and community-based service providers.

Activities: **Figure 14** provides examples of activities eligible for funding. These domains are not mutually exclusive, for example a provider could submit a proposal with primary care and oral health elements. Proposals should involve **community-driven design** and integrate with and complement existing healthcare and social service systems.

Figure 14: Potential Service Expansions Activities

Domain	Examples
Primary Care, Chronic Disease Management, Oral Health, and Specialty Care	- Start-up expenditures for recruitment and retention of staff to expand or add services. - Equipment and infrastructure to expand, update, or modify services. - Minor alterations or retrofitting to convert underutilized cost-intensive spaces within existing healthcare facilities to clinic or community-based treatment spaces. - Training, technical assistance, and support for integrated care models. - Training, technical assistance, and support to integrate allied health professionals into care teams. - Community outreach to engage patients in new or expanded services.
Primary Care	- Co-located and integrated primary care and behavioral health.
Oral Health	- Preventive and restorative oral health services integrated with chronic disease care.

HIT Advances

Background: Rural residents face a multitude of challenges in overcoming long distances to access healthcare, often without adequate transportation. Our RHTP stakeholder engagement process identified technology-enabled chronic disease management tools such as remote patient monitoring and wearable devices such as continuous glucose monitors as key strategies to overcome access barriers. Some of these technology initiatives exist in rural Maryland. However, there is opportunity to **scale and connect efforts to bring healthcare directly to rural residents**. Technology-enabled solutions **empower individuals to manage their chronic conditions,** support post-discharge monitoring, and increase patient-provider communication.

Objectives: Funding will deploy technology-enabled chronic disease management tools by supporting provider start-up costs and patient adoption.

Potential applicants: Potential applicants will be regional collaborations inclusive of healthcare providers, technology vendors, LHDs, AAAs, and/or community-based organizations. The competitive RFP/RFA proposal process will describe the required partner types. Each collaboration must designate a lead.

Activities: **Figure 15** shows examples of the types of activities eligible for funding.

Figure 15: Potential HIT Advances Activities

Domain	Example
Needs Assessment	- Assessment/planning for identification of services gaps and digital health needs.
Technology Infrastructure	- Hardware: tablets, smartphones, laptops. - Support for rural providers to assess, implement, enhance, and maintain their HIT infrastructure and cybersecurity to support remote patient monitoring. This can include support for provider revenue cycle management for monthly remote patient monitoring vendor fees. - Events to connect providers and technology vendors via education, technology demos, and networking opportunities.
Technology-Enabled Chronic Disease Management	- Service model design and deployment for technology solutions including for remote patient monitoring and wearable devices. - Pilots to assess effectiveness of new remote patient monitoring benefits in improving chronic disease management. - Remote monitoring devices/equipment for chronic disease management not already covered.
Integration with Existing Care	- Protocols for follow-up and continuity of care, e.g., care coordination with the medical home, community paramedicine support, CHW visits, or community-based organizations. - Clinical protocols including triage, escalation, and follow-up. - Linkage to CRISP.
Workforce and Training	- Training for digital health navigators and other members of the care team to help patients learn to use new technologies. - Training and technical assistance to care team members to implement new technologies into clinical workflows.
Patient Engagement and Accessibility	- Patient-centered design and support e.g., to help patients learn how to use remote patient monitoring devices and other technologies.

RHTP funding will cover **start-up costs of technology or pilot programs**. Staff will assess health and cost outcomes for continued and expanded payer investment and/or integration with value-based care models to achieve sustainability. MDH and MHCC will assess regulatory policy in Maryland to support expansion. Based on assessment results, we will bring evidence to CMS to explore any necessary policy changes.

Mobile Health Transformation Fund

Stakeholders identified mobile health as a key strategy to overcome access barriers by bringing care directly to rural residents. Maryland's **rural LHDs** will administer this transformation fund. LHDs in each of the State's rural regions will work together with a lead

LHD to administer the fund for that region. Each region will issue a competitive RFP/RFA. The regional approach ensures awards are specific to the needs and strengths of local communities.

Background: Several mobile health programs currently exist in rural Maryland. However, there is opportunity to **scale and connect efforts for a more coordinated approach**. This transformation fund is inclusive of a range of mobile health solutions recommended by stakeholders, including chronic disease screening, mobile clinics, partnerships with EMS to expand community paramedicine and mobile integrated health models, and community-based care teams that provide home visiting.

LHDs are effective at bringing together community partners to design and implement critical health programming. Many have experience in mobile health service delivery. To support LHD administration of the Mobile Health Transformation Fund, we will **allocate resources to LHDs for planning, implementation, financial oversight, and programmatic monitoring**.

RHTP funds will **support initial mobile health start-up costs**. As patient volumes grow, providers will bill public and private payers. Sustainability sources include hospital contracts for readmission reduction and ED diversion, MCO partnerships for chronic care management, cost-sharing agreements among EMS and county agencies, and integration into ACO shared savings programs.

Objectives: This transformation fund will increase access to priority health services in rural areas via mobile solutions.

Potential Applicants: While one organization will serve as the lead applicant to this transformation fund, only partnerships/collaborations of multiple organizations will be eligible to apply. Examples of potential organizations include health care providers, hospitals/health

systems, EMS providers, social service providers, diagnostic service providers, and home and community-based service providers.

Activities: **Figure 16** shows examples of activities eligible for funding.

Figure 16: Potential Mobile Health Activities

Domain	Example
Planning and Service Model Design	- Needs assessment. - Service delivery model elements including: centralized hubs/smaller satellites, health education, referral pathways, clinical triage, diagnostics, follow-up and coordination. - Development of formal agreements.
Start-Up Implementation Costs	- Staffing. - Training, technical assistance, and support. - Technology infrastructure. - Vehicle acquisition/improvements. - Funding for micro access points or place-based sites of care, such as pharmacies, libraries, churches, and retail centers to bridge access gaps and facilitate community engagement. - Mobile diagnostic services, such as mammography, sonography, and point of care testing. - Integration of workflows/data across clinical care and community-based supports (e.g., CHWs and Peers).

Innovative Care Transformation Fund

The Innovative Care Transformation Fund will help rural providers position themselves to manage the health of the communities that they serve and **succeed under payment models that incentivize reduced healthcare costs, improved quality of care, and shifts to lower cost care settings. HSCRC** will administer the fund.

