Massachusetts Executive Office of Health and Human Services
Rural Health Transformation Program Application Summary
CMS Funding Opportunity CMS-RHT-26-001

Of MA's 351 jurisdictions, 160 are designated rural. Representing 57% of the state's land mass, sparsely populated rural towns have a density of 198 people per square mile, compared to non-rural communities (2,256 people per square mile). The target population of this project includes MA's 700,000 rural residents representing 10% of the state's population who experience persistent gaps in access to essential health and social services.

MA's rural communities face significant barriers to healthcare including higher uninsurance rates, greater reliance on public insurance, rising chronic disease, behavioral health, and substance use disorder burdens. Care is often distant, with fewer primary and specialty care access points, fragile EMS, and healthcare systems strained by aging infrastructure. Shrinking access points reflect broader system decline such as rural hospital reductions (11 in 2014 to 6 in 2025), with limited clinics, behavioral health, pharmacies, and long-term care options. Technology and transportation gaps further restrict access.

Key health challenges include maternal and pediatric service shortages, long specialty care wait times, workforce shortages (PCP ratio 79/100,000 vs. 102 non-rural), and financial fragility of rural providers. These factors lead to worse outcomes: chronic disease prevalence and ED visit rates are consistently higher in rural communities (e.g., hypertension 32.4% vs. 28.5% non-rural; mental health ED visits 1,016 vs. 756 per 100,000). Addressing these differences requires targeted investments in rural workforce, infrastructure, and access to primary and specialty care.

Through the Rural Health Transformation Program, we will catalyze transformative investments that strengthen rural MA communities, enabling them to thrive and sustain improved health and well-being for generations. To actualize this vision to transform rural health, we have three overarching goals: (1) Ensure rural residents can readily access healthcare services, (2) Generate opportunities to improve the health and well-being of rural residents, and (3) Scale systems, policies, and investments to meet unique needs of rural communities.

The MA RHTP is structured around seven broad Initiatives to transform rural healthcare in MA, and within each Initiative, multiple Activities to achieve the Initiative goals.

- Initiative I. Population Health Advancement: improving clinical infrastructure, increasing coordination, and expanding payment methodologies to advance rural providers' value-based care and efforts to lower cost and increase quality of care.
- Initiative II. Innovation in Rural Care Models: Facilitating the introduction and redesign of models in rural MA to increase access, broaden service availability, and improve efficiency in the delivery of health care.

- Initiative III. Training Healthcare for Retention. Innovation, & Excellence (THRIVE): Strengthen the full continuum of the healthcare workforce in rural communities with targeted activities focused on workforce development, recruitment, and retention.
- Initiative IV. Healthy Rural Communities: Supporting community-informed and led prevention activities to increase opportunities and empower communities to address gaps related to the root causes of health.
- Initiative V. EMS Service Integration: Investments and programs to increase viability, integration, and expanded role of EMS in rural communities.
- Initiative VI. Enhancing Technology Interoperability and Connectivity: Improving technological infrastructure of rural health providers to increase connectivity, create efficiencies, and support better outcomes.
- Initiative VII. Facility Modernization & Re-Use: Support minor renovations of rural facilities to optimize space and expand access.

The total budget is $1,000,000,000 across five years.

Together, MA is confident these Initiatives can truly transform and improve the health of our rural communities.

Project Narrative

Decades of underinvestment in rural communities have weakened local economies and exacerbated health conditions compared to urban and suburban regions. Through the Rural Health Transformation Program, we will catalyze transformative investments to strengthen rural Massachusetts communities, enabling them to thrive and sustain improved health and well-being for generations.

Rural Health Needs and Target Population

Target population: Of **Massachusetts' 351 jurisdictions, 160 are designated as rural**. Representing 57% of the state's land mass, sparsely populated rural towns have an average density of 198 people per square mile, compared to 2,256 people per square mile in non-rural communities.[i] **The target population of this application includes Massachusetts' 700,000 rural residents, representing 10% of the state's population, who experience persistent gaps in access to essential health and social services.** In 2002, the state's Office of Rural Health established a definition of *rural* to improve the representation of rural health-related data, and to better understand the needs of the target population. This definition differentiates levels of rurality (Rural 1: somewhat isolated; Rural 2: most isolated; see Fig.1) and classifies geographic rural regions within the state (see Fig. 2, *Rural Clusters*). The data standard created by this definition is updated every ten years with each new census.

Figure 1: Rural Communities by Level

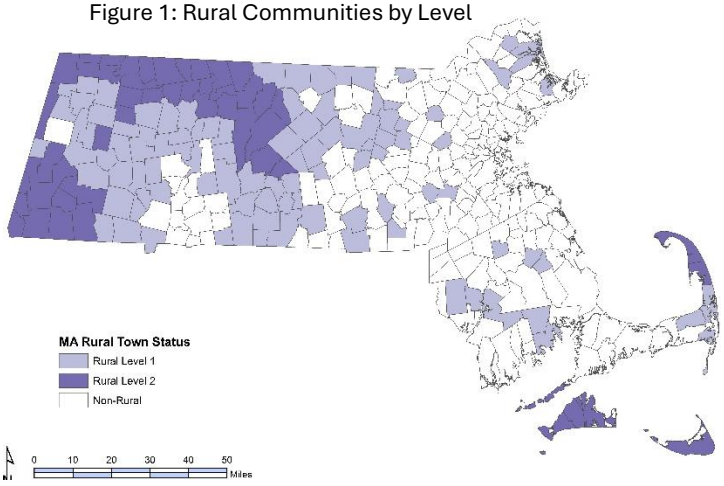
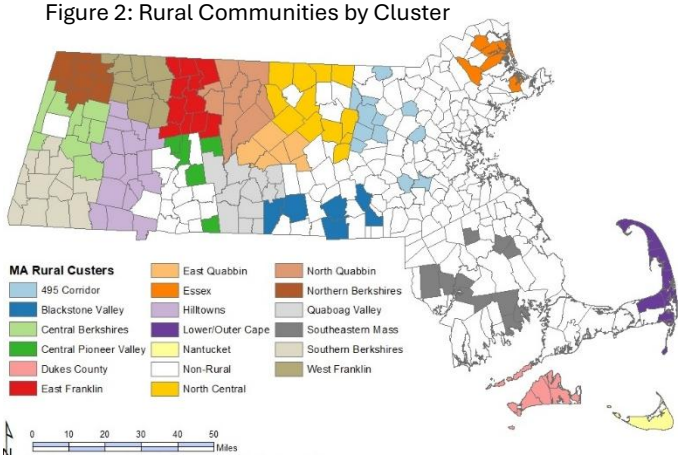


Figure 2: Rural Communities by Cluster



Rural Demographics:

Population & Geography: Our state's geography and limited rural infrastructure isolate residents.

Small mountains, large reservoirs, rivers, and difficult roads—22% are unpaved in rural communities[ii]—**impact residents' ability to easily travel for health services**. The road network density in rural MA is 3.2 roads per square mile compared to 8.8 in non-rural communities.[iii] In our rural communities, **adults aged 60 and older make up a higher share of the population**—ranging from 34% to 68%— compared to the statewide average of 23.8%.[iv] Rural communities have a lower proportion of family compared to individual households (63% statewide vs. 27% in rural communities),[v] highlighting the higher share of adults living alone in rural areas. Massachusetts has 70,000 residents who identify as American Indian/Alaska Native, with 34% residing in our rural areas.[vi] Our state has two federally recognized tribes: the Mashpee Wampanoag Tribe and the Wampanoag Tribe of Gay Head (Aquinnah). One tribe is in a rural county, and the other is rural-adjacent. Additionally, members of our two state-recognized tribes—the Nipmuc and the Herring Pond Wampanoag—reside primarily in rural Central Massachusetts and the Outer Cape regions.

Income, Employment & Education:

Income: The average annual income of households in Massachusetts' most rural communities is $23,000 lower than the statewide average. Five rural clusters have household incomes under $105,000, and two have an **average annual income more than $50,000 less than the state average:** the North Quabbin ($83,434) and Northern Berkshires ($88,913).[vii]

Employment: The main employment sectors in rural MA are hospitality, education, and social services. Non-rural communities' top employment sectors are technology, finance, and healthcare, which have higher wage opportunities. Self-employment is more common in rural communities (5.6% statewide vs. 7.1% Rural Level 1 vs. 11.7% Rural Level 2). The two most rural counties have average weekly wages **40% lower than the two most populated counties** (averages of $1,080 in Franklin and $1,232 in Berkshire compared to $2,169 in Middlesex and $1,720 in Suffolk Counties).[viii]

Education: Massachusetts sees similar high school graduation rates, but **fewer rural residents complete a bachelor's degree** (47% statewide vs. 42% in rural communities). In our more

economically disadvantaged rural clusters, the population with a bachelor's degree is even lower: 23% in North Quabbin, 32% in Quaboag Valley, and 33% in Northern Berkshire.[ix]

Health Outcomes:

Chronic Conditions: Residents of rural Massachusetts experience disproportionately poorer health outcomes for several health conditions. The major causes of illness, disability, and death for Massachusetts' rural population, and the leading drivers of excess healthcare cost are heart disease, hypertension, diabetes, cancer, and behavioral health conditions. In Table 1[x], **we see higher prevalence across four conditions when comparing rural and non-rural**. Rural cluster regions have even larger disparities. The prevalence of **hypertension** is 28.5% in non-rural areas compared to 43.2% in the Outer Cape, 43.2% in North Central, 43.6% in North Quabbin, 42.3% in Quaboag Valley, and 41.1% in Southern Berkshires. Similarly, **diabetes** prevalence is higher in these rural clusters—9.6% in non-rural areas versus 11.2% in the Outer Cape, 12.4% in North Central, 14.3% in North Quabbin, 11.9% in Quaboag Valley, and 11.5% in Southern Berkshires. **Chronic Obstructive Pulmonary Disease (COPD)** disproportionately burdens rural communities, with higher emergency department visit rates per 10,000 in two rural state health regions, Western (69.70) and Southeast (73.40), than the two most urban regions, Boston (49.30) and Metrowest (27.20).[xi] **Invasive cancer** incidence statewide is 455 cases per 100,000, with a 13% higher incidence in Rural Level 2 (468). **Colorectal cancers** (statewide: 32.8 vs. Rural Level 2: 38) and **bladder cancers** (statewide: 21.5 vs. Rural Level 2: 25.4) have the largest disparities in prevalence.[xii]

Table 1: Prevalence of Chronic Conditions by Geography

	18+ ever diagnosed with			
	Heart disease	**Hypertension**	**Diabetes**	**Stroke**
Non-Rural	6.4%	28.5%	9.6%	3.0%
Rural 1	7.0%	30.3%	9.7%	3.1%
Rural 2	**8.1%**	**32.4%**	**10.6%**	**3.7%**

There are similar prevalence of **behavioral health conditions** across rural and non-rural communities, but rural areas have notably higher rates of alcohol and tobacco use (Table 2):[xiii]

Table 2: Use of alcohol and drugs, Rural levels, Non-Rural

2023 CHES Survey Responses	Rural Level 1	Rural Level 2	Non-Rural
Tobacco, past month	9.9%	**15.3%**	13.6%
Alcohol, past month	**55.8%**	**53.0%**	48.4%
Medical cannabis, past year	**9.7%**	7.6%	7.0%
Non-medical cannabis, past year	16.6%	**22.7%**	17.6%

Rural communities also have higher rates per 100,000 of overdose deaths than non-rural (34.5), vs. Rural Level 1 (37.3) and Rural Level 2 (40.2).[xiv] We also see an increased rate of mortality (Table 3) in our most isolated residents (Rural Level 2) in preventable chronic diseases. These communities have less access to primary care and prevention, with increased distance to travel for specialty care.

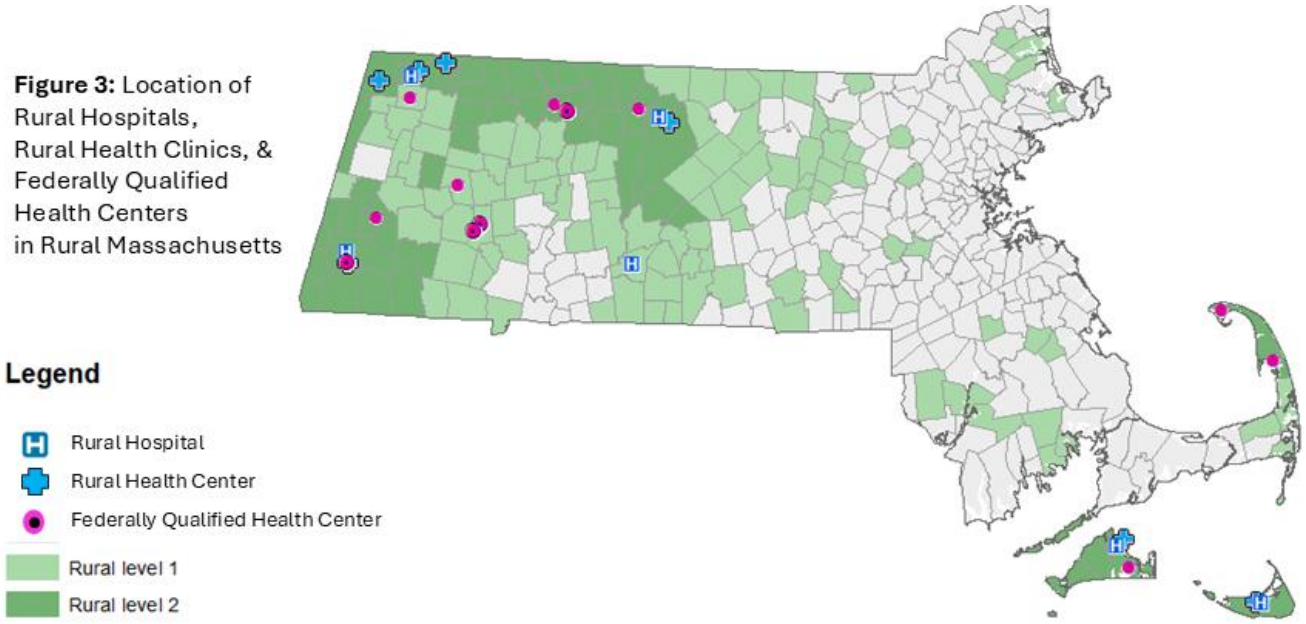
Table 3: Mortality from preventable chronic disease					
Age Adjusted Mortality by Cause (rate per 100,000)					
	Stroke	**Heart Disease**	**Cancer**	**Diabetes**	**Chronic Lower Resp.**
Statewide	25.032	126.629	134.977	16.187	26.410
Non-Rural	25.161	126.928	135.431	16.558	26.423
Rural Level 1	24.656	128.818	136.478	13.244	26.450
Rural Level 2	**26.576**	**132.946**	**136.183**	**16.551**	**29.952**

Child & Maternal Health: Infant mortality is higher in rural communities, with non-rural communities at 3.7 deaths per 1,000 live births as compared to 4.1 (Rural Level 1) and 4.5 (Rural Level 2). Of six rural hospitals, only three offer maternity services. **Since 2018, four rural hospitals have closed or filed to close their maternity service**, further shrinking birthing access points.[xv]

Healthcare Access:

Healthcare Facilities: Rural Massachusetts has less healthcare access. In 2014, there were 70 acute care hospitals 11 of which were rural hospitals. Today, there are 58 acute care hospitals, and 6 of these are rural hospitals. Of the six rural hospitals, four are Critical Access Hospitals (CAH) and two are Prospective Payment System (PPS) hospitals. **Three rural hospitals have completely closed since 2014, with the most recent closure last year**. One rural hospital reopened in 2024 as a CAH. Rural hospitals also provide a large share of primary care through Rural Health Clinics (RHCs) and hospital-affiliated group practices. As seen in Figure 3, most rural health facilities are geographically located in the same handful of rural towns, leaving large gaps in access to primary and acute care. There is a similar uneven geographic distribution of nursing homes, behavioral health and treatment centers in rural areas. Of the state's 342 skilled nursing facilities, only 30 are in rural areas. Only three of the state's 29 Community Behavioral Health Centers and five of the state's 66 Opioid Treatment Centers are in rural areas.

