# Rural Health Transformation Grant Guide — Maryland

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**AUDIENCE:** State health agencies, Medicaid, rural providers, collaboratives

**AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.**

# 1. Executive Summary

Maryland can leverage the Rural Health Transformation (RHT) Program cooperative agreement to extend its nationally recognized all-payer/global budget infrastructure into rural primary, behavioral, and emergency care while modernizing cybersecurity and data exchange. The CMS RHT Program provides up to $50B nationally across FY26–FY30, with awards to states via cooperative agreements and a distribution that is half baseline (equal across approved states) and half points-based on rural/facility and technical factors; applications are due November 5, 2025. (cms.gov)

The Rural Health Transformation Collaborative (the Collaborative) provides a configurable portfolio of technology, clinical, analytics, and integration partners that can support Maryland's objectives under the NOFO—tele-specialty capacity (Avel eCare), remote monitoring and post-acute transitions (BioIntelliSense), consumer triage and multilingual intake (Humetrix), retail-based access and medication management (CVS Health, Walgreens, Walmart), AI decision support (Viz.ai, Pangaea Data), cybersecurity and cloud (Microsoft), and statewide program integration and measurement (Accenture, KPMG, PwC, AVIA). These offerings are documented in the Collaborative catalog and can be aligned to specific NOFO use-of-funds categories and technical scoring areas, subject to contracting and integration.

Maryland's policy and delivery-system context positions the state to credibly propose rural primary-care enhancement, EMS support, tele-behavioral expansion, and data infrastructure investments that complement the Maryland Total Cost of Care model and the state's participation in CMS's AHEAD Model starting January 2026. CRISP—the state-designated HIE and Health Data Utility—provides a statewide backbone for program measurement and multi-payer analytics. (cms.gov)

Cybersecurity is a foundational risk. Microsoft's Cybersecurity for Rural Hospitals program reported 550+ participating rural hospitals by March 2025, and the American Hospital Association (AHA) later noted participation above 700 by July 2025—offering discounted security products, assessments, and training that can be combined with the Collaborative's integration support for Maryland's rural facilities. (aha.org)

One-page printable summary

- CMS RHT Program: cooperative agreement to states; half of funds equally distributed; half allocated via points on rural/facility and technical factors; application due Nov 5, 2025; awards by Dec 31, 2025. (cms.gov)
- Maryland context highlights (latest available):
    - 2020 Census: 333,237 Marylanders lived in Census-defined rural areas (~5.4%). State policy defines 18 of 24 jurisdictions as rural (≈ quarter of residents). (richmondfed.org)
    - No Critical Access Hospitals (CAHs); historically Maryland's all-payer waiver; RHC presence is minimal. (ruralhealthinfo.org)
    - Drug overdose death rate 39.3 per 100,000 (2022). (cdc.gov)
    - BEAD broadband allocation ≈ $267.7M; NTIA approved Maryland's BEAD initial proposal in 2024; recent rural connections (e.g., Smith Island) illustrate last-mile challenges. (benton.org)
    - Maryland in CMS AHEAD Model Cohort 1; transition from TCOC to AHEAD performance in 2026. (cms.gov)
- Collaborative fit (illustrative):
    - Tele-ER/ICU/Behavioral via Avel eCare; home monitoring via BioIntelliSense; multilingual triage and consumer apps via Humetrix; pharmacy-enabled chronic care via Walgreens/CVS/Walmart; analytics via Pangaea Data; program integration and evaluation via Accenture/KPMG/PwC/AVIA; cybersecurity via Microsoft.
- Quick compliance notes: single state applicant; Governor's endorsement letter; project narrative with needs, plan, initiatives, metrics, sustainability; Grants.gov submission. (cms.gov)

Assumptions and Open Questions

- The CMS Grants.gov posting (CMS-RHT-26-001) is active, but the NOFO PDF was not retrievable through Grants.gov in this environment; citations herein use CMS's RHT Program overview and FAQs. Before submission, replace high-level references with precise NOFO section/page citations (e.g., scoring tables, funding caps). (cms.gov)
- Maryland-specific Medicaid enrollment details and DSH hospital counts for the most recent state program year should be confirmed with MDH/HSCRC for the application attachments.