Background: Maryland will **help rural providers adopt value-based care and alternative payment models**. Rural providers have traditionally faced barriers to participation such as financial strain from low patient volumes and limited access to specialized care.

The Innovative Care Transformation Fund will help **align rural providers with the incentives** built into Maryland's hospital payment system and enable them to participate in **alternative payment mechanisms such as ACOs**. For example, the fund could support **clinically integrated network implementation** to help rural providers achieve the scale and develop the infrastructure necessary to successfully participate in value-based care and payment

opportunities. Shared infrastructure and operational resources through a clinically integrated network can **improve the financial viability of rural providers**, support specialty access, and help providers focus on care coordination and population health improvement.

Applicants will be able to request funding to **enable practices to participate in value-based care arrangements**, including geographic-based approaches, and alternative payment models. **Geographic payment models are especially suited to rural areas**, where providers have accountability for the care of a more distinctly defined population to align post-acute care and reduce utilization across the care continuum. Rural providers will have the opportunity to **improve care coordination, focus on preventative care interventions, increase hospital control of cost growth, and accelerate the transition to true value-based payment models**. We include RHTP funds to support an evaluation to identify effective practices.

Providers will continue to bill public and private payers for ongoing sustainability. Provider success under value-based arrangements will also contribute to long-term sustainability.

Objectives: The objective for this transformation fund is to prepare rural health providers to **participate in innovative, value-based care models** such as geographic-based models.

Potential Applicants: Potential applicants include (1) rural health providers (primary care and specialty care practices, FQHCs, SBHCs, hospitals, pharmacies, post-acute, and others), (2) consortiums of healthcare providers, and/or (3) healthcare provider collaborators.

Activities: **Figure 17** shows examples of the types of domains eligible for funding.

Figure 17: Potential Innovative Care Activities

Domain	Examples
Infrastructure	- Readiness assessment. - Clinically integrated network development. - Staffing, training, and support for workflow redesign, managing value-based payment models. - Revenue management including coding for billing and quality reporting and financing mechanisms to support value-based care arrangements. - Consultation for legal and contractual structure of shared savings/risk agreements and

	clinically integrated networks. - Organizational change management and process standardization.
Workforce	- Training for team-based care and population health management principles. - Role expansion for care team members to practice at top of license. - Staffing optimization for panel outreach and management. - Change management coaching.
Technology and Data	- EHR optimization to configure templates and reporting tools. - Data analytics dashboards for risk stratification, care gap identification, alerts, and performance tracking. - Education of patients on portals for secure messaging and scheduling, education and self-management. - Community linkage to resources to address non-clinical needs such as food..
Clinical Care and Quality Improvement	- Care management workflows, including protocols for evidence-based chronic disease management, care transition management, behavioral health integration, preventive care outreach, and population health management with patient risk stratification and intervention. - Training on quality metrics/benchmarks and reporting and continuous improvement coaching.
External Partnerships	- Learning collaboratives to share lessons and best practices. - Integration with public health systems, streamlining specialty referral networks. - Planning and engagement with payers to gain conceptual buy-in to develop operational mechanics and pilot new models.

Behavioral Health Transformation Fund

Maryland is committed to **increasing sustainable access to the full behavioral health continuum of care across the lifespan** in our rural communities, resulting in holistic, whole-system transformation. **BHA** will administer the fund.

Background: The need for expanded behavioral health services was a **major theme from our RHTP stakeholder engagement** process. Maryland's children and adolescents, like those across the nation, are suffering declines in mental and emotional health. Data from recent years indicates that 30% of Maryland middle and high school students report feeling sad or hopeless, the state is losing more than 100 young people a year to drug and alcohol overdoses, behavioral health patients board in emergency departments at a median time of 34 hours, and suicide is the third leading cause of death among young people.[12]

[12] Roadmap to Strengthen Maryland's Public Behavioral Health System for Children, Youth and Families. June 2025.https://health.maryland.gov/bha/Documents/MDH%20BH%20Roadmap%20for%20Children%202025.pdf?utm_source=chatgpt.com

The Behavioral Health Transformation Fund will provide resources to proposals that are **responsive to demonstrated local need based on quantifiable metrics** of service gaps and outcomes (e.g., lowest quartile of provider to condition ratio, opioid and suicide fatalities); evidence-based interventions; and **aligned with State and RHTP priorities** including scaling telehealth. RHTP funds will **support initial service expansion start-up costs**. As patient volumes grow, providers will bill public and private payers for ongoing sustainability.

Objectives: The objective for this transformation fund is to **increase sustainable access to priority services across the full continuum** of behavioral health care in rural areas.

Potential Applicants: Potential applications include local behavioral health authorities, LHDs, non-profit and for-profit behavioral health service providers.

Activities: **Figure 18** shows examples of the types of activities eligible for funding.

Figure 18: Potential Behavioral Health Activities

Domain	Examples
Behavioral Health and Primary Care Integration	- Training, technical assistance, and infrastructure to expand models that support integrated care such as the Collaborative Care Model, Screening, Brief Intervention, Referral and Treatment (SBIRT), and Healthy Steps.
Prevention and Promotion	- Development of referral pathways from Maryland schools. - Training for providers to expand access to community-based treatment via in-person and telehealth modalities. - Start-up staffing to increase access to opioid-associated disease prevention and outreach programs operated by LHDs and/or community-based organizations.
Primary Behavioral Health and Early Intervention	- Start-up staffing to increase access to Intensive In-Home Service Providers to provide individualized support to children and their families to prevent out-of-home placement and reduce psychiatric symptoms. - Training, technical assistance, and support to expand the number of Young Adult Certified Peer Recovery Specialists.
Urgent and Acute Care	- Mobile response and stabilization services for youth and families.
Treatment and Recovery	- Training, technical assistance, and start-up staffing to increase access to intensive case management programs for older adults with substance use disorders. - Training, technical assistance, and start-up staffing to expand medication for opioid use disorder.