Figure 3: Location of Rural Hospitals, Rural Health Clinics, & Federally Qualified Health Centers in Rural Massachusetts



Public Transportation & Distance to Care: Rural MA has limited access to public transportation. Where regional transit is available, it is fixed route services that pick up passengers from single locations in a more populated rural town. In non-rural communities, 7.7% of people use public transportation to commute to work, compared to 1.0% in rural.[xvi] Drive times to routine healthcare vary but range from 20 minutes for towns that have a facility locally to a one-hour drive for more isolated communities. For residents to access specialty care, transportation times can range from one to three hours. This lack of access increases non-urgent use of emergency departments. There is a correlation between rurality and the use of the emergency department for preventable care.

Health Insurance Coverage: While Massachusetts has historically had good health insurance coverage rates, with the uninsurance rate at only 2.56%, those who are uninsured are disproportionately in rural areas.[xvii] Public insurance of non-rural residents is 38% compared to **47% of Rural Level 2 residents**. Additionally, many rural residents are underinsured (41.3% report affordability issues[xviii]) and have limited network plans because many rural employers are smaller and have less negotiating power. Individual cost burdens of these plans are higher, and facility coverage is limited.

Primary Care & Provider Availability: Our rural areas have severe primary care shortages – of the state's 15 non-facility-based primary care Health Professional Shortage Areas (HPSAs), 9 are located

in rural areas.[xix] The primary care provider (PCP) to population ratio shows 79 PCPs per 100,000 people in Rural Level 2, and 92 in Rural Level 1, well behind the non-rural rate of 102. Seven of our rural cluster regions have PCP rates lower than 90 and our East & West Franklin (63), Southeast (56), Nantucket (41), and Dukes (47) clusters see the greatest shortages, well below the national ratio of 78.[xx] Although we have shortages of primary care in rural Massachusetts, we have seen progress made on increasing access points. In 2018, the State Office of Rural Health supported the introduction of Rural Health Clinics (RHCs) in the state. To date, the state has 7 RHCs, adding more safety net sites in rural areas. Although Federally Qualified Health Centers (FQHCs) are a main access point for our rural communities, of the 143 FQHC sites in the Commonwealth, only 14 are in rural areas. Specialty appointment wait times are up to one year for some rural regions for critical services like gastroenterology and neurology. Pharmacies, another key access point, are limited in rural areas with only 25 pharmacies serving 160 rural communities.

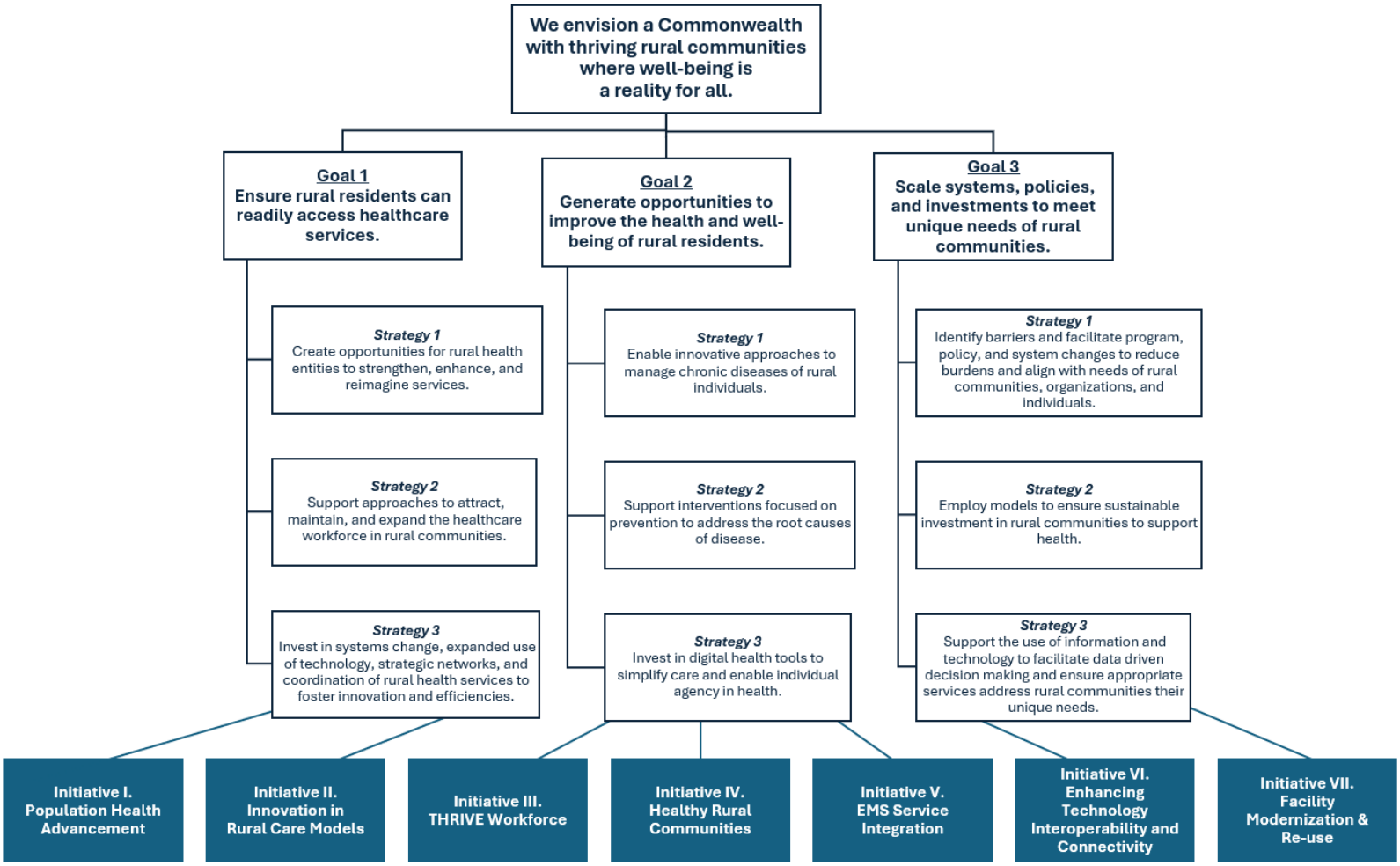
Rural Facility Viability

Rural Facility Financial Health & Utilization: While our rural facilities maintain high ratings for quality and safety, they face many financial and operational challenges. Statewide hospital operating margins have only increased by 1.8% since 2024, compared to the 6% increase seen nationally.[xxi] Most notably, one rural hospital closed in August of 2024 and another rural health system with a CAH is vulnerable to closure having recently emerged from Chapter 11 bankruptcy. Staffing for clinical and non-clinical services is an overwhelming challenge and expense. Facilities struggle with recruitment, retention, the ability to offer competitive salaries, and competition with other jobs in the area that have less financial and safety risk, exposure to disease, and challenging patient situations. Capacity limitations of rural-area long-term care facilities, behavioral health resources, and specialized care have led to longer waits for patients to be transferred to appropriate services, resulting in both increased emergency department boarding and significantly longer lengths of stay[xxii], especially for patients with both long-term care and behavioral health needs. While the state has made great progress over the last five years in extending the last mile of broadband internet

access to all communities across the state, rural health facilities still rely on outdated electronic health records and other technologies due to lack of resources and expertise.

Rural Health Transformation Plan: Goals and strategies

Below are our Vision, Goals, Strategies, and proposed Initiatives to transform rural health in MA:



How our Rural Health Transformation Plan Meets the Statutory Elements: Below we outline how our proposal **aligns directly with each of RHTP's statutory requirements**. For full details, please see: *Proposed Initiatives and Use of Funds Section*.

Improving Access: Rural communities in MA have limited access to health services, are strained financially, and are challenged with health workforce. To address these needs and meet the RHTP strategic goal of **sustainable access** we propose the following Activities in our Initiatives:

- Stand up mobile health units that coordinate with and extend existing brick-and-mortar access points into rural access deserts. (*Initiative II*)
- Expand telehealth for services with critical shortages and launch a digital health sandbox to encourage the solicitation, testing, and implementation of new tech to expand healthcare access. (*Initiative II*)
- Launch integrated specialty care networks and chronic disease management programs leveraging remote patient monitoring to further extend access to care. (*Initiatives I and II*)
- Coordinate social services, community organizations, local public health, and clinical services through integrated networks, technology platforms, and care navigation. (*Initiatives I, II, and IV*)
- Enhance and support the rural healthcare workforce by training local workforce to support critical positions, incentivizing rural training placements, removing barriers like housing to longer-term rural employment, developing facility-specific staff retention strategies, and creating virtual platforms to upskill and connect current professionals. (*Initiative III*)
- Provide funding to support critical updates to existing rural health facilities to re-use space and expand local service offerings, and support infrastructure investments to create more substance use treatment service access points. (*Initiatives II and VII*)

Improving Outcomes: Rural communities in MA see poor outcomes in multiple disease areas, including diabetes, heart disease/hypertension, lower respiratory disease, behavioral health, and cancer, leading to increased mortality risks and strains on health resources. To address these areas, improve the health of our rural communities, and meet the RHTP strategic goal of **Make Rural America Healthy Again**, we propose the following Activities in our Initiatives:

- Create chronic disease management networks that coordinate providers, services and community-based organizations, empower patients to make informed decisions about their healthcare, use clinical strategies including remote patient monitoring and community health workers, connect community-based education supports, and leverage technology platforms to effectively communicate and manage patient needs. (*Initiatives I and IV*)

- Implement population specific programs to target populations with poorer health outcomes, including aging adults and tribal populations. Using evidence-based models, the above-mentioned technology platforms, and remote patient monitoring tools will ensure these targeted approaches also link back to the care management networks for maximum impacts. (*Initiatives I and IV*)
- Encourage participation in Community Paramedicine models by reducing barriers created by the need for funding, equipment, TA, and other costs associated with establishing a new program, resulting in improved health outcomes, enabling patients to remain in the setting of their choice, reduced ED use, and increased opportunities for workforce participation. *(Initiative V)*
- Multiple Activities noted above in "Improving Access" including mobile health units, telehealth services and launching a digital health sandbox, and integrated specialty care networks and chronic disease management programs will also support the goal to Make Rural America Healthy Again.

Technology Use: The historic lack of investment in technology infrastructure has left rural providers and communities behind in implementing more advanced tech to modernize care and improve operational efficiency. Rural providers are often unable to join into existing systems because they do not meet hardware/software requirements and cannot afford to upgrade. To address these challenges, operationalize more emerging technologies with our rural communities, and meet the RHTP strategic goal of **tech innovation**, we propose the following Activities in our Initiatives:

- Expand and link rural providers and services to existing statewide systems and networks, such as our advanced Health Information Exchange (HIE) services, real-time bed availability tracking, and emergency service directional network. (*Initiative VI*)
- Launch a rural health digital sandbox to catalyze innovation in rural healthcare enabling testing and piloting of innovative models to improve health outcomes in rural communities. (*Initiative II*)
- Provide support and technical assistance to rural providers to facilitate telehealth expansion, adoption of new technology solutions to enhance administrative and clinical efficiencies (e.g., AI for patient scheduling, virtual remote ASL interpreting, clinical note scribing, and referrals management), and ensuring cybersecurity protocols are updated and in place. (*Initiatives I and II*)

- Create and operationalize a mobile application for prehospital protocol and medication dosing to support rural ambulance services to reduce resource drain, improve patient care, and improve education. *(Initiative V)*

Partnerships: Our rural communities and organizations have long histories of successful partnership and coordination but have often struggled to expand one-time projects and informal partnerships without seed funding to support the operational costs needed to organize more mature networks. To build and formalize partnership networks and meet the RHTP strategic goal of **innovative care** we propose the following Activities in our Initiatives:

- Expand community-based organization and social service networks with infrastructure and operational investments, coordinate with existing public health shared service arrangements, and link clinical partners with our newly created chronic disease management networks. (*Initiatives I and IV*)
- Launch a technology platform to connect clinical providers, social service organizations, and community organizations to unite clinical care, social support, and community resources, increasing patient access to services, and reducing rural facility costs to access specialty services. (*Initiative I*).
- Build integrated specialty care networks using hybrid technology to provide real-time direct linkages for consults and ongoing care supports to better coordinate with specialty providers and larger medical providers. (*Initiative I*).

Workforce: A key challenge for rural providers is recruitment and retention of health professionals. A lack of local educational and training opportunities, strained resources to offer competitive benefits, rising costs of living in rural tourist areas, and limited opportunities for professional development of current staff are creating complications within the workforce crisis. To support recruitment, training, and retention in rural areas, and to meet the RHTP strategic goal of **workforce development,** we propose the following Activities within our Initiatives:

- Expand rural training networks to support shortages and upskill local workforce, including by establishing programs in rural schools to expose students to health career pathways. (*Initiative III*)

- Support rural facilities to build capacity to host field placements and expand Nurse Practitioner residency training, including support to students to complete field placements, internships, apprenticeships and practicums that are typically unpaid. (*Initiative III*)
- Build facility capacity by providing on-site technical assistance to create and implement long term recruitment and retention action plans, including developing infrastructure for recruitment committees, outreach, referral programs, and retention activities to support long term employment of staff, as well as supporting pathways for permanent housing in rural tourist areas. (*Initiative III*)
- Leverage technology to support virtual training to encourage professional connections and provide continuing education opportunities locally. (*Initiative III*)

***Data-Driven Solutions*:** Real time data, shared among coordinated networks, allows rural health providers to be more responsive to individual and collective needs, but current capacity remains limited. Rural facilities have lagged in technological upgrades to better connect and coordinate service delivery. To support providers in building efficiencies, facilitating increased quality improvement, and to meet the RHTP strategic goals of **sustainable access**, **innovative care, and tech innovation,** we propose the following Activities in our Initiatives:

- Expand and link rural providers and services to existing statewide systems and networks, such as our advanced HIE services, real-time bed availability tracking, and emergency service directional network. (*Initiative VI*)
- Create data dashboards and bi-directional communication modalities to support chronic disease management programs and population specific interventions. (*Initiative I*)
- Leverage new technological platforms to support real-time adverse event monitoring to identify opportunities to reduce patient harm. (*Initiative I)*

Financial Solvency Strategies: Rural MA providers struggle to contain costs and maintain fiscal and operational sustainability. Lack of appropriate technology and population health platforms to successfully implement value-based care models, workforce shortages, and a lack of capital to modify facilities to expand service offerings are just some of the challenges faced by rural providers.