# 2. Eligibility and RFP Fit

## 2.1 Program overview and dates

- Eligible applicant: one of the 50 States (DC/territories ineligible). Cooperative agreement award; awards by Dec 31, 2025. Submission via Grants.gov by Nov 5, 2025; CMS hosted applicant webinars in late September 2025. (cms.gov)
- Distribution: half baseline (equal across approved states); half points-based (rural population/facility and other technical factors specified in NOFO). (cms.gov)
- Application content: needs assessment, transformation plan with targets, initiatives and outcomes, implementation timeline, stakeholder engagement, metrics/evaluation, sustainability; Governor's endorsement letter required. (cms.gov)

### 2.2 Compliance checkpoints (non-exhaustive)

- Single official application per State; last on-time submission counts. Maintain SAM.gov/UEI; Grants.gov submission. Optional LOI is recommended but not required. (cms.gov)
- Cooperative agreement implies substantial CMS involvement and reporting; annual continuation and performance reporting. (cms.gov)

### 2.3 Requirement-to-Collaborative capability mapping (examples)

| NOFO requirement (high level) | Collaborative capability | Evidence |
|---|---|---|
| Extend rural access via technology-enabled services (tele, remote monitoring) | Avel eCare tele-ER/ICU/hospitalist; BioIntelliSense BioButton continuous monitoring; consumer triage/intake (Humetrix). | Collaborative catalog; news.microsoft.com |
| Consumer-facing chronic disease tools | Retail partner screening and management programs; multilingual mobile tools and RPM enrollment workflows. | Collaborative catalog; marchofdimes.org |
| EMS and emergency readiness support | Avel eCare 24/7 specialty support; integration with statewide EMS modernization and EDAS alerts. | 2025mdmanual.msa.maryland.gov; conduitstreet.mdcounties.org |
| Data exchange/interoperability and HIE integration | CRISP HDU integration; eClinicalWorks registered HIE; analytics via Pangaea Data; SI support. | crisphealth.org; mhcc.maryland.gov |
| Cybersecurity and IT resilience | Microsoft rural hospital cybersecurity program (discounts, assessments, training) with Collaborative implementation. | news.microsoft.com; aha.org |
| Workforce training and burnout reduction | Ambient clinical documentation, tele-mentoring, pharmacist workforce models, CHW enablement. | Collaborative catalog |
| Program management, measurement, economic modeling | PMO and economic modeling from Accenture/KPMG/PwC/AVIA; dashboards and KPI tracking. | Collaborative catalog |

## 3. Maryland Context Snapshot

### 3.1 Population and rural designation

- Census-defined rural population: 333,237 (2020), ~5.4% of Marylanders. (richmondfed.org)
- State definition: 18 of 24 jurisdictions designated rural; State Office of Rural Health notes approximately one-quarter of residents live in rural jurisdictions. (health.maryland.gov)

### 3.2 Facility mix

- CAHs: none (Maryland among five states without CAHs). (ruralhealthinfo.org)
- Rural Health Clinics: historically very limited; HRSA listed one RHC in Maryland in COVID-testing allocation (contextual indicator). (hrsa.gov)
- HIE/HDU: CRISP is the state-designated HIE and Health Data Utility; MHCC lists registered HIE entities (including eClinicalWorks and CRISP). (crisphealth.org)

- EMS: MIEMSS oversees a coordinated statewide EMS network; EDAS modernization underway. (2025mdmanual.msa.maryland.gov)

### 3.3 Health and access indicators

- Drug overdose death rate: 39.3 per 100,000 (2022). (cdc.gov)
- Maternal and infant health: Preterm birth 10.2% (2023); infant mortality 6.0 per 1,000 (2022). (marchofdimes.org)
- Broadband: BEAD allocation ≈ $267.74M; NTIA approved Maryland's BEAD initial proposal (2024); recent rural connectivity progress (Smith Island). (benton.org)