Description of Initiative Three: Empower Marylanders to Eat for Health

Figure 19: Overview of Initiative Three

Initiative Three	Empower Marylanders to Eat for Health
Main Strategic Goal	Make Rural America Healthy Again
Use of Funds	A. Prevention and chronic disease J. Capital expenditures and infrastructure
Technical Score Factors	B.2. Health and lifestyle
Key Stakeholders	SORH, MDA, MDHCD, MDEM, Rural Maryland Council, LHDs, food producers, food retailers, institution buyers, preschools/schools, farmers' markets, food councils, food buyers and/or consortiums of buyers. See Acronym List Attachment.
Outcomes	See *Metrics and Evaluation Plan* for detail. (1) Participants in targeted nutrition education programs with increased knowledge regarding consumption of healthy foods and reduced consumption of processed foods, # with percentage increase, as available (**program implementation metric**) (2) Sustainable infrastructure improvements, # (**program implementation metric**) (3) New or expanded initiatives to strengthen healthy food distribution across rural Maryland, # (**program implementation metric**) (4) New or expanded initiatives to strengthen healthy food purchasing strategies across rural Maryland, # (**program implementation metric**)
Impacted Counties	Maryland law recognizes 18 counties as rural. The initiative will impact residents in all 18 counties. The Federal Information Processing Series (FIPS) codes for these counties are: 24001, 24009, 24011, 24013, 24015, 24017, 24019, 24021, 24023, 24025, 24029, 24035, 24037, 24039, 24041, 24043, 24045, and 24047.
Estimated Required Funding	$88,017,624 over all five years Please see detailed information in the Budget Narrative.

Addressing **consistent access to food is important for health promotion, chronic disease prevention, and overall well-being**. Maryland's work on promoting healthy food is key to addressing the **diet-related chronic disease epidemics** of heart disease, diabetes, and obesity. Maryland's **cross-agency approach** brings together multiple State entities, **eliminating silos to improve health.** Maryland will invest in **infrastructure to improve access to nutritious, locally grown and raised foods**. No RHTP funds will be used to purchase food and this work does not supplant any existing funding. RHTP funds will not replace any State or federal funds.

Figure 20 shows the elements we propose for *Initiative Three*. The *Budget Narrative* includes additional detail.

Figure 20: Initiative Three Proposed Elements

Initiative Three: Empower Marylanders to Eat for Health	
Immediate Impact Funding	
Investments: - Post-Harvest Infrastructure (Technical Score Factor B.2) - Expand Grocers and Mobile Markets (Technical Score Factor B.2) - Create Demand for Healthy Foods (Technical Score Factor B.2) - Support Food Planning and Coordination (Technical Score Factor B.2)	**Key Uses of Funds:** - Prevention and chronic disease - Capital expenditures and infrastructure
Transformation Funding	
Funding Opportunities: - Increase Local Healthy Food Access: Aggregation (Technical Score Factor B.2) - Increase Local Healthy Food Access: Purchasing Strategy (Technical Score Factor B.2)	**Key Uses of Funds:** - Prevention and chronic disease

Immediate Impact Funding

Post-Harvest Infrastructure

Post-harvest infrastructure expands the availability of nutritious, fresh, healthy food for distribution to communities. Annually, Maryland farms produce over $429 million in fruits, vegetables, dairy, seafood and proteins. Maryland's small to mid-size producers are uniquely vulnerable to post-harvest losses—the degradation or spoilage of food that occurs between harvest and consumption. A **lack of effective refrigeration for perishable crops like fruits and vegetables results in a 44% loss of all food produced**. The lack of accessible and affordable cold storage is a persistent and structural challenge for Maryland's "middle of the supply chain" agricultural food producers. The inability of small to mid-size farms to store and preserve perishable goods like fresh produce means they cannot consistently supply local markets. This **issue is exacerbated in rural areas, where residents already lack access to full-service supermarkets**. Cold storage that accommodates larger equipment (e.g., pallet jacks) enhances

wider distribution of a variety of foods, including fresh produce. We propose allocating RHTP funds to the **Maryland Department of Agriculture** (MDA) to **strategically locate cold storage infrastructure within rural communities to expand food aggregation and distribution capacities**.

Cold storage infrastructure for agriculture and food distribution includes freezers, refrigerators, cold storage lockers, cold storage trucks, and other related equipment. Investing in cold storage and distribution of fresh, healthy produce will **improve Marylanders' dietary quality**.

Expand Grocers and Mobile Markets

Low access food areas or **"hunger hotspots" are prevalent in rural Maryland** and especially concentrated in Western Maryland. Smaller-scale food retailers often have limited capacity and infrastructure to shoulder the **financial liability of stocking perishable foods with a short shelf life**. By investing in the ability of small food retailers to have improved customer-facing inventories of perishable foods as opposed to shelf-stable highly processed foods, Marylanders will have **better access to healthy produce and fresh foods**. A lack of transportation is another major barrier to accessing fresh, local foods. **Mobile markets, pop-up markets, and other temporary farm sales channels are highly effective in increasing access to healthy, locally produced food**.

We propose allocating RHTP funds to the **Maryland Department of Housing and Community Development (DHCD)** to expand the NourishMD: Healthy Food Access Grant Program to provide c**apital to small grocers and mobile access points** serving rural Maryland. This program will help local food retailers overcome the financial barriers that limit access to affordable, healthy foods. Funds will support equipment purchases (e.g., refrigeration, shelving), minor facility alterations, technology infrastructure, and marketing to create a sustainable

business by expanding the demand pool. Eligible businesses must **demonstrate a commitment to offering healthy, affordable food options**, including fresh fruits, vegetables, dairy, proteins, and other staple items, and are encouraged to **partner with local and regional farmers to source products that strengthen Maryland's agricultural economy and food supply chain**. Additional staff support will provide operational support for program implementation and enhance technical assistance to small grocery retailers.

Create Demand for Healthy Foods

Improving the diet of rural Marylanders requires education to **increase the demand for healthy, fresh foods**, in addition to increasing the supply. Many rural Maryland children and adults have low intake of fruits, vegetables, and water, and limited engagement in physically active behaviors. We propose allocating RHTP funds to **rural LHDs** to provide targeted nutrition education to **improve healthy behaviors among rural residents**. LHDs will deliver educational interventions in collaboration with partners at settings such as faith-based organizations, preschools, health care organizations, schools, and farmers' markets. Objectives include **increased consumption of fruits and vegetables, increased water consumption, and decreased consumption of processed foods**.