To support the long-term financial solvency of our rural health providers and meet the RHTP strategic goal of **sustainable access,** we propose the following Activities in our Initiatives:

- Create new financial incentives, payment programs, and technical assistance to support rural providers in expanding participation and engagement in population health management and value-based payment models. (*Initiative I*)
- Upgrade facility infrastructure and connect facilities to statewide technology platforms, investing in technology supports to coordinate care, simplify billing, and streamline operations. (*Initiative VI*)
- Support rural health providers to make critical updates to existing rural health facilities to re-use space and expand services to sustainably meet local demand. (*Initiative VII*)
- Implement a pilot reimbursement program for EMS programs for uncompensated services such as transport to non-emergency department healthcare facilities, patient evaluations, providing treatment on scene with no transport, and supporting population health activities. *(Initiative V)*

***Cause identification*:** Although MA does not have stand-alone rural hospitals, several rural hospitals are part of small health systems. While all facilities continue to maintain high quality benchmarks and continue to support adequate patient volume, facilities struggle to contain costs, manage workforce shortages, and are spread thin due to complex community and patient needs. Additionally, MA has recently seen the closure of a rural hospital and reductions of services at both rural-located and rural-serving facilities. The most recent service reductions for maternity and cardiology care occurred due to staffing shortages that challenged providers' ability to meet quality care standards. Our outlined Strategies and proposed Initiatives and Activities were developed to meet the immediate needs of our providers and communities, while also implementing a broader approach to delivery system reform for the medium-term to address the root causes of ongoing challenges rural providers face.

Program Key Performance Objectives:

The overall program is designed to achieve the vision of **"A Commonwealth with thriving rural communities where well-being is a reality for all"** through comprehensive, measurable improvements across three core goals: healthcare access, health and well-being outcomes, and

systemic resilience. The evaluation outcomes and metrics for the seven Initiatives are consistent with and complementary to these overall program performance objectives. Below we outline the specific and measurable objectives for the program, with illustrative baseline data and concrete targets to be achieved by the end of the funding period (FY 2031).

Goal 1: Ensure rural residents can access healthcare services.

Key Performance Objective: Access & Service Availability: Increase the percentage of rural residents living within a defined geographic distance of essential healthcare services. *Metric*: Percentage of rural residents within a 30-minute drive of a primary, ambulatory specialty care, pharmacy, or mobile healthcare access point. *Baseline*: TBD%. *Target* by Year 5: 90%

Key Performance Objective: Workforce Stability: Significantly reduce the annual turnover rate for high-demand clinical positions in rural facilities. *Metric*: Number of rural primary care physicians per 100,000 population. *Baseline*: 137 per 100,000. *Target*: 140 per 100,000. Number of rural physician assistants per 100,000 population. *Baseline*: 7.2 per 100,000. *Target*: 9.2 per 100,000.

Key Performance Objective: Technological Capacity & Interoperability: Achieve high-level, secure data exchange capability across the supported rural health network participants. *Metric*: Percentage of rural health entities fully integrated into an interoperable data-sharing platform. *Baseline*: 25% of entities. *Target*: 100% of entities.

Goal 2: Generate opportunities to improve the health and well-being of rural residents.

Key Performance Objective: Health Outcome Improvement: Demonstrate a significant reduction in premature mortality associated with target chronic diseases within rural communities. *Metric*: Age-adjusted mortality rate (per 100,000 residents) for cardio-metabolic conditions (heart disease and diabetes). *Baseline*: Heart Disease, Rural Level 1 128.8 per 100,000 Rural Level 2, 132.9 per 100,000. Diabetes, Rural Level 1 13.2 per 100,000 Rural Level 2, 16.5 per 100,000. *Target*: Heart Disease, Rural Level 1 123.8 per 100,000 Rural Level 2, 127.9 per 100,000. Diabetes, Rural Level 1 11.2 per 100,000 Rural Level 2, 14.5 per 100,000.

Key Performance Objective: Preventive Care Engagement: Increase the number of rural residents who have an established primary care provider or medical home relationship. *Metric*: Percent of MA residents reporting difficulty in accessing care in the past 12 months. *Baseline*: 41.2%. *Target* 31.2%

Key Performance Objective: Individual Consumer Health Agency: Increase the successful adoption and regular use of digital tools and remote monitoring programs. *Metric*: Percentage of enrolled program participants actively utilizing digital health and remote patient monitoring tools at least once per month. *Baseline*: TBD utilization. *Target*: 75% utilization.

Goal 3: Scale systems, policies, and investments to meet unique needs of rural communities

Key Performance Objective: Policy & Regulatory Alignment: Facilitate adoption of regulatory or state-level program changes that increase operational flexibility for rural health entities. *Metric*: Number of new, state-level policies, regulatory changes, program changes, or federal waivers successfully advocated for and implemented. *Baseline*: 0 adopted. *Target*: 9 adopted.

Key Performance Objective: Sustainable Investment: Secure and document new, diversified, and sustainable non-federal funding streams to support long-term rural health infrastructure. *Metric*: Total value of new, non-federal, sustainable annual investment secured for rural health infrastructure and initiatives. *Baseline*: $0 annually. *Target*: $5 million annually.

Key Performance Objective: Data-Driven Systems: Establish and fully activate regional collaborative structures for data sharing and analysis to inform local decision-making and resource allocation. *Metric*: Number of fully operationalized, multi-sector regional data networks using aggregated program data to issue evidence-based service recommendations. *Baseline*: 0. *Target*: 10.

For the complete list of outcomes by Initiative and detailed Evaluation Plan, please see the *Metrics and Evaluation Plan* section of this application.

Legislative and Regulatory Actions: For Technical Score Factors categorized as State Policy Actions, we summarize below the status and actions Massachusetts proposes:

State Policy Action Items	Current Policy	Action to be Taken	Intended Impacts	Timeline
B2. Health & Lifestyle; Presidential Fitness Test	MA enables local decision making for school requirements to empower community-based decision making, including implementation of the Presidential Fitness Test. Individual school districts each make their own determination on policy.	None	MA school districts have local decision-making authority.	N/A
B3. SNAP waivers	To incentivize healthy SNAP purchases, including local fruits and vegetables, MA has implemented the Healthy Incentives Program,[xxiii] which directly credits funds back to beneficiaries for purchase of certain nutritious foods. MA does not have a SNAP Food Restriction Waiver prohibiting the purchase of non-nutritious items.	None	N/A	N/A
B.4 Nutrition CME	MA does not currently include nutrition as a required CME for physicians. This would require legislation to update the requirement.	None	N/A	N/A
C.3. CoN restrictions & barriers	The cited Cicero report puts MA regulations in the 25-point category for RHTP. One area to note on Cicero scoring, restrictions to Behavioral Health Outpatient CON would only apply to a DPH-licensed BH outpatient project that exceeds a capital expenditure of $43,438,034.73	None	N/A	N/A
D2. Licensure Compacts	*Physician:* Legislation Introduced[xxiv] *Nursing:* Enacted, Awaiting Implementation[xxv] *EMS:* Not a member state[xxvi] *Psychology:* Legislation introduced[xxvii] *Physician Assistant:* Legislation Filed[xxviii]	MA is monitoring introduced legislation and working to implement the Nursing compact.		Implementation for the Nursing compact is estimated to take 18 months or more, currently the FBI has requested a statute be passed to enable federal criminal background checks which MA is actively working to pass.
D3. Scope of Practice (SOP)	*Physician Assistants (PA):* Advanced[xxix] *Nurse Practitioner (NP):* Full Practice[xxx] *Pharmacists (RPh):* 2/10 in Cicero * This score does not align with actual SOP. They have a Formula Based Authority and participate in the Collaborative Drug Therapy Model.[xxxi] *Dental Hygienists (DH):* Semi-restricted[xxxii]	*PAs:* none *NP:* none *RPh:* none *DH:* Legislation introduced.	Expanding Scope of Practice will support our workforce and improve rural healthcare, including future models we plan to implement.	Dental Hygienists: We are actively monitoring the progress of the legislation submitted for expanding scope.
E3. STLDI	In MA, there is no law that restricts STLDI's, however carriers are not currently electing to offer STLDI plans in the Massachusetts market. The MA Division of Insurance has created a regulatory environment under M.G.L. c. 176J and 211 CMR 66.00 that defines standard product terms for STLDI plans.	None	N/A	
F.1 Remote Care Services	Live video reimbursement: Yes[xxxiii] Store & forward reimbursement: Yes RPM reimbursement: Yes[xxxiv] In state licensing exception: No Telehealth license process: No	None	N/A	N/A

Other Required Information

For factor A.2.: List of Certified Community Behavioral Health Clinic (CCBHC) entities as of September 1, 2025: Massachusetts has Community Behavioral Health Centers (CBHCs) authorized through the rehabilitative authority of the Massachusetts State Plan, as well as SAMHSA-designated sites. Please see attached supplemental material for full listing of sites in Massachusetts.

Factor A.7. - During federal fiscal year 2025, Massachusetts has 70 hospitals that receive payments under Massachusetts' Disproportionate Share Hospital (DSH) authority, inclusive of acute and non-acute hospitals.[xxxv]

Proposed Initiatives and Use of Funds

Initiative I: **Population Health Advancement Initiative**

Main Strategic Goal: Sustainable Access

Description & Activities: This Initiative will improve clinical management of chronic disease through clinical infrastructure, enhance clinical and community coordination, and expand participation in value-based payment models, creating stronger linkages between rural providers. These new networks will advance rural population health, improve quality of care, increase efficiencies, and lower healthcare costs. To do this we will implement the following program Activities:

1. Create Chronic Disease Management (CDM) Networks to convene rural hospitals, RHCs, FQHCs, and group practices to build a network of providers that will assess local needs for chronic disease management, stand up regional CDM programs, and further build local capacity for medium and long-term management of chronic diseases throughout rural communities. To ensure local sustainability, CDMs will also integrate community-based allied health positions (community health workers, community paramedics, care coordinators, public health nurses, community navigators) to support chronic-disease outreach, education, and self-management programs stood up through CDM networks.

2. Launch "Rural MA Connect," a bi-directional technology platform that will connect clinical providers, social service organizations, and community-based-organizations throughout rural MA to unite clinical care, social support, and community resources. This electronic referral and data sharing platform will provide real-time directories of community resources, closed-loop referrals, EHR integration, care management systems, clinical workflows, and billing supports. MA intends to model Rural MA Connect on similar initiatives in other rural areas, like the Transformation of Rural Community Health (ToRCH) program in Missouri.[xxxvi]
3. Rural Innovation for Systems Change & Effectiveness (RISE) will transform how rural Massachusetts places and cares for youth and young adults with complex behavioral, developmental, and medical needs. Currently, placement delays lead to long ED boarding times, costly out of region placements, and capacity mismatches where some beds sit empty while others are over capacity. RISE will build a real-time, cross-agency data platform to track bed and service availability across rural providers ("beds not buildings"). Like the Admission Transfer Center model at Mayo Clinic Health System,[xxxvii] this coordinated approach will match youth to the right care setting and reduce boarding times, transfer delays, and costs. Crucially, this platform supports workforce stabilization and retention by giving providers real-time visibility into demand, enabling predictable scheduling. RISE will pair this infrastructure with targeted workforce training and aligned state licensing and contracting to reduce fragmentation and provider burnout. Finally, innovative payment models, including braided and blended funding with shared savings will sustain the model beyond year five. RISE turns a patchwork of services into a coordinated, flexible rural care system that delivers timely, appropriate care for vulnerable youth.
4. Extend an Automated Adverse Event Monitoring (AAEM) pilot to rural providers in MA. Currently, the Betsy Lehman Center for Patient Safety is using AAEM to improve clinical quality in hospitals in urban MA. By continuously scanning every patient's EHR chart, AAEM enables near real-time detection of adverse events in hospitals using automated triggers, artificial intelligence, and clinical expertise, leading to rapid and sustainable improvement. Patients exposed

to adverse events during admissions had on average 2 additional hospital bed days and 14% higher odds of readmission.[xxxviii] This work in MA and in other states has demonstrated ROI. Expanding this AAEM pilot to rural areas will provide enhanced quality improvement for rural health providers to identify real-time opportunities to reduce patient harm, increase positive patient outcomes, reduce throughputs, and save costs.

5. Expand Remote Patient Monitoring (RPM) Programs Integrated with Primary Care and Population Health Management. RPM is an evidence-based intervention to enhance local management of chronic disease. MA Medicaid recently began covering RPM; however, there remains limited infrastructure or uptake of RPM in rural MA, limiting its impact for rural residents. Expansion of RPM will focus on training, TA, and infrastructure for providers to support chronic disease management programs leveraging RPM and will be closely integrated into parallel efforts to expand mobile integrated health programs as described in Initiative V: EMS Service Integration, Activity 1. In collaboration with PCPs, RPM closely integrated with Mobile Integrated Health (MIH) programs can extend primary care reach, expanding prevention and management efforts for chronic diseases. In parallel with other efforts, including Home Visiting Programs and Hospital at Home programs (Activities 6 and 7), this coordinated ecosystem can expand access to health services and reduce facility-based care for rural residents, improving health outcomes.
6. Implement New Home Visiting Programs that will help facilitate Activities 1 and 5. These programs will provide in-home services such as complex care coordination, service delivery, education, and RPM for specific populations (e.g., aging adults, families with young children, postpartum families) and conditions (e.g., diabetes, asthma, heart disease), to help meet the needs identified in assessments implemented in Activity 1 and will use proven models like Parents as Teachers[xxxix], Homebased Heart Failure Program[xl], and Geriatric Resources for Assessment and Care for Elders[xli] to meet local needs and reduce facility-based care.
7. Expand Hospital at Home Programs to rural communities to provide acute, hospital-level care in patients' own homes, empowering individuals to choose the setting of care they prefer. Hospital at

Home programs have extensive implementation in more urban MA however remain limited in rural communities. Support would include TA for rural facilities to obtain CMS waivers, establishing partnerships with existing programs, and customizing models to support the needs of rural patients. In parallel with efforts to expand RPM and chronic disease management programs, Hospital at Home programs can further localize care provided to rural residents and reduce use of facility-based care, improving access and quality of care throughout our rural communities.

8. Create new incentives and payment programs to assist rural providers in expanding their participation and engagement in population health management practices and value-based payment models, including for example MassHealth's Accountable Care Organization program, Medicare ACO programs, or global budget initiatives, e.g., CMMI's AHEAD Model. Support will include both financial incentives for providers participating in value-based programs, as well as training and technical assistance for participating providers.