### 3.4 Medicaid and payment landscape

- HealthChoice (Maryland's Medicaid MCO program) operates statewide under an 1115 demonstration; TCOC model transitioning to AHEAD in 2026, aligning multi-payer cost and quality targets. (health.maryland.gov)

### 3.5 Licensure compacts and workforce policy

- Maryland participates in the Nurse Licensure Compact; Interstate Medical Licensure Compact processes active; ASLP-IC enacted; PSYPACT enacted. (health.maryland.gov)

### 3.6 Context-to-capability table (selected)

| Metric (year) | Value | Source | Relevant Collaborative capability |
|---|---|---|---|
| Census-rural residents (2020) | 333,237 (~5.4%) | (richmondfed.org) | Demand forecasting and rural service-line modeling; telehealth reach planning. |
| Drug overdose death rate (2022) | 39.3/100k | (cdc.gov) | Tele-behavioral access; risk analytics; opioid-safety consumer tools. |
| Preterm birth (2023) | 10.2% | (marchofdimes.org) | Maternal RPM, remote consults, community screening in retail/CHC settings. |
| CAHs (2025) | 0 | (ruralhealthinfo.org) | Prioritize tele-specialty and EMS support to maintain local access. |
| BEAD allocation | $267.7M | (benton.org) | Clinic connectivity; device security; patient-facing digital tools. |
| HIE/HDU | CRISP (state-designated) | (crisphealth.org) | Data ingestion, alerts, and dashboards for RHT metrics. |

## 4. Strategy Aligned to RFP

### 4.1 Concept

A Maryland Rural High-Value Network (HVN) model can connect independent rural hospitals, FQHCs/RHCs, EMS, and retail pharmacies, supported by CRISP and Collaborative partners. Objectives: improve access (tele-ER/ICU/behavioral), chronic care at home (RPM), maternal/infant health, EMS stabilization, and cybersecurity hardening, with AHEAD-consistent primary care investment and multi-payer alignment. ; (cms.gov)

### 4.2 Alignment to RHT pillars and technical factors (illustrative)

- Prevention/chronic disease: retail/community screening; RPM; multilingual apps; AI gap-closure.
- EMS and emergency: 24/7 tele-ER/ICU; state EMS data links (EDAS). ; (conduitstreet.mdcounties.org)
- Workforce: ambient documentation; tele-mentoring; pharmacy workforce development.
- Payment innovation: actuarial/economic modeling for rural shared savings/global budgets (consistent with AHEAD/TCOC). ;

(cms.gov)

- Tech modernization & cybersecurity: Azure-based security patterns; Microsoft/AHA rural program; HIE integration. (news.microsoft.com); (crisphealth.org)

### 4.3 Equity and Tribal considerations

Focus counties with high overdose and maternal risk; multilingual intake and outreach; mobile and retail access in under-served towns; CRISP HDU for population analytics and closed-loop referrals. ; (crisphealth.org)

### 4.4 Data use and privacy

Use CRISP HDU as system of engagement for alerts, care-team notifications, non-controlled medication data where permitted, and reporting while aligning with MHCC HIE rules and information-blocking protections. (mhcc.maryland.gov)

## 5. Program Design Options (Maryland-tuned)

Option A. Rural Acute Stabilization and Tele-Specialty Grid (primary)

- Target: CAH-absent geographies and frontier-like pockets (e.g., Garrett/Allegany, Lower Shore). Problem: distance to specialty care; ED boarding; EMS strain. Evidence: statewide EMS leads; no CAHs; overdose and maternal risks. (2025mdmanual.msa.maryland.gov)
- Services: Avel eCare tele-ER/ICU/hospitalist; tele-behavioral; EMS medical command support; EDAS data exchange; Viz.ai for stroke/LVO alerts.
- Payment logic: hospital global budgets (HSCRC) augmented with tele-consult carved-outs and value credits; alignment with AHEAD hospital stability tools. (cms.gov)
- Partners/IT: CRISP alerts; hospital EHRs; secure cloud; cybersecurity onboarding. (crisphealth.org)
- Pros/risks: rapid access improvement; requires credentialing, call schedules, broadband. Risk mitigations: compact licensure, EMS integration, BEAD coordination. (mbp.state.md.us)