Support Food Planning and Coordination

To **improve diets and achieve better health outcomes**, regional convening and coordination is essential. We propose allocating RHTP funds to the **Maryland Department of Emergency Management** (MDEM). MDEM serves as the coordinator and convenor of food system partners across agencies and jurisdictions statewide. MDEM will establish a **Rural Food Coordination program** with a regional approach to convening and coordinating. In addition to conducting in-person outreach to rural stakeholders to understand the needs of Maryland's farmers, MDEM's

Rural Food Coordinators will coordinate efforts across local food councils, food banks, and local government agencies in rural communities. MDEM will partner with the Rural Maryland Council to ensure that the transformation fund opportunities described in the next section help improve the dietary quality of rural communities.

Transformation Fund Opportunities

Increase Local Healthy Food Access: Aggregation

The establishment and expansion of local farm food aggregators in Maryland can help provide a **link between the small to mid-size farmer and the large-scale buyer** such as a wholesaler or large institution that is looking to purchase locally grown food. We propose allocating RHTP funds to the **Rural Maryland Council** for **development and expansion of healthy food aggregation**.

Background: Food aggregators, hubs, and associated coordination and IT infrastructure are **critical in rural areas where farms are small and dispersed**. Coordination prevents fragmentation and helps **build economies of scale**. The primary functions of food aggregators include coordination and planning, aggregation of food supply, and transportation. RHTP funds will **cover the start-up costs for food aggregation systems**. In addition to food aggregators, RHTP funds will help offset food safety equipment. A farm with good existing infrastructure may only spend a few hundred dollars, while a farm that needs to modify an aging packing area will spend significantly more. Examples of expenditures include harvest containers, cleaning tools and supplies, packing surfaces, packhouse modifications, and packing line equipment. Once operational, the revenue from foods sold will support ongoing food aggregation sustainability.

Objectives: Develop food aggregators and hubs to **stimulate increased market access** for small to mid-size Maryland farmers who wish to sell healthy food to wholesale and institutional buyers, ultimately **increasing the volume and value of healthy local food sold**. This investment will **improve the dietary quality of Marylanders and will improve the economic viability of Maryland farmers**.

Potential Applicants: Potential applicants include producers (collaboratives of small to mid-farms or existing farming operation aggregators seeking to expand) and food councils.

Activities: **Figure 21** shows examples of the types of activities eligible for funding.

Figure 21: Potential Aggregation Activities

Domains	Examples
Needs Assessment and Planning	- Conduct a regional assessment to identify farm production, food demand (schools, hospitals, retailers, food banks), transportation links, and storage capacity. - Map existing aggregation points (e.g., co-ops, cold storage, food pantries, wholesale markets). - Identify aggregation deserts—areas without shared infrastructure or processing capacity. - Assess potential anchor buyers (e.g., universities, hospitals, prisons) to guarantee demand.
Hub Development	- Create a shared logistics network (e.g., hub-and-spoke model) where smaller aggregation points feed into regional hubs or piloting innovative distribution models. - Support shared services (e.g., food safety certification, training, insurance, coordinated marketing). - Design protocols for collective product pooling and sales management. - Develop memoranda of understanding.
Core Physical Infrastructure/ Supply Chain	- Aggregation and post-harvest processing centers for washing, packing, grading, light processing (e.g., cutting vegetables). - Cold storage and refrigerated trucks to maintain food safety and freshness. - Cross-docking site for regional redistribution. - Support for last-mile delivery.
Establish Digital Infrastructure	- Implement IT infrastructure for virtual aggregation with an online coordination platform that manages ordering and logistics (e.g., trucking route optimization) but not physical storage. - Develop e-commerce digital marketplaces and ordering systems to connect producers with institutional buyers.

Increase Local Healthy Food Access: Purchasing Strategy

We propose allocating RHTP funds to the **Rural Maryland Council** to **spur Maryland institutions to purchase locally grown food**. This addresses the demand side to maximize the purchase of healthy foods and ensure that **more Maryland food feeds Marylanders**.

Background: Maryland institutions such as community colleges, childcare centers, local school systems, hospitals, and senior centers need support to pivot away from their current food acquisition operations to develop new strategies to purchase local foods. Transitioning institutional purchasing towards fresh foods improves the diets of large numbers of Marylanders. RHTP funds will cover the **start-up costs of pivoting away from traditional food purchasing systems to focus on locally produced foods**. Once operational, the new system will be sustainable within existing institutional food budgets.

Objectives: This transformation fund will provide resources to food purchasers to plan for and implement processes to purchase local, healthy foods on an ongoing basis, ultimately increasing the volume and value of local food sold.

Potential Applicants: Potential applicants are buyers and/or consortiums of buyers. These could include county governments, municipalities, community colleges, universities, local school systems, food pantries, childcare centers, and healthcare facilities.

Activities: **Figure 22** shows examples of the types of activities eligible for funding.

Figure 22: Potential Purchasing Strategy Activities

Domains	Examples
Policy and Procurement Framework	- Alignment with federal and state rules, e.g., USDA National School Lunch Program cost and competition requirements. - Administrative support and training for food service directors and procurement officers on how to legally and efficiently source local food. - Policies to prioritize local sourcing, such as a "geographic preference" in bids. - Clear procurement guidance with simplified templates, vendor qualification processes, and model contracts for local vendors.

	- Incorporate local food goals into health improvement and economic development.
Menu Planning and Culinary Capacity	- Volume coordination systems to forecast demand and match it with supply (e.g., forward contracts or seasonal menus). - Menu alignment for seasonal menu planning based on local availability. - Scratch cooking capacity and training for kitchen staff to prepare fresh, whole foods. - Equipment upgrades including better refrigeration, preparation, and cooking equipment to handle raw or minimally processed ingredients. - Nutrition education to integrate local food into curriculum and cafeteria promotions to increase consumer acceptance.
Data systems	- Dashboards tracking purchases, pricing, sales to assess/refine procurement and menu planning and justify continued investment.

Note we combine the two *Initiative Three* transformation fund opportunities in the *Budget Narrative*. This reflects an efficient staffing approach across the two transformation funds.