Use of Funds: A, B, C, D, F, G, H, I, K (non-exhaustive)

Technical Score Factors: B.1, B.2, C.1, E.1, F.1, F.2, F.3

Key Stakeholders: Rural Hospitals, Critical Access Hospitals, Rural Health Clinics, Primary Care Offices, EMS providers, Community Based Organizations, Local Public Health SSAs, Aging Services Access Points/Area Agencies on Aging, Independent Living Centers, Chronic Disease Subject Matter Experts, Rural Individuals with Chronic Diseases, State Office of Rural Health, MassHealth, State Center for Patient Safety, and Mass Health Information Highway.

Outcomes: (1) Decrease rates of emergency department use in rural communities for treatment of chronic conditions. (2) Reduce costs of care for rural populations with complex needs. (3) Increase rates of preventative care visits in the targeted rural communities. (4) Increase connectivity of clinical providers, social services, and community support organizations. (5) Increase use of community based allied health positions to support chronic disease management programs. (6) Increase uptake of remote patient monitoring programs in rural areas. (7) Increase clinical quality

improvement in targeted healthcare organizations. (8) Increase rural providers' participation in population health management practices and value-based payment models.

Impacted Counties: Rural Counties: Franklin 25001, Dukes 25007, Nantucket 25019. Rural Areas of Barnstable 25001, Berkshire 25003, Hampshire 25013, Hampden 25013, Worcester 25027.

Estimated Required Funding: **Total: $291,695,762** (Year 1: $52,954,076; Year 2: $54,498,060; Year 3: $72,648,766; Year 4: $56,965,759; Year 5: $54,629,101)

Initiative II: **Innovation in Rural Care Models**

Main Strategic Goal: Innovative Care

Description & Activities: This Initiative will facilitate the introduction of new rural-appropriate care models, support the expansion of proven models to increase access, broaden service availability, and improve efficiency in the delivery of rural healthcare. Investments will support infrastructure and equipment required for these models, as well as provide technical assistance and capacity building supports to simplify implementation and ensure long-term sustainability. To achieve these goals, we will implement the following Activities:

1. Stand Up Mobile Health Units to support delivery of essential clinical and preventative care in underserved rural regions. These units will be customized to integrate into existing clinical infrastructure and coordinate with other proposed Initiatives to support portable care delivery, mobile integrated health models, and chronic disease management. Units will be equipped with diagnostic equipment (e.g., portable imaging, lab kits) and tech supports (e.g., telemedicine software, diagnostic devices, AI support systems). These tech-enabled mobile health units will provide clinical services, screenings, connections to specialty care to those unable to access traditional care points, and provide patients with choice of setting for their care. Similar models have shown cost savings from avoidable ED visits with an ROI of $36 for every $1 invested.[xlii]
2. Build Integrated Specialty Care Networks to increase availability of specialty consults and services to rural residents. These hybrid networks will use technology to provide real-time linkages for

consults and ongoing care supports, as well as coordinate with specialty providers and larger medical providers to ensure timely access to in-person specialty care. Networks will support models like Project ECHO[xliii] and eConsults,[xliv] as well as use technology and diagnostic tools to increase provider-to-provider and direct-to-consumer specialty services. Creating networks and investing in startup costs will reduce provider barriers to offering these specialty services. These networks will also leverage investments made in Initiative I: Population Health Advancements and Initiative VI: Enhancing Technology Interoperability and Connectivity.

3. Expand Telehealth Use for Pharmacy, Dental, and Behavioral Health in rural areas with limited access to such services. Telehealth can enhance patient self-management by providing accessible educational resources, reducing stress and anxiety, and offering reliable information. Personalized skill development through telehealth includes patient education videos, medication reminders, and other online resources, facilitating effective self-management.[xlv] Tele-pharmacy investments will support remote pharmacist dispensing and counseling in rural areas, pharmacy robots to enable prescription pickup, automated medication dispensing systems, and existing pharmacies to expand coverage. Tele-dental investments will increase our state's portable dental services, tele-dental capabilities, services provided by hygienists in the tele-dental program and increase availability of dental services in rural areas. Investments will expand the school-based tele-behavioral health program into more rural schools, a proven model piloted in Massachusetts rural schools by HRSA and Massachusetts' Health Policy Commission.[xlvi] These tele-programs will be sustainable beyond the RHTP investments via pre-existing reimbursement mechanisms, but capital funding and technical assistance will be essential to get programs launched for target rural organizations.
4. Launch the Rural Digital Health Sandbox Program through a partnership with the Massachusetts e-health Institute (MeHI) to encourage tech innovations focused on rural healthcare and create an innovation marketplace. Selected entrepreneurs will participate in Mass Digital Health Connects, a virtual workshop program, and will be matched with opportunities to pitch for funding. This program will establish a dedicated track for consumer health technology innovation (e.g.,

wearables, sensors), emphasizing real-time solutions that extend care access, engagement, self-management, and patient outcomes for rural communities that can be utilized in this application's Initiative I: Population Health Advancement and Initiative IV: Healthy Rural Communities.

5. Launch "Stronger and Healthier Communities through Integration of Emerging Health Tech" (SHINE HT) Program to provide financial resources, TA, and implementation support to FQHCs serving rural populations implementation and adoption of new technology solutions within their existing EHR systems. Additionally, SHINE HT will include AI solutions for patient scheduling, clinical note scribing, referrals management, and other tools to enhance administrative and clinical efficiencies to reduce provider workload and optimize patient care.
6. Implement Rural Maternal Health Continuum of Care Project to support existing clinical and community organizations with additional consulting, expertise, training, and equipment to improve rural maternal health access and outcomes. Investments will support organizational assessments, development of maternal health dashboards, training for providers, creation of networks with community-based services, flexible reimbursement models for sustainability, and expansion of intensive support for higher risk populations. This project will improve rural maternal health outcomes, reduce higher risk situations, and allow more complex maternal care to happen closer to home. Based on evidence-based programs, like the University of Arkansas Institute for Community Health Innovation program on maternal and child health[xlvii], we will use clinical and community integrated solutions to improve rural maternal health across the continuum of care. These efforts include expanding prenatal care to harder-to-reach populations via mobile health, training and developing rural doula supports and specialized community health workers, and providing 24/7 resources for parenting support and innovative strategies for maternal nutrition needs
7. Expand Opioid Treatment Program Sites to support rural access to these services. Funding will support assessments, startup costs, technical assistance, and coordination of community support to remove the current barriers of expanding these services in rural communities. This effort is intended to design programs to meet rural needs and support the mechanics of site establishment to

participate in reimbursable services supported by the state's Bureau of Substance Addiction Services and Medicaid program (MassHealth). This will model local site designs on rural best practices such as expanding mobile services,[xlviii] one stop shop integrated care models,[xlix] and connections to telehealth[l] services to provide broader behavioral health supports.

Use of Funds: A, C, D, F, G, H, I, J, K (non-exhaustive)

Technical Score Factors: B1, B2, C1, D3, F1, F2, F3

Key Stakeholders: Rural Hospitals, Critical Access Hospitals, Rural Health Clinics, Primary Care Offices, Community Behavioral Health Providers, Rural School Districts, EMS providers, Community Based Organizations, State Office of Rural Health, MassHealth, State Center for Patient Safety, and Massachusetts e-Health Institute.

Outcomes: (1) Increase rural utilization of multi-disciplinary mobile and telehealth strategies to deliver patient care. (2) Expand use of innovative models by rural providers and organizations. (3) Increase access to specialty care for rural residents and providers. (4) Increase availability of rural-appropriate digital health solutions. (5) Reduce burden on rural primary care providers to manage complex conditions. (6) Increase access to pharmacy, dental, and behavioral health services.

Impacted Counties: Rural Counties: Franklin 25001, Dukes 25007, Nantucket 25019. Rural Areas of Barnstable 25001, Berkshire 25003, Hampshire 25013, Hampden 25013, Worcester 25027.

Estimated Required Funding: **Total: $114,502,232** (Year 1: $24,266,526; Year 2: $24,022,190; Year 3: $21,735,396; Year 4: $22,674,889; Year 5: $21,803,231)

Initiative III: **Training Healthcare for Retention, Innovation, and Excellence (THRIVE)**

Main Strategic Goal: Workforce Development

Description & Activities: This Initiative aims to strengthen the full continuum of the healthcare workforce in rural communities, with targeted projects focused on pipeline development, recruitment, and retention. These efforts will focus on programs that will attract, train, and support healthcare providers in rural areas to commit to serving their rural communities for a minimum of 5

years and thrive professionally. To support our current and future workforce we will implement the following Activities:

1. Launch a Rural Talent Recruitment Campaign to partner with local community-based organizations, career centers, provider entities, and educational institutions to encourage individuals in rural communities to pursue health professions. "Grow-your-own" workforce development programs address shortages by cultivating local individuals to support workforce needs, while empowering residents' economic independence. Providing rural residents with employment opportunities with benefits helps reduce outmigration and strengthen local economies. Funding will support local planning, marketing services, creation of local engagement programs like HOSA, support for student engagement, and exposure experiences. This long-term strategy enables rural communities to more effectively address their future healthcare workforce needs.
2. Expand Statewide Rural Training Networks and Pipeline Programs for allied health professionals such as medical and dental clinical assistants, behavioral health providers, physical therapists, nutritionists, respiratory therapists, midwives, and paramedics, focusing in particular on professions with extreme shortages in rural communities and on creating access to healthcare for populations that face barriers created by disability (e.g., hearing loss). Modeled off of MA's successful Community Health Worker Training Network[li] model, we will fund collaborative regional networks of community entities, educational providers, and local providers to develop curriculum pathways and localized supports to establish training hubs for both professional certification and expansion of skills. By aligning resources and dividing responsibility locally, sharing materials and best practices across regional networks, and training residents for employment and economic mobility, we will create long term sustainability once programs are developed and piloted. To establish programs and pilot training models, participant tuition and fees will be linked to a five-year service commitment to rural areas.
3. Create Rural Nurse Practitioner (NP) Residency Programs to support training new NPs and expand the skills of currently practicing NPs in rural areas. Investments would establish NP residency

programs by funding technical support, creation or use of accredited educational programs, design of clinical experiences, incentives for rural clinical sites, mentorship and preceptor funding, and student resources. Residency programs would offer reduced and/or free tuition in exchange for five-year service commitments in rural areas and facilities. New residency programs will focus on areas of need for rural communities including Psychiatric NPs, Women's Health NPs, and Adult-Gerontology NPs.

4. Support Pathways to Permanent Housing for Clinical and Support Staff[lii] in rural areas with extreme housing shortages and high housing costs to increase retention in rural communities. Funding would help establish housing support programs at health provider facilities to support workforce transitions and retain providers long term. Several healthcare organizations in Massachusetts' rural tourism areas struggle to retain staff who can't find and afford long term housing options, due to the lack of available homes and inflated costs caused by the second homeowners in the market. This high demand from the tourist market is leaving year-round, locally based healthcare workers unable to find affordable housing, resulting in outflow from the market and an inability to recruit and retain new healthcare workforce. Although some facilities have created short-term housing for seasonal workforce, this still leaves year-round workers without permanent housing. Funding will support local models that encourage partnership with local government, private businesses, and non-profits to create local solutions like down payment matches,[liii] cash builder programs,[liv] rental off-sets,[lv] relocation supports, and local coordination.[lvi i] All recipients of support would be required to make a five-year commitment to ongoing work in rural facilities and communities.
5. Launch Incentive Programs for Field Placements and Supervising Clinicians. There are limited opportunities for healthcare professional students to train in rural communities and facilities. Evidence shows that healthcare workers are more likely to live and work in areas they have trained in, thus the limited training opportunities limit long-term workforce development in rural areas. To increase availability of rural facility-based and community-based placements, and to support

student completion of traditionally unpaid educational requirements, this program will build capacity for rural-based workforce training. Specifically, this Activity will support rural organizations to take on student placements and supervise/train students working towards training and licensure. It will also provide incentives to students completing requirements, providing financial support for unpaid field placements, internships, apprenticeships and practicums in rural areas to catalyze medium and long-term rural workforce development. Providing rural exposure during field training increases the probability healthcare workers will work long term in rural practices. [lvii,lviii] Students receiving placement incentives will be required to make a five-year service commitment in a rural area.

6. Facilitate Recruitment and Retention Plans at rural provider organizations to increase and maintain workforce by building out local capacity and infrastructure. Funding for this Activity will support on-site assessments and technical assistance for provider organizations to create and implement site-specific, medium- and long-term recruitment and retention action plans. Modeled after the National Rural Recruitment and Retention Networks facility assessments,[lix] these plans support the development of community recruitment committees, outreach materials, resources for sourcing candidates, establishing referral programs, approaches for candidate matching, and strategies to support retaining employees from their first day of employment. In a survey administered by the Massachusetts Department of Public Health in 2019, over 80% of rural provider organizations indicated that due to limited capacity, they did not have a recruitment and retention plan or had plans that were missing multiple key elements. This Activity will support rural providers to develop and/or update these plans to ensure long-term workforce development strategies are in place for all rural communities.
7. Create a virtual workforce training platform. Rural healthcare professionals can feel isolated from peers and lack easy access to continuing education and skill building. This Activity will support development of a workforce training platform including training modules, simulations, AI decision supports, virtual mentorship pipelines, peer-support apps, and digital learning networks to build

professional capacity and create networks of support for rural healthcare providers. Funding would support the development of virtual programs in a collaborative environment. This will support professional needs and further increase skills and connectivity of clinical providers and allied health positions to create better patient outcomes and facilitate retention of staff in rural communities and organizations.

Use of Funds: D, E, F, K (non-exhaustive)

Technical Score Factors: B.1, C.1, D.1, D.3 (non-exhaustive)

Key Stakeholders: Rural Hospitals, Critical Access Hospitals, Rural Health Clinics, Primary Care Offices, EMS providers, Community Based Organizations, Area Health Education Centers, Rural School Districts, Local Public Health, Rural Health Professionals, Rural Job Seekers, Independent Living Centers, State Office of Rural Health, Healthcare Workforce Center, MassHealth, State Workforce Investment Boards, and State Secondary Education Providers.

Outcomes: (1) Increase the number of healthcare professionals practicing at rural organizations. (2) Increase retention of healthcare professionals serving rural patients. (3) Reduce patient wait times for primary care appointments. (4) Increase number of youth and adults interested in pursuing rural health careers. (5) Increase number of rural sited residency programs and field placements to meet certification requirements.

Impacted Counties: Rural Counties: Franklin 25001, Dukes 25007, Nantucket 25019. Rural Areas of Barnstable 25001, Berkshire 25003, Hampshire 25013, Hampden 25013, Worcester 25027.