Option B. Home-Based Chronic & Maternal Care with Retail On-Ramps

- Target: uncontrolled hypertension/diabetes; perinatal risk; rural medication access. (marchofdimes.org)
- Services: BioIntelliSense RPM; retail BP/retinopathy screening; pharmacist-led adherence/MTM; multilingual symptom triage and Blue Button-based consumer tools.
- Payment logic: care-management PMPMs; shared savings under AHEAD/TCOC; Medicaid SPA for RPM/telepharmacy (subject to State policy). (cms.gov)
- Pros/risks: reduces ED/admits; depends on device logistics and data integration. Mitigation: CRISP device data feeds; retail logistics. (crisphealth.org)

Option C. Rural Behavioral Health Access and Recovery

- Target: overdose and SMI/SUD access gaps. (cdc.gov)
- Services: tele-psychiatry; crisis support; opioid risk notifications to patients/providers; EMS co-response.
- Payment logic: Medicaid behavioral integration incentives; regional shared savings on avoidable utilization (AHEAD alignment). (cms.gov)

Option D. Rural Data & Cyber Modernization (cross-cutting)

- Target: fragmented data and cyber risk. Approach: CRISP HDU reporting suite, multi-payer dashboards, cyber assessments/training, identity/MFA rollout. (crisphealth.org)

## 6. Governance and Collaborative Roles

### 6.1 Structure (conceptual)

- State lead agency (Governor-designated) sets strategy, approves initiatives/budget, and interfaces with CMS.
- PMO (State+Collaborative integrator) coordinates procurement, milestones, reporting, and evaluation support.
- Regional HVN(s) convened by Cibolo Health to steer investments and hold providers jointly accountable, subject to State oversight.

- Data governance through CRISP HDU; compliance overseen with MHCC/MHBE/MDH.

### 6.2 RACI (abbrev.)

| Function | State (Lead) | Medicaid (MDH) | CRISP | Hospital Assoc./HVN | Collaborative partners |
|---|---|---|---|---|---|
| Strategy, CMS interface | R | C | C | C | C |
| Procurement & PMO | R | C | C | C | A (SI/Advisors) |
| Data strategy & reporting | A/R | C | A/R | C | C |
| Clinical program ops (tele/RPM) | C | C | C | R/A (HVN) | A (Avel, BioIntelliSense, retail) |
| Cybersecurity program | C | C | C | C | A (Microsoft) |

A=Accountable; R=Responsible; C=Consulted. Evidence of roles and offerings in Collaborative catalog.

## 7. Payment and Funding

### 7.1 Paths consistent with CMS programs

- Align with AHEAD: hospital stability/global budgets and primary-care investment; geographic ACO constructs where applicable. (cms.gov)
- Within RHT allowable uses: provider payments for items/services (gap-filling), tech-enabled care, workforce, IT/cyber, behavioral health, innovative models (value-based). (cms.gov)

### 7.2 Illustrative cost/deliverable table (planning placeholder; subject to procurement)

| Cost category | ROM (annual) | Potential funding | Timing | Collaborative deliverables |
|---|---|---|---|---|
| Tele-ER/ICU coverage (8–10 sites) | $18–25M | RHT, hospital global budgets | Yr1–5 | Avel eCare staffing, credentialing, analytics. |
| RPM (2,500 pts/yr) | $4–7M | RHT, Medicaid PMPMs | Yr1–5 | BioIntelliSense devices, dashboards, training. |
| Behavioral tele-psychiatry network | $6–9M | RHT, Medicaid | Yr1–5 | Tele-BH panels, protocols, outcome tracking. |
| Cybersecurity uplift (20 facilities) | $3–6M | RHT, Microsoft program discounts | Yr1–3 | Assessments, MFA, hardening, training. (aha.org) |
| Data/HIE integration & dashboards | $5–8M | RHT, AHEAD TA | Yr1–3 | CRISP/analytics connectors, KPI dashboards. (crisphealth.org) |