Implementation Plan and Timeline

Maryland will achieve RHTP goals and milestones with a **robust and active governance structure, effective project management, and close collaboration** with State agencies, transformation fund partners, and stakeholders. **Figure 23** shows a summary of Maryland's Implementation Plan. We include Maryland's detailed RHTP **implementation plan and timeline** for all FY26 – FY31 activities, **including implementation stages**, in Attachments.

Figure 23: Summary of Maryland's Implementation Plan

Activity	BP1	BP2	BP3	BP4	BP5
Governance	0-2	3	3	3-4	4-5
Initiative One: Transform the Rural Health Workforce					
Pathways to Health Careers	0-2	3	3	3	4-5
Area Health Education Centers	0-2	3	3	3-4	4-5
Health Workforce Infrastructure	0-1	2-3	3	3-4	4-5
Workforce Pipeline Training Programs	0-2	3	3	3-4	4-5
Provider Training, Recruitment, and Retention Strategies	0-2	3	3	3-4	4-5
Initiative Two: Promote Sustainable Access and Innovative Care for Rural Marylanders					
Expand Primary Care and Specialty Practice Capacity	0-1	2	3	4	5
Increase Efficiency of Local Agency Operations	0-2	3	3-5	N/A	N/A
Strengthen Emergency Trauma Response					
Expand School-Based Health Center Capacity	0-2	3	3	3-4	4-5
Optimize HIT Connectivity and Use of CRISP Tools	0-2	2	2-3	4	5

Centralize Telehealth Infrastructure	0-2	2-3	2-3	3-4	5
Sustainable Access through Service Expansions and IT Advances	0-2	3	3	3-4	4-5
Mobile Health Transformation Fund	0-2	3	3	3-4	4-5
Innovative Care Transformation Fund	0-2	3	3	3-4	4-5
Behavioral Health Transformation Fund	0-2	3	3	3-4	4-5
Initiative Three: Empower Rural Marylanders to Eat for Health					
Post-Harvest Infrastructure	0-2	3	3	3-4	4-5
Expand Grocers and Mobile Markets	0-2	3	3	3-4	4-5
Create Demand for Healthy Foods	0-2	3	3	3-4	4-5
Support Food Planning and Coordination	0-2	3	3	3-4	4-5
Increase Local Healthy Food Access: Aggregation	0-2	3	3	3-4	4-5
Increase Local Healthy Food Access: Purchasing Strategy	0-2	3	3	3-4	4-5

Governance and Project Management Structure

MDH is the lead agency for the RHTP. SORH is the designated office within MDH **responsible for overall implementation, management, and assessment** of RHTP initiatives. SORH will serve as the central coordinating entity for all activities under Maryland's RHTP and Cooperative Agreement. SORH will **ensure consistency with CMS requirements** per the Notice of Award and subsequent Cooperative Agreement, along with State policies, resources, and initiatives to support rural health transformation. **Sara Seitz, SORH Director, will serve as the RHTP Project Director** and will oversee daily operations, reporting, and coordination among internal and external partners. With nearly 20 years as a public health professional, Sara Seitz, MPH, has **extensive experience engaging stakeholders to expand healthcare access and improve health outcomes**. Her leadership will draw on first-hand knowledge of rural health via the SORH directorship role, extensive federal grants management expertise, working experience in a rural LHD, and as a **current resident of rural Maryland**.

The RHTP work will benefit from direct oversight and engagement from the **Assistant Secretary for Population Health and Strategic Initiatives Elizabeth Edsall Kromm, Ph.D., M.Sc.**, which offers a direct line to the Office of **MDH Secretary Meena Seshamani, M.D., Ph.D**. To fulfill the responsibilities under this Cooperative Agreement, **SORH will add staff**

capacity for project management, performance management, outreach, and contract management. We will dedicate contractual FTEs to support implementation over five years of *Transformation Plan* as described with additional detail in the *Budget Narrative*. With **approval for expedited hiring**, we anticipate completing the recruitment process with staff in place by February 2026. We will engage contractors to support the work of (1) Developing RFPs/RFAs for the transformation funds, (2) Structuring review committee processes and (3) Drafting evaluation/scoring rubrics. The contractors will also support coordination with partner agencies administering immediate impact funds.

Coordination with State Agencies and Funding Partners

Frequent communication and a defined decision-making process will be key for this scope of transformation. MDH contains many of the key roles and resources critical to achieving RHTP goals, including SORH, the State's Medicaid Agency, the Program Management Office of the Maryland Primary Care Program, BHA, the Prevention and Health Promotion Administration (PHPA), and the Public Health Services Administration. **As the central coordinating entity, SORH will engage with agency and funding partners** described in Initiatives One, Two, and Three. LHD Health Officers report to the Deputy Secretary for Public Health Services. LHDs will support mobile health partnerships, including programs that work to create partnerships with county-based EMS.

SORH will lead engagement with Maryland's rural communities, providers, and stakeholders for input on the further development of initiatives, implementation, and achievement of milestones.

SORH is well-positioned to manage initiatives in close collaboration with other MDH administrations and funding partners outside of MDH. SORH has **effective systems for coordination** among MDH administrations and Maryland agencies. It has **successfully carried out multiple federal grants**. Sara Seitz participates in a number of commissions and councils, including leading the **Maryland Statewide Telehealth Interest Group** and serving on the advisory board of the **Mid-Atlantic Telehealth Resource Center**, Executive Board Member of the **Rural Maryland Council** and Chair of its Health Committee, and **Rural Maryland Prosperity Investment Fund Committee member**. SORH's coordination efforts will focus on:

- **Funding Coordination**: Align and coordinate the deployment of funding streams across agency partners to avoid duplication and promote complementary investments. Collaborate with CMS on the Cooperative Agreement.
- **Policy Alignment and Milestone Tracking**: Monitor the implementation of the *Transformation Plan*, assess progress toward milestones, identify gaps in state policy or regulation that may impede progress, and coordinate responses to address gaps as needed.
- **Performance Assessment:** Oversee collection and analysis of impact metrics to assess the effectiveness of funded initiatives and inform continuous improvement efforts.
- **Grantee Performance and Accountability**: Review grantee financial and outcome reporting to ensure accountability and confirm that no program duplication exists.