Estimated Required Funding: **Total: $123,084,335 (**Year 1: $23,754,706; Year 2: $23,782,613; Year 3: $19,854,896; Year 4: $27,831,890; Year 5: $27,860,230)

Initiative IV: **Healthy Rural Communities**

Main Strategic Goal: Make Rural America Healthy Again

Description & Activities: This Initiative will support community infrastructure to maximize opportunities and address gaps related to the root causes of chronic disease through preventive

measures and wraparound community services/education to keep people healthy. This means providing tailored chronic disease education and services to rural residents via engagement with community-based providers and organizations. This Initiative will create critical linkages to clinical activities in other RHTP-supported Initiatives and will leverage community-based networks to support activities aimed at the prevention of chronic disease by encouraging and supporting healthy behaviors. To support this Initiative, we propose the following Activities:

1. Establish Community-Based Chronic Disease Prevention Programs leveraging community-based partners to expand capacity for screening, education, and interventions addressing chronic disease (CD) and associated risk factors. These programs will empower rural populations to engage in and choose activities that reduce risks for CDs like eating healthy, local foods, limiting ultra-processed foods, taking part in regular physical activity, and reducing the use of drugs and alcohol. Funds will support the creation of tailored interventions that leverage technological innovation from our other Initiatives and build on rural communities' assets related to diabetes, hypertension, COPD, obesity, cancer, and other CDs. Local interventions will model rural evidence-based programs, like technology-supported multicomponent counseling to monitor blood pressure and reduce weight,[lx] or build further capacity for programs not fully available in rural communities, including nutrition support services currently paid for by MassHealth that have demonstrated significant decreases in hospitalizations, ED use, and total cost of care.[lxi] These interventions will strengthen linkages between community-based and clinical services, helping support population health initiatives to further save healthcare costs, empower residents, and reduce severity of chronic disease outcomes.
2. Expand Community Based Organization (CBO) Networks to organize local activities through trusted organizations and individuals to provide assessment, inform customized approaches, and establish local programming. Each rural region is unique, with different rates of chronic conditions as well as protective factors. Rural residents rely on community ties and trusted messengers, so local networks are critical to support the prevention and management of chronic disease. Massachusetts has stood up similar network supports[lxii] to manage and prevent infectious disease

outbreaks, with overwhelming success. However, chronic disease management supports are limited. Rural CBO networks support tailored, innovative, and cost-saving approaches at the community level, resulting in more effective disease prevention and management. Funds will support network convening, the provision of CBO expertise, capacity building of network members, and facilitation of identified activities. Our previous infectious disease prevention networks operationalized over 1,000 rural community partners supporting community interventions. The cost of sustainable continued coordination support is low once infrastructure is established and capacity supports are in place, and networks can be sustained through reimbursement models that fund prevention.

3. Coordinate with Local Public Health Shared Service Arrangements (SSAs) to support pooled staffing, service coordination, and real time data feedback to support preventative health activities in rural areas. SSAs are arrangements in which municipalities pool staff, resources, and services to strengthen local health systems regardless of community size or budget. Many SSAs include both urban and rural communities but are limited in their ability to support rural activities due to funding and model limitations. Funding for this Activity would create linkages with the rural serving SSAs to support data sharing, service referrals, and expand the role of SSA community health workers to support this Initiative and Activities 1, 2, and 6 in the Population Health Advancement Initiative (see above). Expanding existing SSA infrastructure to increase rural support will utilize existing workforce and share critical health data to support several activity areas and create multiple pathways to sustain local activities in the medium and long term.
4. Implement Population Specific Programs to provide targeted resources and wraparound supports to aging adults, people with disabilities, indigenous populations, school-aged youth, and young families to increase impacts for more vulnerable populations.

   4a. Aging adults, people with disabilities, and indigenous populations are disproportionately represented in our rural regions as noted in our needs assessment, and these populations have poorer health outcomes compared to other rural populations. Focusing more intensive and tailored community resources to these populations will create larger impacts on health outcomes and ROI

by preventing acute events and therefore reducing clinical costs. Aging adult programs will follow models like Walk With Ease[lxiii] and we plan to adapt proven interventions from Mass in Motion[lxiv] into Tribal Populations to support their community-specific needs.

4b. School-aged youth and young families are less predominant in our rural regions and due to economies of scale, have far less access to prevention programs and direct resources in rural areas as compared to their non-rural counterparts. This lack of resources leads to poorer health outcomes for these populations. We plan to utilize school-based supports to build out engagement programs on topics including healthy foods, limiting ultra-processed foods, the importance of physical exercise, walkability/Safe Routes to School, reducing screen time, and building healthy relationships. Young family interventions will be based on evidence-based models like Healthy Families America[lxv] and Home-Based Head Start.[lxvi] Program data for these models have demonstrated increases in the number of well-child visits attended, decreases in reports to Child Protective Services, and an increase in developmental screenings.[lxvii] Creating the infrastructure to directly support youth and young families will not only impact current health outcomes but will build the foundation for healthy behaviors into adulthood.

Use of Funds: A, C, D, F, G, I, K (non-exhaustive)

Technical Score Factors: B.1, B.2, F.1, F.3

Key Stakeholders: Rural-serving and located community-based organizations and municipal and tribal governments, local Boards of Health, councils and coalitions, faith-based organizations, healthcare providers, health-related organizations, local community leaders, mental/behavioral health organizations, State Office of Rural Health, MassHealth, Interagency Tribal Partnership Workgroup, rural health clinics, critical access hospitals, social service providers, schools, out-of-school time providers, Councils on Aging, Aging Services Access Points/Area Agencies on Aging, Independent Living Centers, and long term care facilities.

Outcomes: (1) Reduce rates of chronic disease in rural residents. (2) Increase number of new community partnerships for increased coordination. (3) Reduce risk factors for chronic disease. (4) Increase rates of rural residents partaking in healthy behaviors. (5) Increase social connectedness of organizations and residents. (6) Improve health outcomes for targeted vulnerable populations.

Impacted Counties: Rural Counties: Franklin 25001, Dukes 25007, Nantucket 25019. Rural Areas of Barnstable 25001, Berkshire 25003, Hampshire 25013, Hampden 25013, Worcester 25027.

Estimated Required Funding: **Total $86,080,222** (Year 1: $15,365,015; Year 2: $23,242,190; Year 3: $15,554,897; Year 4: $15,944,890; Year 5: $15,973,230)

Initiative V: Emergency Medical System (EMS) Service Integration Initiative

Main Strategic Goal: Innovative Care

Description & Activities: This Initiative will support integrating new EMS services in rural areas to increase their role in providing clinical care and supporting healthcare efficiencies, while ultimately providing more operational stability to these local agencies and systems that provide critical services. To support this Initiative, we propose the following Activities:

1. Provide Support to Encourage Participation in Community Paramedicine Models by addressing funding and equipment barriers to encourage participation in standalone programs and supporting Activities outlined in Initiative I: Population Health Advancement. Community Paramedicine can include home visiting, healthcare navigation, patient education, and wellness programs, and has been shown to improve health outcomes and reduce ED use, as well as provide another avenue to attract workers into healthcare.[lxviii] Although Massachusetts has Mobile Integrated Health Care (MIH) and Community EMS programs, many barriers exist to bringing this model to rural EMS agencies, including a lack of ongoing financing and reimbursement models. At least five rural communities could immediately benefit from a detailed assessment of and plan for sustainably supporting a local community paramedicine program. Additional supports would include focused TA for program development, including facilitating stakeholder-led service gap identification,

focused staff training in optimizing triaging to non-emergency services, behavioral health/SUD, chronic disease and other identified needs, staffing plans for expanded services, as well as MIH licensing funding and improved integration with existing preventative and primary care resources.

2. Implement a Pilot Reimbursement Program to support Activity 1 and EMS activities within our other RHTP Initiatives. We will include the following: transport to non-emergency department healthcare facilities, such as Community Behavioral Health Centers (CBHCs); patient evaluations where EMS is called to evaluate a patient, including an on-scene clinical assessment, but in which they do not ultimately transport the patient; providing treatment on-scene in situations in which transport is unnecessary; and supporting population health activities such as community paramedicine programs and home risk assessments. Each of these activities reduces utilization of more expensive services, including ED visits, and therefore provides key opportunities to localize care in the community, decrease healthcare costs, and support community-based interventions to improve health outcomes. Current reimbursement for EMS services means ambulance services are operating at a deficit and putting them at risk of closure, especially in rural communities. This pilot would test the potential for new reimbursement mechanisms and, if successful, could be scaled with local municipalities and payers to improve EMS access in rural areas, enhance community-based care, and decrease overall healthcare costs.
3. Develop and Launch a Prehospital Protocol and Medication Dosing Mobile Application that can make the statewide treatment protocols an easier resource to navigate on mobile devices for EMS providers in rural areas. EMS clinical care in Massachusetts is primarily governed by a set of statewide treatment protocols. Medication errors are one of the most common types of errors in the medical field. Medication errors are a particularly high risk in rural ambulance services where there is frequently only one advanced life support paramedic to provide care and where underfunding necessitates ambulance service switching formulations more frequently to maximize the impact of every dollar. Many existing third-party mobile applications to navigate treatment protocols have challenging and fluid pricing models making it difficult for many ambulance services to purchase

them, especially rural service providers with more acute fiscal constraints. The new application would be free to all EMS providers, improving care throughout rural communities. Simultaneously, the application would track utilization data, which can inform clinical service protocol updates and opportunities for training EMS providers, ultimately improving care provided to residents.

Use of Funds: A, B, D, F, G, I, K (non-exhaustive)

Technical Score Factors: B.1, C.1, C.2, D.3, F.2

Key Stakeholders: Ambulance services serving rural communities, Office of Emergency Services and Management, MassHealth, EMS Industry experts, Rural municipalities, Rural Hospitals/Primary Care.

Outcomes: (1) Increase financial viability of ambulance agencies serving rural communities. (2) Reduce costs of prehospital care to patients in rural communities. (3) Reduce number of emergency transports by rural ambulance services for unnecessary emergency department utilization. (4) Increase collaborative relationships between rural ambulance services and other community health partners. (5) Reduce emergency department boarding and hold times for patients meeting throughput criteria.

Impacted Counties: Rural Counties: Franklin 25001, Dukes 25007, Nantucket 25019. Rural Areas of Barnstable 25001, Berkshire 25003, Hampshire 25013, Hampden 25013, Worcester 25027.

Estimated Required Funding: **Total $63,279,097** (Year 1: $14,299,586; Year 2: $11,824,069; Year 3: $9,373,561; Year 4: $12,876,770; Year 5: $14,905,111)

Initiative VI: **Enhancing Technology Interoperability and Connectivity Initiative**

Main Strategic Goal: Tech Innovation

Description & Activities: This Initiative strengthens the technological infrastructure of rural healthcare providers to improve care coordination, data interoperability, cybersecurity, and emergency response. It will coordinate projects designed to modernize rural health IT systems, enhance secure data exchange, and promote statewide connectivity to better support rural areas and

providers. To undertake this Initiative to modernize rural healthcare we propose the following Activities:

1. Expand Rural Provider Participation in the State's Health Information Exchange (HIE) to promote interoperability, reduce provider burden, and build sustainable rural HIE capacity, supporting timely, complete, and bidirectional data exchange across the continuum of care. Rural providers and healthcare organizations have financial, technological, and staff capacity limitations that prevent them from fully participating in state and national HIEs. Funds will support rural providers through a state-designated HIE Technical Assistance Hub. The Hub will deliver shared onboarding, training, and implementation playbooks to help small and rural organizations connect to statewide and national networks (e.g., MA Clinical Gateway,[lxix] MA ENS Framework,[lxx] TEFCA/QHIN,[lxxi] and NCPDP pharmacy exchange standards[lxxii]) using secure, standards-based methods, including Fast Healthcare Interoperability Resources (FHIR) based Application Programming Interfaces (APIs) and resource exchange to enable real-time data sharing across EHR systems and state public health platforms. Core focus areas include public health data integration, behavioral health and long-term services and supports (LTSS) connectivity, practice-level event notifications, query-based exchange onboarding, and community pharmacy data sharing. The Hub will provide procurement-compliant subsidies and local technical support to reduce onboarding barriers and ensure workflow fit within EHR systems. The Hub will also coordinate statewide interoperability alignment to ensure rural participants can fully leverage national frameworks and public health systems for secure, bi-directional data exchange.
2. Link Rural EMS Providers and Hospitals to Critical Systems to support patient distribution and transfer, connect to modernized communication networks, and improve patient outcomes. This will include connecting rural hospitals and EMS to the Automated Capacity and Occupancy Reporting Network (ACORN) that allows them to receive near real time occupancy data allowing for quicker decision-making regarding patient distribution and transfer, reducing staff time and increasing hospital throughput. Funding will support the installation of the ACORN software system for rural

providers, as well as providing technical assistance and start-up maintenance costs. This Activity will also support rural providers and EMS to purchase and install new radio equipment to participate in Central Medical Emergency Direction (CMED) modernization. Moving providers from the current patchwork system, where EMS is using various independent communication channels to notify and communicate with an area hospital, to a statewide, interoperable radio network, already supported by coordinating dispatchers, will enable better communication and resource communication in rural communities where radio and cell service is insufficient.

3. Create and Deploy a Local Public Health (LPH) Electronic Record System with integrated billing and reporting functionality to support local communities' public health entities. A centralized hosting and maintenance model will allow these smaller public health entities to share system infrastructure while maintaining secure, independent records. The system will enable electronic claims submission and reimbursement for clinical services, maternal and child health, chronic disease management, and communicable disease case management, allowing LPH Shared Service Arrangements to participate in and support this application's Initiative I: Population Health Advancement's Activities 1, 2, 5, and 6 as well as Initiative IV: Rural Healthy Community's Activities 1 and 3. Funding will support the design, configuration, and implementation of the EHR platform, ensuring compatibility with state immunization and public health reporting systems and national interoperability standards (e.g., HL7, FHIR). The implementation will include training for local public health staff, onboarding support for participating agencies, and integration with the state's insurance clearinghouse. The system will reduce administrative burden, improve data accuracy, and establish a sustainable platform for long-term public health service delivery.
4. Provide Needed Cybersecurity Supports to Rural Providers to combine technical expertise, direct assistance, and targeted funding, to reduce provider burden, enhance interoperability security, and builds a sustainable foundation for future-ready rural health IT systems. This program will partner with Massachusetts eHealth Institute (MeHI)[lxxiii] and the MassCyberCenter[lxxiv] to administer cybersecurity implementation grants to financially constrained rural providers, enabling adoption of

secure technologies and practices. This Activity promotes a culture of security and resilience through provider education, shared best practices, and alignment with the HHS Cybersecurity Performance Goals and the updated HIPAA Security Rule. This program will leverage established MassCyberCenter programs to provide essential cybersecurity services for rural healthcare organizations via a state-funded Security Operations Center. Supported services include the following: Managed 24x7 Endpoint Detection and Response; Network Discovery; Vulnerability Assessment; Active Directory and Entra Hygiene; Active Directory Identity Protection; Software and Asset Inventory; Zero Trust; Log and Alert Management; and AI-based Email Protection. Cybersecurity Assessments will evaluate rural healthcare organizations against the Center for Internet Security (CIS) Critical Security Controls, provide technical testing of key aspects of defenses, and assist organizations with interpreting the HIPAA Security Rule. This program will provide the needed one-time boost for rural health providers to adopt modern cybersecurity procedures and tools establishing a culture of shared understanding around the need for all health data exchange to be private and secure.