The RHTP governance model will establish a **RHTP Steering Committee as part of an integrated Engagement and Advisory Framework**, consistent with CMS Notice of Award and Cooperative Agreement. The framework **combines formal advisory processes with broad community engagement mechanisms** to ensure rural stakeholders are actively involved in shaping and assessing transformation strategies. The RHTP Steering Committee will monitor

Maryland's implementation of our *Transformation Plan* and provide **ongoing oversight and accountability for RHTP funding**. SORH will report to the RHTP Steering Committee on the progress on implementation, the achievement of milestones, and the outcomes of initiative-specific metrics. The Steering Committee will include all the State agency and funding partners, and representatives from rural hospitals, primary care and specialty care providers, behavioral health providers, EMS, and other key stakeholders including the perspective of rural residents. We describe stakeholder engagement further below.

Stakeholder Engagement

Engagement Framework

Maryland's collaboration and **partnership with providers across the healthcare delivery system is a hallmark of decades of innovation** in care. We will continue leveraging our infrastructure and experience in coalition-building to advance rural health transformation. See Attachments for letters of support.

The RHTP governance model will include an **Engagement and Advisory Framework** to formalize advisory processes combined with broad community engagement mechanisms to **ensure rural stakeholders are actively involved** in shaping and evaluating transformation strategies, consistent with the Notice of Award and Cooperative Agreement. The Framework ensures **input from rural communities, including patients and providers**.

As part of the Framework, we will establish a **RHTP Steering Committee** to monitor Maryland's implementation of our Rural Health Transformation Plan and provide ongoing oversight and accountability for RHTP funding. SORH will report to the RHTP Steering Committee on the **progress of funds deployment, implementation, the achievement of**

milestones, and the outcomes of initiative-specific metrics. The Steering Committee will include all the State Agency and funding partners as well as MDH – Maryland Medicaid and Maryland's SORH – in addition to representatives from rural hospitals, primary care providers, specialists, behavioral health programs, EMS, and other key stakeholders. The RHTP Steering Committee will monitor Maryland's implementation of our Rural Health Transformation Plan and **provide ongoing oversight and accountability for deploying funds, tracking milestones, and assessing impact metrics**. Steering Committee functions include:

- **Program Oversight**: Review progress on the Immediate Impact Fund and advise on alignment of funded projects within the RHTP goals.
- **Strategic Input**: Provide guidance on the design and goals of Transformation Funds to ensure alignment with community priorities and participate in application review committees absent any conflicts.
- **Accountability and Transparency**: Review and interpret metrics on program outcomes, and progress and milestones, ensuring accountability and transparency in implementation.

SORH will work with the RHTP Steering Committee to **continue the broad-based stakeholder engagement** critical to developing our RHTP proposal. Maryland will require funding partners and grantees to engage community partners in their activities and share feedback with SORH and the RHTP Steering Committee. SORH will create **ongoing opportunities to share information** on RHTP progress with rural communities and stakeholders to **gain their feedback and recommendations.** Avenues include regular community meetings (monthly or at least quarterly depending on the organizer) convened at the local level by LHDs, Local Health Improvement Coalitions, and Local Behavioral Health Authorities. At the state level, Maryland's Health Secretary has regular community convenings, and we will partner with existing standing

convenings of the Rural Maryland Council, the Medicaid Advisory Committee, and other groups to **keep rural health transformation at the forefront of discussions**. We will continue sharing regular updates via the rural health transformation webpage launched for our RHTP planning process.

Engagement to Develop Rural Health Transportation Plan and Proposal

To engage stakeholder input on this rural health transformation plan and proposal, MDH implemented a **two-pronged strategy** consisting of a request for information (RFI) survey and a series of community listening sessions in rural jurisdictions.

Request for Information Survey

On September 8, 2025, MDH broadly disseminated a RFI describing the RHTP opportunity and **encouraging residents and stakeholders to submit project ideas** by the end of the month. MDH announced the RFI survey via a press release, publication of a web page, a public webinar, and direct email to various stakeholder groups and email addresses via MDH, Medicaid, BHA, HSCRC, MHCC, Maryland Philanthropy Network, MedChi (the Maryland State Medical Society), Maryland Hospital Association, Mid-Atlantic Association of Community Health Centers, Maryland Rural Health Association, and the Rural Maryland Council. **We received more than 325 RFI survey submissions and letters.** We include a summary in Attachments. Participants in the RFI process included provider associations (Maryland Hospital Association, MedChi, the Mid-Atlantic Association of Community Health Centers) as well as individual rural hospitals, primary care physicians, behavioral health providers, community-based organizations, for-profit vendors, and Medicaid managed care organizations among others.

Community Listening Sessions

MDH, in partnership with our local health departments, held **17 community listening sessions in Maryland's rural jurisdictions**. **More than 250 people participated** in the listening sessions. Meetings were in virtual, hybrid and in-person formats and occurred at different times of the day. LHD leaders facilitated the discussions to **gain understanding of needs and opportunities**. MDH provided a discussion guide for LHDs to use and a standardized template for collecting feedback. LHDs completed the template after each session.

Additional Efforts

A number of additional stakeholder engagement efforts informed the RHT plan and proposal. For example, MDH leadership participated in **three roundtables convened by the Maryland Hospital Association** in October 2025. The State also held roundtable discussions with Directors from its **Local Departments of Social Services, its Local Health Officers, and the Maryland Medicaid Advisory Committee**. MDH drew on its SORH efforts throughout 2023 and 2024 to identify rural health strengths and obstacles. Inputs included Community Health Needs Assessments from all 18 rural Maryland counties and stakeholder meetings with community members, local health departments, hospitals, universities, community-based organizations, and government agencies. MDH also leveraged its regular engagement with the **Rural Maryland Council** and **Rural Maryland Prosperity Investment Fund**.

Metrics and Evaluation Plan

Maryland's RHTP *Metrics and Evaluation Plan* aligns with the CMS RHTP NOFO requirements with an **evidence-based framework for assessing implementation progress, measuring outcomes, and ensuring accountability** for the three initiatives described in the State's

Transformation Plan. Many of the proposed RHTP activities enable infrastructure or new programs to address rural health care needs. We will require grant **awardee agreements to identify specific evidence-based measures and identify milestones**. This will inform the SORH staff's assessment of the RHTP implementation.