5. Provide Targeted Technical Assistance (TA) Supports to Rural Providers to assess and plan for IT modernization and capability expansion. TA will include training in interoperability standards and ensure alignment with the CMS Health Technology Ecosystem and the Commonwealth's existing HIT resources. All activities will promote adoption of FHIR-based interoperability standards in alignment with Office of the National Coordinator for Health Information Technology (ONC) and CMS Health Technology Ecosystem criteria. The Initiative will also develop a shared technical assistance and support network to help rural facilities maintain interoperability and cybersecurity systems over time. Participating providers will have access to ongoing help desk and managed services support, ensuring sustained operations after the grant period.

   Use of Funds: C, D, F, G, I, J (non-exhaustive list)

   Technical Score Factors: B.1, B.2, C.1, C.2, E.2, F.2, F.3,

Key Stakeholders: Federally Qualified Health Centers, Rural Health Clinics (RHCs), Primary care and multi-specialty practices, Critical Access Hospitals and rural community hospitals, Behavioral health and LTSS providers, Local Boards of Health and public health departments, Emergency Medical Services (EMS) agencies, Rural Ambulance Services, Community-based organizations supporting rural health access, State agencies including EOHHS, Executive Office of Public Safety and Security (EOPSS), DPH and its Office of Emergency Medical Services and Office of Preparedness and Emergency Management, and the Massachusetts eHealth Institute.
Outcomes: (1) Increase participation and advance use of rural healthcare providers of statewide HIE. (2) Ensure rural participation of all hospitals and EMS agencies in statewide ACORN and CMED projects. (3) Increase percentage rural providers meeting cybersecurity maturity benchmarks. (4) Increase local service provision through new LPH EHR project.
Impacted Counties: Rural Counties: Franklin 25001, Dukes 25007, Nantucket 25019. Rural Areas of Barnstable 25001, Berkshire 25003, Hampshire 25013, Hampden 25013, Worcester 25027.
Estimated Required Funding: **Total: $83,198,412 (**Year 1: $16,122,205; Year 2: $17,516,689; Year 3: $16,492,397; Year 4: $16,519,390; Year 5: $16,547,731)

Initiative VII: **Facility Modernization and Re-Use Initiative**

Main Strategic Goal: Sustainable Access

Description & Activities: This Initiative will support minor renovations and enhancements of rural healthcare facilities to optimize space, improve operational efficiency, and expand access to health services for residents of rural areas. Renovations of existing facilities will increase local access to services, increase facility services and capacity, improve patient safety and quality of care, reduce unused space in facilities, and increase facility accessibility to create more multi-use and flexible spaces. To support this Initiative, we propose the following Activities:

1. Fund Critical Capital Updates for Rural Hospitals. Most rural hospital facilities in the state are still housed in buildings that have foundational features and/or existing wings that were built in the mid-

20th century. Facilities are in dire need of investments to support renovations and upgrade equipment to enhance preventive care, increase service offerings, and repurpose underutilized space to both meet community needs and increase revenue for long term fiscal sustainability. Funding would support rural hospital renovations to modernize facilities to enhance safety, address accessibility, increase efficiency, and expand opportunities to provide diagnostic and specialty services on-site, including by enhancing functional effectiveness and reducing costs by replacing outdated lighting, heating/cooling systems, and improving water and waste efficiencies. Thoughtful upgrading of rural hospital facilities will create long-term flexibility and these efforts will ensure sustainability of hospitals' ability to serve their rural communities.

2. Fund Critical Capital Updates for Rural Primary Care Sites. Rural primary care sites, such as Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHCs) have experienced historic underinvestment in their facilities and are often unable to secure the financing they need due to their smaller patient population and revenue streams. In addition, rural primary care providers, in order to create access in remote communities, usually have multiple smaller facilities, which require more overhead and have fewer economies of scale. The result is that aging facilities are repeatedly repaired to eke out one more year, but the critical systems are not modernized. Under this Activity, these rural primary care providers will receive funding for upgrades to their infrastructure and equipment, improvement of their physical plants, and expansion of their ability to address the need for up-to-date diagnostic, chronic disease treatment, and telehealth capabilities. Funding this Activity will enable providers to make improvements to existing facilities and/or expand in ways that meet current community needs and position providers for future transformation, including the integration of new technologies, telehealth capabilities, and innovative care models. Additional needs include HVAC upgrades, roofs, accessibility improvements, parking lots, and energy-efficiency/resiliency upgrades. Fluctuations in volume, seasonal requirements, and unpredictable health-related events further support the development of flexible use space as another vital element of rural health clinic/rural primary care facility needs.

3. Fund Critical Capital Updates for Rural Nursing Facilities. Long-term care facilities that serve residents of rural communities in Massachusetts require significant renewed investment including in their physical plant. In 2024, MA convened a Viability and Sustainability of Long-Term Care Facilities Task Force[lxxv] to review the worsening condition and sustainability of long-term care facilities statewide. The Task Force found that Massachusetts has an aging long-term care infrastructure and that it must be careful to ensure existing facilities are able to invest in that infrastructure to continue to provide adequate care. Massachusetts will only have sufficient nursing facility capacity until 2034, and existing limited capacity in rural areas could restrict patient choice even sooner, resulting in exceeded capacity in certain rural geographies earlier than others. Funding will support nursing home infrastructure improvements, enhance safety, and improve resident care, through the following pathways: facility modernization and renovations (e.g., upgrading resident rooms, common areas, dining spaces, and ensuring all spaces meet accessibility standards and are in compliance with current fire, safety, and infection control standards); improved energy efficiency and sustainability (e.g., replacing outdated lighting, windows, or heating/cooling systems to reduce ongoing utility costs, installing renewable energy sources to reduce operational costs, improving water efficiency and reducing waste through plumbing upgrades); and enhanced infection control and public health upgrades (e.g., installing negative pressure or isolation rooms for infection prevention and upgrading air filtration systems to reduce airborne pathogen transmission). These infrastructure improvements will ensure medium and long-term sustainability for these nursing facilities and continuity of their critical services throughout rural MA.
4. Fund Specialized Rural Nursing Facility Units for Behavioral Health & Substance Use Disorder Services. Funding will support the establishment of specialized units at rural nursing facilities to provide care dedicated to residents with Behavioral Health and/or Substance Use Disorder. To establish and sustain these units, nursing facilities will need to reconfigure existing nursing facility units, increase availability of specialized Behavioral Health and/or Substance Use Disorder services, establish partnerships with local Opioid Treatment Programs, provide increased training to

all nursing facility staff and improve referral processes with local Critical Access Hospitals to identify appropriate referrals for the specialized unit.

Use of Funds: G, H, J (non-exhaustive)

Technical Score Factors: C.1

Key Stakeholders: Rural Hospitals, Critical Access Hospitals, Rural Health Clinics, Rural Primary Care Providers, Rural Nursing Facilities.

Outcomes: (1) Enhance safety and increase efficiency of rural healthcare facilities. (2) Expand availability of diagnostic and specialty services on-site in rural communities. (3) Position rural providers for future growth in new models of care. (4) Increase local access to healthcare services for rural residents. (5) Increase financial sustainability of rural facilities.

Impacted Counties: Fully Rural Counties: Franklin, Dukes, Nantucket. Rural Areas of Barnstable, Berkshire, Hampshire, Hampden, Worcester.

Estimated Required Funding: **Total: $238,159,940** (Year 1: $53,237,886; Year 2: $45,114,189; Year 3: $44,340,087; Year 4: $47,186,412; Year 5: $48,281,366)

Implementation Plan and Timeline

Governance and Project Management Structure

Please see Attachment: Governance Org Chart for a visual representation of program supports. The RHTP will be managed through the Executive Office of Health and Human Services (EOHHS), supported by the strategic oversight of a state Leadership Council and governance by an interagency Governance Team and Community Advisory Group . The existing Director of Health Policy and Strategic Initiatives at EOHHS will serve as the 0.25FTE Project Director for the RHTP, providing oversight of key staff and liaising between the Leadership Council, Governance Team, and Community Advisory Group to ensure there is strategic alignment and clear direction for project implementation.

The Leadership Council will be chaired by the Secretary of EOHHS, and will include the

Undersecretary for MassHealth, the Commissioner for DPH, the Deputy Chief of Staff for the Governor's Office, and other key agency executives. The interagency Governance Team will include representation from the implementing agencies, namely the Massachusetts Executive Office of Health and Human Services (EOHHS) including the Office of Medicaid (MassHealth), the Massachusetts Department of Public Health (DPH), including its State Office of Rural Health, and the Massachusetts Executive Office of Economic Development's (EOED) Office of Rural Affairs, EOHHS Office of IT, Executive Office of Aging and Independence (AGE), and other key state agencies.

Three full-time Program Managers will staff the Governance Team to provide project implementation. They will oversee and support the RHTP Initiative leads, fiscal manager, and evaluation manager, as well as coordinate with the Community Advisory Council (details outlined in the Stakeholder Engagement section). A 1.0 FTE Fiscal Manager will coordinate with the EOHHS Office of Federal Finance and Revenue and Secretariat Finance to support fiscal management of the project. A 1.0 FTE Evaluation Manager will coordinate with the Office of Health Data Strategy and Innovations (OHDSI) at DPH to coordinate evaluation efforts for the project. Each RHTP Initiative identified in this project will have a 0.5FTE lead, who will be accountable for overall successful execution of each Initiative. Each Initiative will be supported by a Workgroup that will provide subject matter expertise and ensure Initiative implementations are meeting program goals.

Initiative Timelines Below are simplified timelines and milestones for each of our proposed Initiatives, to demonstrate major Activity points. Due to space limitations, we have not included more granular points for each discrete Activity. We have also outlined these timelines in our Attachment: Workplan. If appropriate, we will furnish detailed plans outlining discrete timelines for all Activities within the seven Initiatives.

Program Oversight & Evaluation		
MILESTONES –	**DATE**	**PHASE**
Initiate: Hire and onboard key staffing. Establish Community Advisory Council and Initiative work groups	Q0 2026-Q1 2026	0
Plan: Establish project, communication, evaluation, fiscal, and decision-making workflows.	Q1 2026-Q2 2026	1
Execute: Begin Leadership Council and Advisory Meetings. Begin quarterly program monitoring and evaluation. All Initiative Activities in process.	Q3 2026-Q4 2026	2
Monitor:		3
Assurance:		4
Close and Transition:		5
Initiative I. Population Health Advancement		
MILESTONES	**DATE**	**PHASE**
Activities 1, 2,3,5,6 & 7: Set up project infrastructure. Hire Staff. Procurements developed with stakeholder input. *Activities 4 & 8:* Procure Vendors	Q1 2026-Q3 2026 Q2 2026-Q3 2026	0
All Activities: Select vendors and organizations. Design program implementation plans. *Activities 2 & 4*: Technology development begins *All Activities*: Data sharing and network agreements in place. *Activity 6:* Begin training and onboarding *Activity 8:* Technical Assistance to providers begins	Q4 2026-Q2 2027 Q4 2026-Q2 2027 Q3 2027 Q1 2027-Q3 2027 Q4 2027-Q1 2028	1
Activities 1, 2,3,4,5,6 & 7: Program implementation begins *Activity 8:* Payment incentives begin.	Q4 2027-Q3 2028 Q4 2027	2
Activities 1,2,3,4,5: Dashboards, analytics & data sharing live. *All Activities:* Quarterly program & data reviews begin.	By Q4 2027 Q4 2027-Q1 2028	3
All Activities: Sustainability- transition planning begins.	By Q2 2029	4
All Activities: Review Outcomes and transition to sustainability.	By Q4 2030	5
Initiative II. Innovation in Rural Care Models		
MILESTONES	**DATE**	**PHASE**
Activities 1-7: Set up project infrastructure. Hire staff. Complete assessments. *Activities 1-6:* Procurements developed with stakeholder input	Q1 2026-Q3 2026 Q1 2026-Q3 2026	0
Activities 1-6: Procurements complete & selection of vendors, providers, and organizations. *Activity 5:* Select cohort 1 and award funding. *Activities 1-7:* Project supports hired and onboarded. *Activities 1-7:* Begin collaborative planning for evaluation and future sustainability with vendors, partners, and stakeholders.	Q4 2026-Q1 2027 Q3 2026-Q4 2026 By Q3 2026 Q4 2026-Q1 2027	1

All Activities: Begin program implementation, first cohorts begin. *Activity 4 & 5.* Select next cohorts. Award grants to partners.	Q1 2027-Q4 2027 Q1 2027-Q2 2027	2
Activities 1-4: Make selections for next funding round. *Activity 5:* Select next cohort *All Activities:* Monitoring and evaluation tasks, quarterly.	Q1 2028-Q2 2028 Q1 2028-Q2 2028 Q1 2028-Q4 2030	3
Activities 1-4: Make selections for next funding round. *Activity 5:* Select next cohort *All Activities*: Sustainability- transition planning begins.	Q1 2029-Q2 2029 Q1 2029-Q2 2029 Q1 2029-Q4 2029	4
All Activities: Make final awards. *Activities 1.2.3.7:* All developed models are fully operational. *All Activities:* Review final outcomes and transition to sustainability.	Q1 2030-Q2 2031 Q1 2030-Q2 2030 Q1 2030-Q4 2030	5
Initiative III. THRIVE Workforce		
MILESTONES	**DATE**	**PHASE**
All Activities: Set up project infrastructure. Hire Staff. Procurements developed with stakeholder input. *All Activities:* Procurements posted for vendors, providers, and organizations.	Q1 2026-Q3 2026 Q3 2026-Q4 2026	0
All Activities: Select vendors, providers, and organizations and execute contracts. Interagency service agreements executed. *All Activities:* Create project plans with vendors, sites, and state agencies.	Q4 2026-Q1 2027 Q4 2026-Q1 2027	1
All Activities: Design and develop program materials (applications, marketing, etc.) and begin to advertise programs. *All Activities*: Launch initial programs and begin implementation. *All Activities*: Quarterly program monitoring & evaluation begins. *All Activities*: Launch second cohort of programs and begin implementation. *All Activities*: Launch third cohort of programs and begin implementation.	Q1 2027-Q2 2027 Q3 2027-Q1 2028 Q3 2027-Q4 2027 Q1 2028-Q3 2028 Q3 2028-Q1 2029	2
All Activities: Midpoint assessment activities. *All Activities:* Launch fourth cohort of programs and begin implementation.	Q2 2028-Q3 2028 Q2 2029-Q3 2029	3
All Activities: Launch fifth cohort of programs and begin implementation. *All Activities:* Sustainability- transition planning begins.	Q4 2029-Q2 2030 Q1 2029-Q4 2029	4
All Activities: Review final outcomes and transition to sustainability.	Q1 2030-Q4 2030	5
Initiative IV. Healthy Rural Communities		
MILESTONES	**DATE**	**PHASE**
All Activities: Set up project infrastructure. Hire Staff. Procurements developed with stakeholder input. *All Activities:* Create communication processes, Complete needs analysis.	Q1 2026-Q3 2026 Q3 2026-Q4 2026	0
All Activities: Post Procurements. Develop implementation plans. *All Activities:* Award procurements and begin onboarding of organizations & vendors.	Q3 2026-Q4 2026 Q4 2026-Q1 2027	1

All Activities: Develop networks. Begin implementation of project plans. *All Activities*: Launch training and technical assistance supports. *All Activities*: Begin peer learning cohorts.	Q1 2027-Q2 2027 Q1 2027-Q3 2027 Q3 2027-Q4 2027	2
All Activities: Begin implementing community prevention interventions. *All Activities*: Quarterly program monitoring & evaluation begins. *All Activities:* Expand prevention programming and network membership.	Q4 2027-Q2 2028 Q4 2027-Q4 2030 Q3 2028-Q2 2029	3
All Activities: Expand target audiences for prevention programs. *All Activities:* Sustainability- transition planning begins.	Q1 2029-Q2 2030 Q1 2029-Q4 2029	4
All Activities: Review final outcomes and transition to sustainability.	Q1 2030-Q4 2030	5
Initiative V. EMS Service Integration		
MILESTONES	**DATE**	**PHASE**
All Activities: Set up project infrastructure. Hire Staff. Begin assessments. *Activity 1 &3:* Procurements developed with stakeholder input. *Activity 2:* Develop pilot reimbursement program.	Q1 2026-Q3 2026 Q1 2026-Q3 2026 Q1 2026-Q3 2026	0
All Activities: Post Procurements. Develop implementation plans. *Activities 1 &3:* Award procurements and onboarding of organizations & vendors. *Activity 2:* Begin outreach on pilot program.	Q3 2026-Q4 2026 Q4 2026-Q1 2027 Q4 2026-Q1 2027	1
Activity 1: Stand up technical supports. First cohort begins implementation. Launch second cohort. *Activity 2:* Begin pilot reimbursement program. *Activity 3:* Develop plan with vendor.	Q1 2027-Q3 2027 Q1 2027-Q3 2027 Q2 2027-Q4 2027	2
All Activities: Quarterly program monitoring & evaluation begins. *Activity 1:* Second cohort begins implementation. Launch third cohort. *Activity 2:* Review data for model improvement. *Activity 3:* Pilot application with vendor and EMS.	Q4 2027-Q4 2030 Q3 2027-Q1 2028 Q3 2028-Q2 2029 Q1 2028-Q4 2028	3
Activity 1: Third cohort begins implementation. Launch fourth cohort. *Activity 2:* Pull data to support advocacy for future use of reimbursement model. *Activity 3:* Launch application and protocols statewide. *All Activities:* Sustainability- transition planning begins.	Q2 2028-Q1 2029 Q2 2029-Q4 2029 Q1 2029-Q4 2029 Q1 2029-Q4 2029	4
Activity 1: Fourth cohort begins implementation.. *All Activities:* Review final outcomes and transition to sustainability.	Q2 2029-Q1 2030 Q1 2030-Q4 2030	5
Initiative VI. Enhancing Technology Interoperability & Connectivity		
MILESTONES	**DATE**	**PHASE**

All Activities: Set up project infrastructure. Hire staff. Complete assessments. Procurements developed with stakeholder input. *Activities 2:* Develop protocol.	Q1 2026-Q3 2026 Q1 2026-Q3 2026	0
All Activities: Post Procurements. Develop implementation plans *All Activities:* Procurements complete & selection of vendors and subrecipients complete.	Q4 2026-Q1 2027 Q3 2026-Q4 2026	1
Activities 1 & 4. Pilot implementations begin (HIE Hub, Cybersecurity)	Q1 2027-Q2 2027	2
Activities 2-5: Infrastructure and TA programs scaled statewide	Q1 2028-Q2 2028	3
All Activities: Quarterly evaluation and performance monitoring. *All Activities*: Sustainability- transition planning begins.	Q1 2029-Q2 2029 Q1 2029-Q2 2029	4
All Activities: Review final outcomes and transition to sustainability.	Q1 2030-Q4 2030	5
Initiative VII. Facility Modernization and Re-Use		
MILESTONES	**DATE**	**PHASE**
All Activities: Set up project infrastructure. Onboard a managing vendor. Complete assessments. *All Activities:* Procurements developed with stakeholder input.	Q1 2026-Q3 2026 Q1 2026-Q3 2026	0
All Activities: Post Procurements. Develop implementation plans. *All Activities:* Selection of round one facilities. *Activity 4:* Begin network planning with facilities.	Q3 2026-Q4 2026 Q3 2026-Q4 2026 Q4 2026-Q1 2027	1
All Activities: Implementation begins for round one facilities. Selection of round two facilities. *Activity 4:* Approve network plans and training support. *All Activities:* Quarterly program monitoring begins.	Q1 2027-Q4 2027 Q1 2027-Q2 2027 Q1 2027-Q4 2030	2
All Activities: Implementation begins for round two facilities. Selection of round three facilities. *Activity 4:* Implementation of plan and training.	Q1 2028-Q4 2028 Q3 2027-Q3 2028	3
All Activities: Implementation begins for round three facilities. Selection of round four facilities. *All Activities*: Implementation begins for round four facilities. Selection of round five facilities. *All Activities*: Sustainability- transition planning begins.	Q1 2029-Q2 2029 Q1 2029-Q2 2029 Q1 2029-Q4 2029	4
All Activities: Implementation begins for round five facilities. *All Activities:* All projects across funding rounds complete. *All Activities:* Review final outcomes and set up monitoring for future impacts.	Q3 2029-Q2 2030 Q1 2030-Q2 2030 Q1 2030-Q4 2030	5

Stakeholder Engagement

Stakeholders we have consulted: The interagency team supporting the application process values authentic engagement and supported several processes to solicit input and ensure a broad representation of stakeholders' input and ideas. The Executive Office of Health and Human Services (EOHHS) is the lead entity coordinating efforts. They have coordinated across EOHHS and with other state agencies to support this process and solicit input. The MA Department of Public Health (DPH) – including the State Office of Rural Health, MassHealth (our state Medicaid / CHIP program), and The Office of Rural Affairs in the Executive Office of Economic Development, with EOHHS, led the application and engagement process.

Through longstanding relationships with key stakeholders and pre-established processes and groups to support direct engagement, the interagency team held early engagement sessions with our state's rural hospitals, rural FQHC's, rural social service organizations, rural community-based organizations, and the Massachusetts Rural Council on Health. These sessions received input from 52 leaders from 41 rural health organizations.

Additionally, we facilitated direct input from trade associations, including the MA Health and Hospital Association, MA League of Community Health Centers, the MA Association of Behavioral Health, the Rural Policy Advisory Commission, and the Small Town Administrators of Massachusetts, which includes administrators from over 100 towns with populations of under 12,000 residents.

To ensure broad opportunities for input from throughout the Commonwealth, EOHHS also posted a public Request for Information, which received 138 responses from various entities with broad sectoral representation, including rural organizations, healthcare providers, social service organizations, rural municipalities, technology companies, expert consultants, non-profits, businesses, and educational providers. EOHHS also issued a Notice of Intent to announce its intended methodology for defining rural health facilities and provide opportunity for other health facilities to respond and demonstrate they should be included as such a rural health facility.

Finally, we coordinated across state agencies, departments, and offices to solicit information and expertise, including the MassHIway, the Massachusetts Executive Office of Aging & Independence, Massachusetts Commission for the Deaf and Hard of Hearing, Mass Commission for the Blind, MassAbility, the Massachusetts Department of Elementary and Secondary Education, the Massachusetts Division of Insurance, and the Massachusetts Department of Transitional Assistance.

In total, across all of our engagement platforms, we received over 200 specific inputs from various stakeholders which, along with data and recent needs assessments, informed the development of this proposal. Although we had broad engagement for this application, we know that our on-going engagement strategies will be important to ensure success and sustainability of the RHTP.

Ongoing Engagement Framework: We plan to take a multi-tiered approach for ongoing meaningful engagement to ensure regular input and feedback at the governance, Initiative, and program Activity levels. Our framework for meaningful engagement includes the following: investing the needed time, capacity, and resources to build trust with partners and rural communities; centering the perspectives of those most impacted by poor health outcomes and that have been systemically excluded by traditional government decision-making processes have systemically excluded; being transparent about what decisions partners can influence; and being willing to divert from original plans if partners recommend changes.

A Community Advisory Council, with multi-sectoral and rural resident representation, will be engaged by the RHTP Governance Team to provide feedback, as well as support decision making related to operational oversight of RHTP. Each of the RHTP Initiatives will be supported by Initiative Workgroups to provide oversight of Activities. These workgroups will include internal staff/contractors, external rural partners, and subject matter experts to provide input into the facilitation of program activities. Workgroup membership selection will ensure Initiative alignment, including representation that aligns with the outlined populations, organizations, and

geographies. Initiative Activity leads will be required to submit engagement plans, outlining the specific engagement, with whom, and how they will use this for continuous improvement of the Activity. We also plan to hold public information sessions and feedback forums, at least twice a year, to share information and solicit input on RHTP. Additionally, we plan to continue engagement with our existing rural advisory bodies, the Rural Policy Advisory Commission and the MA Rural Council on Health, providing updates and soliciting feedback at their regularly scheduled meetings.

Project Governance to Support Ongoing Engagement:

A Governance Team will be assembled to provide leadership, management, and oversight of the Massachusetts RHTP in coordination with the Initiative Workgroups, who will support direct administration of programs. The Governance Team will sit within EOHHS, and will have representatives from government leadership, MassHealth, DPH, the State Office of Rural Health, the Interagency Tribal Partnership Workgroup, EOHHS IT Office and other entities key to support implementation of the RHTP. As noted in our engagement framework, the Governance Team will work directly with the Community Advisory Council, who will inform RHTP implementation and share in decision making. The Community Advisory Council will meet at least bi-annually with the RHTP Governance Team for decision making.

Metrics and Evaluation Plan

Framework: We will conduct a mixed methods evaluation of the Rural Health Transformation Program (RHTP) using a cumulative and iterative process. The Evaluation Team will be based in the Department of Public Health, Office of Health Data Strategy and Innovations (OHDSI), and will work closely with program staff to ensure evaluation efforts support their work and drive continuous program quality improvement. This evaluation will progress through 3 stages: **Formative**, **Process**, and **Outcome**. These stages will not be discrete. Rather, each stage will build upon the prior stage(s): Process will build upon Formative, and Outcome will build upon

Process and Formative. Further, the evaluation may iterate through these three stages multiple times, reflecting programmatic needs. Finally, all three evaluation stages will sit within a fourth evaluation domain, **Community**, which will serve to center the evaluation on measuring community empowerment and program sustainability. The Formative stage will entail providing data support to programs to answer questions to inform program design and implementation. The Process evaluation will focus on program implementation metrics, including reach, program successes, and program challenges. The Outcome evaluation will assess select outcome measures. Finally, the Community evaluation will focus on partnerships, sustainability, and community strengths.

Data Sources: Massachusetts has numerous pre-existing, rich data sources with which to evaluate the RHTP. This includes clinical datasets, such as hospitalization, claims, electronic health record, and ambulance data; community-level datasets, such as small area estimates and survey data; and organizational data, including provider, training, certification, and employment data. Additionally, Massachusetts will supplement these resources with qualitative data to gain a more holistic understanding of program success, challenges, and implementation, collected through structured and unstructured interviews, observation, and survey free text fields.

Methods: Qualitative data collection will include several approaches and methods to ensure we capture perceptions, experiences, and behaviors of our target populations. For quantitative data, methods include difference-in-difference and time-series analyses for aggregate and community-level interventions, and machine learning and multivariable modeling for outcome evaluations, such as survival analysis, pooled logistic regression, and random forests. To strengthen inference that our programmatic efforts are having a causal impact, we will leverage robust adjustment methods, including propensity scores, inverse probability weighting, and marginalization/standardization.

Basic Timeline for Evaluation:

(1)	FY2026	Establish an interagency Evaluation Team, select evaluation metrics, and plan primary data collection.
(2)	FY2027	Finalize evaluation plan, finalize and initiate primary data collection, develop and implement algorithms for metrics, run reports, begin formative evaluation, begin process evaluation.
(3)	FY2028	Support continuous program quality improvement, complete formative evaluation, continue process evaluation, run reports, and disseminate findings.
(4)	FY2029	
(5)	FY2030	
(6)	FY2031	

Evaluation Questions & Corresponding Metrics Here are some overarching Evaluation questions for the interventions, along with the corresponding measures for each Initiative and Activity workstream.

Initiative I. Population Health Advancement					
Proposed Outcomes					
(1)	Decrease rates of emergency department use in rural communities for treatment of chronic conditions.				
(2)	Reduce costs of care for rural populations with complex needs.				
(3)	Increase rates of preventative care visits in the targeted rural communities.				
(4)	Increase connectivity of clinical providers, social services, and community support organizations.				
(5)	Increase use of community based allied health positions to support chronic disease management programs.				
(6)	Increase uptake of remote patient monitoring programs in rural areas.				
(7)	Increase clinical quality improvement in targeted healthcare organizations.				
(8)	Increase rural providers' participation in population health management practices and value-based payment models.				
Proposed Measures					
Proposed Measure 1: *Reduction in emergency department utilization per 100K* in targeted rural communities. All measures are age-adjusted. Baseline period: federal fiscal years 21-23.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(1a)	**Diabetes**: reduction of 10 per 100K population	1	106.55 per 100K	101.55 per 100K	96.55 per 100K
		2	194.98 per 100K	188.98 per 100K	184.98 per 100K
(1b)	**Hypertension**: reduction of 10 per 100K population	1	137.99 per 100K	132.99 per 100K	127.99 per 100K
		2	200.29 per 100K	195.29 per 100K	190.29 per 100K
(1c)	**COPD / Asthma**: reduction of 25 per 100K population	1	263.10 per 100K	253.10 per 100K	238.10 per 100K
		2	526.14 per 100K	516.14 per 100K	501.14 per 100K
Proposed Measure 2: *Increased rate of preventive visits per 1,000* in targeted rural communities. Baseline period: CY24. Potential data sources for this measure include MDPHnet and All Payer Claims Database.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(2)	Increase of 25 per 1K population	1	TBD	TBD	TBD
		2	TBD	TBD	TBD
Proposed Measure 3: *Improvements in diabetes control (NQF0059) and hypertension control (NQF0018)* in targeted healthcare organizations. Baseline period: CY24. We will identify and engage with clinical partners in rural communities to obtain measurements.					