Performance Measures and Outcomes

Maryland is proposing specific, measurable outcomes to **monitor the progress of each of our three RHTP initiatives** and support the goals and strategies of our *Transformation Plan*. **Figure 24** shows our performance measures. In addition, we will **track supplemental metrics at the individual program level**. We may add measures upon program initiation and in discussion/consultation with CMS.

Figure 24: Proposed RHTP Performance Measures

Measure	Data Source/Availability at County or Community Level	Timing of Data and Ability to Collect and Analyze	Rationale
Initiative One: Transform the Rural Health Workforce			
(1) Student participants in pipeline programs across medical and behavioral health, # of programs with percentage increase, as available (**workforce and program implementation metric**)	Subrecipient reporting at the county level (e.g. AHEC; 4,000 rural 6-12 grade students per year, Transformation Fund via Dept of Labor)	Bi-annual collection Targets to be set based on partner baselines established prior to project initiation.	Accommodates new and expanded workforce development programming, including Transformation Fund progress
(2) Participants in training and education programming related to medical, behavioral, and dental health, # with percentage increase, as available (**workforce and program implementation metric**)	Subrecipient reporting at the county level (e.g. AHEC; 100 apprentices per year, Dept. of Labor)	Bi-annual collection Targets to be set based on partner baselines established prior to project initiation	Accommodates new and expanded workforce development programming, including Transformation Fund progress
(3) Participants providing professional services to meet Maryland's health needs for the first time (as a student or new employee) or in a promoted role due to newly earned credentials (#)	Subrecipient report at the county level (e.g. 15% annual increase in clinical rotation preceptors; AHEC clinical rotations, 500 newly employed rural RAMP model)	Bi-annual collection Targets to be set based on partner baselines established prior to project initiation	Provides interim evaluation metric for long term impacts on state of health workforce to be seen beyond RHTP end

(**workforce and program implementation metric**)			
(4) Sustainable infrastructure improvements related to workforce transformation efforts, # (**workforce and program implementation metric**)	Subrecipient reporting at the county level, where appropriate (e.g Southern AHEC, new apprenticeship programs, Data Clearinghouse)	Annual collection Targets based on RHTP implementation plan.	Infrastructure improvements will result in transformed foundations to support rural health improvements
Initiative Two: Promote Sustainable Access and Innovative Care for Rural Marylanders			
(1) Increase in primary care capacity within state-designated rural counties (**access metric**)	Subrecipient reporting of # of expansion projects by geographic location/county of service, with count of new primary care visits (e.g. HSCRC, Transformation Fund)	Bi-annual collection Target is to reach rural counties at a level at which MD is able to demonstrate progress toward 5-year RHTP goals.	Demonstrates transformation across rural Maryland geography in priority service area
(2) Increase in behavioral health capacity within state-designated rural counties (**access metric**)	Subrecipient reporting of # of expansion projects by geographic location/county of services with count of new behavioral health visits (e.g. Transformation Fund)	Bi-annual collection Target is to reach rural counties at a level at which MD is able to demonstrate progress toward 5-year RHTP goals.	Demonstrates transformation across rural Maryland geography in priority service area
(3) New connectivity points to HIE benefiting rural Marylanders, # connections, with percentage increase (**technology use, quality and health outcomes metric**)	Subrecipient reporting of newly established connections (CRISP)	Bi-annual collection Targets to be set based on partner baselines established prior to project initiation.	Demonstrates expanded access to data for improved care coordination across priority service areas in rural Maryland and long-term impact on improved rural health outcomes
(4) New rural provider participation in advanced care models, # with percentage increase, as available (**quality and health outcomes metric**)	Subrecipient reporting by county (e.g. HSCRC, LHDs, CRISP)	Bi-annual collection Targets to be set based on partner baselines established prior to project initiation.	Demonstrates initial reach toward long term goal of improved rural health outcomes
Initiative Three: Empower Rural Marylanders to Eat for Health			
(1) Participants in targeted nutrition education programs with increased knowledge regarding consumption of healthy foods and reduced consumption of processed foods, # with percentage increase, as available	Subrecipient reporting by county (e.g. LHDs)	Bi-annual collection Targets to be set based on literature review of outcomes in similar rural health programming.	Demonstrates initial reach toward long term goal of improved rural health outcomes due to improved dietary practices

(**program implementation metric**)			
(2) Sustainable infrastructure improvements, # (**program implementation metric**)	Subrecipient reporting at county level, as appropriate (e.g 200 small-scale cold storage units, MDA, DCHD, MDEM, RMC)	Bi-annual collection Targets based on RHTP implementation plan.	Infrastructure improvements will result in transformed foundations to support Maryland healthy food distribution and long-term improved health outcomes
(3) New or expanded initiatives to strengthen healthy food distribution across rural Maryland, # (**program implementation metric**)	Subrecipient reporting on food preparation and aggregation activities by geographic location (county) of food supply (Transformation Fund, RMC)	Bi-annual collection Targets to be set based on partner baselines established prior to project initiation.	Demonstrates increased market access Maryland farmers to sell healthy food to larger buyers to reach Marylanders
(4) New or expanded initiatives to strengthen healthy food purchasing strategies across rural Maryland, # (**program implementation metric**)	Subrecipient reporting by geographic location (county) of purchaser/ distribution locale (Transformation Fund, RMC)	Bi-annual collection Targets to be set based on partner baselines established prior to project initiation.	Demonstrates increased purchasing intent of healthy Maryland foods for distribution to reach Marylanders

Baseline Data, Targets, and Evaluation Metrics

We will work with grantees and transformation fund partners to develop baseline data for related metrics and establish specific and measurable targets. Where available, we will collect **data at the county or community level** to demonstrate the impact of RHTP funding across rural communities. SORH will develop grantee reporting requirements that ensure our ability to collect data at the county or community level when appropriate.

Maryland has **sophisticated health data expertise** with the ability to connect health data across sectors. We have **data use agreements in place** across agencies, with solid processes for **data security**. SORH will work with the MDH Chief Information Officer to develop tools to monitor performance and **hold funding partners accountable** for meeting the objectives of the initiatives. We will enhance existing statewide data dashboards by **adding rural/non-rural analysis** and routinely sharing data with transformation fund partners and the RHTP Steering Committee. We will provide performance reports to CMS, as required in the Notice of Award

and Cooperative Agreement, including progress reports along and non-competing continuation applications. Maryland will participate in any CMS-led evaluation or monitoring.