	Target	Level	Baseline	Year 3	Year 5
(3a)	2% absolute increase NQF0059	1	TBD	TBD	TBD
		2	TBD	TBD	TBD
(3b)	2% absolute increase NQF0018	1	TBD	TBD	TBD
		2	TBD	TBD	TBD
Initiative II. Innovation in Rural Care Models					
Proposed Outcomes					
(1)	Increase access to and utilization of multi-disciplinary mobile care units.				
(2)	Increase access to and utilization of telehealth strategies to deliver patient care.				
(3)	Expand use of innovative models by rural providers and organizations.				
(4)	Increase utilization of school-based health-center programs among youth (ages < 18 years).				
(5)	Increase access to substance use disorder (SUD) and behavioral health services.				
Proposed Measures					
Proposed Measure 1: *Increase rate of utilization of multi-disciplinary mobile units per 1,000* in targeted rural communities. Baseline period: CY24.					
	Target	**Level**	**Baseline**	**Year3**	**Year5**
(1)	Increase in rate of utilization of 50 per 1K	1	0 per 1K	20 per 1K	50 per 1K
		2	0 per 1K	20 per 1K	50 per 1K
Proposed Measure 2: *Increased rate of utilization of telehealth per 1,000* in targeted rural communities. Baseline period: CY24. Potential data sources for this measure include MDPHnet and All Payer Claims Database					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(2)	Increase in rate of utilization of 50 per 1K	1	TBD	TBD	TBD
		2	TBD	TBD	TBD
Proposed Measure 3: *Increase in total number of rural expansion sites for innovative models* Baseline period: CY24.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(3)	Increase of 36 rural expansion sites	N/A	0	18	36
Proposed Measure 4: *Increase in rate of targeted healthcare organizations implementing innovative models utilizing behavioral health/SUD services per 1K.* Baseline period: CY24.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(4)	Increase of 50 orgs per 1K patients	N/A	0	15	50
Proposed Measure 5: I*ncrease in youth (<18) utilizing school-based health center programs per 1K* Baseline period: CY24. To obtain measurements, we will identify and engage with schools in targeted rural communities					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(5)	Increase of 25 per 1K youth	N/A	TBD	TBD	TBD
Initiative III. Training Healthcare for Retention, Innovation, and Excellence					

Proposed Outcomes					
(1)	Increase the number of healthcare professionals practicing at rural organizations.				
(2)	Increase retention of healthcare professionals serving rural patients.				
(3)	Reduce patients' wait times for primary care appointments.				
(4)	Increase number of youth and adults interested in pursuing rural health careers.				
(5)	Increase number of rural sited residency programs and field placements to meet certification requirements.				
Proposed Measures					
Proposed Measure 1: *Increased retention rates of existing healthcare professionals in targeted healthcare organizations*. Baseline period: CY24. To obtain measurements, we will identify and engage with healthcare providers in rural communities					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(1)	Increase retention rate by 15%	N/A	TBD	TBD	TBD
Proposed Measure 2: *Reduced attrition among new employees during first year of employment in targeted healthcare organizations*. Baseline period: CY24 To obtain measurements, we will identify and engage with healthcare providers in rural communities					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(2)	Decrease attrition rate by 15%	N/A	TBD	TBD	TBD
Proposed Measure 3: *Increase in total new employees hired in targeted healthcare organizations*. Baseline period: CY24. We will identify and engage with clinical partners in rural communities to obtain measurements					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(3)	180 new hires (10 per cluster)	N/A	TBD	TBD	TBD
Initiative IV. Healthy Rural Communities Initiative					
Proposed Outcomes					
(1)	Reduce rates of chronic disease in rural residents.				
(2)	Increase number of new community partnerships for increased coordination.				
(3)	Reduce risk factors for chronic disease.				
(4)	Increase rates of rural residents partaking in healthy behaviors.				
(5)	Increase social connectedness of organizations and residents.				
(6)	Improve health outcomes for targeted vulnerable populations.				
Proposed Measures					
Proposed Measure 1: *Reduction in rate per 100,000 population of ambulatory sensitive condition emergency department utilization in targeted rural communities.* All measures are age-adjusted. Baseline: federal fiscal year 2023.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(1)	Decrease of 20 per 100K	1	240.14 / 100K	230.14 / 100K	220.14 / 100K
		2	355.05 / 100K	345.05 / 100K	335.05 / 100K

Proposed Measure 2: *Reduction in rate per 100,000 population of emergency department encounters where the patient left against medical advice (proxy measure of not being seen in ED)*. All measures are age-adjusted. Baseline: federal fiscal year 2023.					
(2)	Decrease 20 per 100K	1	74.57 / 100K	64.57 / 100K	54.57 / 100K
		2	108.56 / 100K	98.56 / 100K	88.56 / 100K
Proposed Measure 3: *Reduction in percent reporting food insecurity in targeted rural communities*. Possible data sources for this measure include MDPHnet or the US Census Household Pulse Survey.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(3)	5% absolute reduction	N/A	TBD	TBD	TBD
Proposed Measure 4: *Increase in number of new community partnerships*					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(4)	36 partnership (2 per cluster)	N/A	0	18	36
Proposed Measure 5: *Reduced prevalence of smoking in targeted rural communities*. Baseline: CY24. Potential data sources for this measure include the Behavioral Risk Factor Surveillance System and MDPHnet.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(5)	2.5% absolute reduction smoking rate	N/A	TBD	TBD	TBD
Proposed Measure 6: *Increased community engagement (e.g., volunteering, participation in clubs) in targeted rural communities*. Baseline: CY24 Potential data sources for this measure include surveys and United States Census data.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(6)	10% absolute increase engagement	N/A	TBD	TBD	TBD
Initiative V. EMS Service Integration					
Proposed Outcomes					
(1)	Increase financial viability of ambulance agencies serving rural communities.				
(2)	Reduce costs of prehospital care to patients in rural communities.				
(3)	Reduce number of emergency transports by rural ambulance services for unnecessary emergency department utilization.				
(4)	Increase collaborative relationships between rural ambulance services and other community health partners.				
(5)	Reduce emergency department boarding and hold times for patients meeting throughput criteria.				
Proposed Measures					
Proposed Measure 1: *Reduced total out of pocket costs of prehospital care to patients in targeted rural communities*. Baseline period: CY23.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(1)	Decrease by $250 per ambulance run	N/A	$0	$125 average per run	$250 average per run
Proposed Measure 2: *Increase number of ambulance services reporting feeling "very" or "somewhat" confident in financial viability of serving rural communities.* Baseline period: CY25. We will likely obtain data for this measure through surveys of EMS networks.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(2)	Absolute increase of 10%	N/A	TBD	TBD	TBD

Proposed Measure 3: *Reduced rate per 100K EMS runs of acute care encounters for ambulatory sensitive conditions in targeted rural communities*. Baseline period: federal fiscal year 2023. We will use the Population Health Data warehouse [PHD], which includes linked ambulance and hospitalization data.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(3)	Reduce by TBD per 100K EMS runs	N/A	TBD	TBD	TBD
Proposed Measure 4: *Increase in total number of new collaborative relationships between rural ambulance services and other community healthcare partners*. Baseline period CY25. We will use the Population Health Data warehouse [PHD], which includes linked ambulance and hospitalization data.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(3)	Increase by 18 (1 per cluster)	N/A	0	9	18
Initiative VI. Enhancing Technology Interoperability and Connectivity					
Proposed Outcomes					
(1)	Increase participation and advanced use of rural healthcare providers in statewide HIE.				
(2)	Ensure rural participation of all hospitals and EMS agencies in statewide ACORN and CMED projects.				
(3)	Increase percentage rural providers meeting cybersecurity maturity benchmarks.				
(4)	Increase local service provision through new LPH EHR project.				
Proposed Measures					
Proposed Measure 1: *Rural Provider Connectivity: Increase the percentage of providers in targeted rural communities actively exchanging data*. Baseline period: CY25.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(1)	Absolute increase of at least 40%	N/A	<30%	=>45%	=>70%
Proposed Measure 2: *Achieve complete participation of acute care hospitals in targeted rural communities in the ACORN system.* Baseline period: CY25.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(2)	Absolute increase of 100%	N/A	0%	50%	100%
Proposed Measure 3: *Increase the percentage of providers in targeted rural communities meeting cybersecurity maturity benchmarks*. Baseline period: CY25.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(3)	Absolute increase of at least 40%	N/A	<40%	>55%	=>80%
Proposed Measure 4: *Increase in total EMS agencies in targeted rural communities with access to the statewide CMED and the protocol and dosing mobile app.* Baseline period: CY25					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(4)	Absolute increase of 100%	N/A	0%	50%	100%
Proposed Measure 5: *Percent of targeted healthcare organizations with connections to local public health departments EHR platforms.* Baseline period: CY25.					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(5)	Absolute increase of 100%	N/A	0%	35%	100%
Initiative VII. I. Facility Modernization & Re-use Initiative					
Proposed Outcomes					

(1)	Enhance safety and increase efficiency of rural healthcare facilities.				
(2)	Expand availability of diagnostic and specialty services on-site in rural communities.				
(3)	Position rural providers for future growth in new models of care.				
(4)	Increase local access to healthcare services for rural residents.				
(5)	Increase financial sustainability of rural facilities.				
Proposed Measures					
Proposed Measure 1:					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(1)	Rural facilities with safety & energy upgrades	N/A	30%	50%	85%
Proposed Measure 2:					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(2)	Rural sites offering new on-site diagnostics	N/A	15	25	40
Proposed Measure 3:					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(3)	Rural facilities equipped for telehealth	N/A	45%	70%	90%
Proposed Measure 4:					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(4)	Residents within 25 miles of upgraded facility	N/A	65%	80%	95%
Proposed Measure 5:					
	Target	**Level**	**Baseline**	**Year 3**	**Year 5**
(5)	Increased operating margin of participating facilities	N/A	-2%	+1%	+5%

Sustainability Plan

RHTP Initiatives and Activities were selected and designed with transformation and sustainability in mind, focusing on systems-level investments to create sustainable change and model pilots that can ultimately generate revenue or be reimbursable through insurance products. Below we outline the major sustainability strategies for each proposed Initiative.

Initiative I. Population Health Advancement: While RHTP funds will support the initial implementation of these efforts, we have built in coordination and technical assistance with partners to build out fiscal sustainability plans. These plans will explore items like braided financing across Medicaid managed care entities, hospital community benefit obligations, and state appropriations. Improved connectivity and updated infrastructure will allow for more advanced billing practices, healthier patient outcomes, and system efficiencies which all support cost savings and revenue generation in value-based payment models.

Initiative II. Rural Care Models: This Initiative will work with partnering state entities (MeHI, DPH, MassHealth, etc.) to strategically plan in Year 2 for sustaining each Activity's sites and capabilities, bringing in external funding resources as appropriate. We plan to use expert technical assistance to ensure business models for these Activities are sound and customized at the community level. Each region we work in has varying populations, payer mixes, and existing infrastructure that will require different strategies for sustainability. By beginning to plan early in the life of this grant there will be more opportunities for innovative and collaborative funding approaches, including exploring reimbursement pathways that may require policy changes.

Initiative III. THRIVE Workforce: These activities will incorporate lessons from previous workforce programs facilitated by the state and use national best practices to support sustainable programs. We will work with partners to ensure that project plans incorporate sustainability principles and strategies. Several of our workforce activities are supporting infrastructure investments for long term programs. Training programs will be sustainable beyond the funding period, as funding will support program design, curriculum supports, and partnership

development, enabling programs to rely on tuition in future years. Facility recruitment and retention plans will ensure facilities have the capacity and processes in place to sustain workforce members, including integrating recruited healthcare professionals into rural communities and provider organizations. Developing pathways for local community members as healthcare professionals will more generally support longer term employment as well as help build economic stability for rural communities. We will track successes, challenges, lessons learned, and the success of sustainability efforts to inform our work, as well as use quantitative and qualitative data from this Initiative to inform future program funding and expansion of successful programs.

Initiative IV. Healthy Rural Communities: This Initiative will ensure that sustainability planning is a key component of the strategic planning and Activities. This Initiative will strengthen networks, increase the flow of information, and reduce redundancies in service, as well as work to increase the billable/reimbursable services of network partners. The project will take advantage of existing sustainability assessment tools such as the Program Sustainability Assessment Tool (PSAT)[lxxvi] to support this process, and will also have support through the services of our proposed RHTP Evaluation Team. We will support CBOs and other grant partners as they do their initial assessments utilizing these sustainability tools. We will help CBOs and grant partners develop a sustainability plan of action by offering training, webinars, and individualized technical assistance. By implementing these tools and strategies we are confident communities will be able to sustain these activities beyond the life of the grant.

Initiative V. EMS Service Integration Initiative: Funding for these Activities is focused on supporting startup costs, piloting innovative reimbursement models, and providing technical support to ensure implemented projects have sustainable business models moving forward. These investments will help small EMS providers transform their operations and connect into local care delivery systems so they can expand service lines and take advantage of pre-existing reimbursement mechanisms. Additionally, the reimbursement pilot will help the state evaluate

this model and potentially take future policy or budget actions to ensure sustainability.

Initiative VI. Enhancing Technology Interoperability and Connectivity: This Initiative is designed to build durable digital health capacity that will persist after RHTP funding ends. It leverages existing Commonwealth programs and infrastructure including the Mass HIway, ACORN, and MeHI's cybersecurity and interoperability programs to sustain service delivery and technical assistance. Each Activity will transition to a shared-service and support model sustained by participating providers, health systems, and public health agencies. Training materials and implementation playbooks developed through the Initiative will embed FHIR[lxxvii] interoperability best practices into ongoing EOHHS HIT policy, procurement, and technical assistance frameworks, while rural providers will be connected to federal and state funding streams to maintain and expand their digital infrastructure. To ensure continued local capacity, the Commonwealth will establish a shared technical assistance network and pilot facility capacity-building subgrants to strengthen internal IT expertise at rural sites. Over time, this shared network will evolve into a public/private partnership that allows providers to access affordable, ongoing IT and cybersecurity support services beyond FY31. This sustainability approach ensures lasting policy integration, continued access to interoperability and cybersecurity services, and measurable long-term improvements in access, quality, and cost of care in rural Massachusetts.

Initiative VII. Facility Modernization and Re-Use: This Initiative will enable rural providers to address long-standing under-investment in their physical plants and correct issues that have been detrimental to their sustainability. Whether they are carrying the cost of unused space that will be revenue generating because of renovation, or they are able to offer a new service to increase their revenue, the Activities in this Initiative will be one-time grants and will enable future expansion of facilities' activities.

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[xxxi] https://www.mass.gov/doc/2020-15-scope-of-practice-pdf/download
[xxxii] We can actively support H.2426/ S.1587, an act authorizing licensed dental hygienists to administer nitrous oxide
[xxxiii] MassHealth All Provider Bulletin 374
[xxxiv] Transmittal Letter PHY-170
[xxxv] The state's DSH authority is the Massachusetts 1115 Demonstration, under which the state has a DSH-like Pool, within the state's Safety Net Care Pool.
[xxxvi] ToRCH | mydss.mo.gov
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[xxxviii] Estimation of the maximum potential cost saving from reducing serious adverse events in hospitalized patients
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