The RFPs/RFAs and grantee agreements associated with RHTP transformation funds will include **data collection and reporting requirements appropriate to hold grantees accountable for performance** and support any necessary evaluations. SORH will develop an overarching RHTP evaluation plan to ensure a comprehensive approach to accountability. SORH staff's **comprehensive evaluation will include community feedback and provider recommendations from rural regions** gathered by LHDs. For *Initiative Three*, MDEM will gather community input through their ongoing convening role.

Maryland's RHTP initiatives include specific pilots. For example, we include RHTP funds to support an evaluation to identify Innovative Care Transformation Fund effective practices. Evaluation **results will inform continuous improvement and guide sustainability planning** beyond the RHTP grant period.

Sustainability Plan

Maryland is **committed to ensuring lasting transformation in our rural communities** beyond this five-year RHTP cooperative agreement. **Figure 25** shows the sustainability plan for each applicable activity under our three initiatives. Importantly, many activities are **one-time infrastructure costs** that will not require ongoing infusions of resources for sustainability.

As described above in *Proposed Initiatives and Use of Funds*, our competitive transformation fund approach will identify the most promising proposals with clear potential impact. Each RFP/RFA will require applicants to address sustainability. The **strength of sustainability plans will factor prominently in evaluating** the proposals/applications.

Figure 25: Sustainability Plan

Initiative	Sustainability Plan
Initiative One: Transform the Rural Health Workforce	**Immediate Impact Funding:** - **Pathways to Health Careers:** Strong relationships with employers, reinforced through agreements with the State will sustain programs. - **Area Health Education Centers:** Sustainability plan unnecessary for one-time start-up infrastructure costs. New Southern AHEC will attain support from partners to diversify funding, similar to the funding model for existing AHECs. - **Health Workforce Infrastructure:** Sustainability plan unnecessary for one-time start-up infrastructure costs. Ongoing IT maintenance costs for the Clearinghouse will be factored into MDH's budget in future years. **Transformation Funding Opportunities:** - **Workforce Pipeline Training Program**: Start-up infrastructure resources will create a self-sustaining pathway to keep rural residents in their communities. - **Provider Training, Recruitment, and Retention Strategies**: RHTP investments will help attract new sources of funds. - For both transformation funds, the increase in the health workforce resulting from five years of RHTP funding will produce a larger workforce. This will reduce burnout and professional isolation, creating a more appealing environment for new and established providers. This creates a cycle to continue to attract more healthcare providers.
Initiative Two: Promote Sustainable Access and Innovative Care for Rural Marylanders	**Immediate Impact Funding:** - **Expand Primary Care and Specialty Practice Capacity**: Seed funding supports providers as they fill patient panels and advance their practices, ultimately achieving sustainability for salaries and operational costs through billing for services and realizing earned savings through value-based care arrangements and alternative payment models. - **Increase Efficiency of Local Agency Operations**: Increased revenue will help sustain ongoing delivery of clinical services and care coordination. - **Strengthen Emergency Trauma Response**: Pilot performance will determine if sustainability path is needed. One option is the expanded Trauma Fund Grant Program. - **Expand School-Based Health Center Capacity**: One-time initial costs will not continue. Access will be sustained through ongoing billing of public and payers. - **Optimize HIT Connectivity and Use of CRISP Tools**: Sustainability plan unnecessary for one-time start-up infrastructure costs. Potential for practices to benefit from future participation in value-based care models if connected and make use of population health management tools for high and medium risk patient panels. Increased CBO billing provides ongoing revenue for operations. - **Centralize Telehealth Infrastructure**: Some activities are one-time start-up costs. For others, updates to the CRISP's assessment and user fee model will support sustainability. **Transformation Funding Opportunities:** - **Sustainable Access through Service Expansions and IT Advances** - **Mobile Health Transformation Fund** - **Innovative Care Transformation Fund** - **Behavioral Health Transformation Fund** - For all four funds, provider billing will support ongoing sustainability, along with potential hospital contracts for potentially avoidable utilization, MCO partnerships for chronic care management, and integration into value-based care arrangements including ACO shared savings programs.
Initiative Three: Empower Rural Marylanders to Eat for Health	**Immediate Impact Funding:** - **Post-Harvest Infrastructure**: Sustainability plan unnecessary for one-time start-up infrastructure costs. - **Expand Grocers and Mobile Markets**: Sustainability plan unnecessary for one-time start-up infrastructure costs. Pilot may provide proof of concept for ongoing investment. Support for marketing can sustain businesses by expanding local demand. - **Create Demand for Healthy Foods**: Sustainability plan unnecessary for one-time start-up infrastructure costs. Once we introduce educational interventions to partners, they will continue to

	be able to integrate them within chronic disease curriculum. Maryland LHDs will explore future sources of funds in partnership with MDA and our State and local education systems. - **Support Food Planning and Coordination**: Sustainability plan unnecessary for one-time planning activities. **Transformation Funding Opportunities:** - **Improved Access to Local Healthy Food**: Sustainability plan unnecessary for one-time start-up infrastructure costs. We will require grantees to develop a revenue model, e.g., tiered payment by suppliers/producers with processing fees. - **Local Foods Purchasing Strategy**: Sustainability plan unnecessary for one-time start-up infrastructure costs of pivoting away from traditional food purchasing systems to focus on locally produced foods. Once operational, the new system will be sustainable within existing institutional food budgets.

Maryland will **integrate lessons learned from RHTP** into ongoing policy through a number of avenues, including through the Rural Health Strategic Plan, State Health Assessment, and State Health Improvement Plan. SORH's connection to and support from the Office of Assistant Secretary for Population Health and Strategic Initiatives elevates its work and provides visibility and ensures leadership support within the Office of MDH Secretary. In addition, as described in the Implementation Plan and Timeline section, our governance structure includes a range of MDH administrations and State agency partners such as Medicaid, PHS and BHAas well as MD Labor, MDA, and LHDs. By design we are **eliminating silos to achieve strategic focus, action, and ultimately, success.** Maryland will keep prioritization of **rural health transformation at the forefront** of existing convenings across State government, including Maryland Medicaid and the Rural Maryland Council. SORH will continue sharing rural health transformation information with rural communities and stakeholders to gain feedback.