## 8. Data, Measurement, and Evaluation

- Measures: access (tele-response time, ED transfer rates), quality (readmissions, BP/HbA1c control, perinatal metrics), behavioral (follow-up after ED for SUD), financial (total cost per beneficiary), workforce (vacancy/turnover, documentation time), program (adoption, interoperability).
- Data sources: CRISP clinical/ADTs; Medicaid/All-payer claims; EMS (MIEMSS/EDAS); pharmacy/retail feeds; device data. (crisphealth.org)
- Evaluation: independent analytics with SI support and HVN benchmarking; alignment with CMS cooperative reporting.

# 9. Implementation Plan

## 9.1 12–24 month Gantt (illustrative; dates in CY2026–2027)

| Workstream | Start | End | Owner | Outputs |
|---|---|---|---|---|
| PMO setup, governance charter | Jan 2026 | Mar 2026 | State+SI | Charter, risk/issue logs, reporting cadence. |
| CRISP data integration & dashboards | Feb 2026 | Sep 2026 | CRISP | KPI dashboards; facility scorecards. (crisphealth.org) |
| Tele-ER/ICU stand-up (wave 1) | Mar 2026 | Oct 2026 | HVN+Avel | Live coverage; transfer reduction baseline. |
| RPM cohort launch (chronic/maternal) | Apr 2026 | Dec 2026 | BioIntelliSense | Enrolled patients; alert protocols. |
| Behavioral tele-psychiatry | May 2026 | Jan 2027 | HVN+Teladoc/partners | 24/7 coverage; follow-up workflows. |
| Cybersecurity assessments & MFA | Feb 2026 | Nov 2026 | Microsoft+sites | Risk reports; MFA penetration >90%. (news.microsoft.com) |
| EMS-EDAS interfaces & protocols | Mar 2026 | Aug 2026 | MIEMSS+CRISP | Incident routing; EMS KPIs. (conduitstreet.mdcounties.org) |
| Evaluation baseline & targets | Jan 2026 | May 2026 | State+SI | Logic model; target trajectories. |

## 9.2 Gating decisions

- Site readiness/credentialing complete; data-sharing agreements with CRISP; cyber minimums (MFA, backups) met before go-live. (crisphealth.org)

## 9.3 Procurement/legal enablers (dependencies)

- Interagency data-use agreements with CRISP; master services agreements for telemedicine, RPM, and cyber; licensure compact utilization; Medicaid coverage/SPA updates if applicable. (crisphealth.org)

# 10. Risk Register (selected)

| Risk | Impact | Likelihood | Mitigation | Owner |
|---|---|---|---|---|
| Broadband gaps delay tele-services | High | Medium | Coordinate with BEAD projects; prioritize sites with adequate backhaul first. (ntia.gov) | State Broadband+PMO |
| Cyber incident disrupts operations | High | Medium | Microsoft assessments; MFA; patching; incident playbooks; backups. (news.microsoft.com) | Sites+Microsoft |
| Provider credentialing delays | Medium | Medium | Use compacts (eNLC, IMLC); standardized tele-privileging. (health.maryland.gov) | Hospitals |
| Data-sharing hesitancy | Medium | Medium | CRISP governance; MHCC HIE rules; consent tools. (mhcc.maryland.gov) | CRISP+MHCC |
| RPM adherence attrition | Medium | Medium | Navigator outreach; device logistics; retail pick-up options. | HVN+Vendors |

| Risk | Impact | Likelihood | Mitigation | Owner |
|---|---|---|---|---|
| EMS integration complexity | Medium | Medium | Joint protocols and EDAS dashboards. (conduitstreet.mdcounties.org) | MIEMSS+Hospitals |
| Budget caps and allowability | Medium | Low | Align budget lines to NOFO uses; segregate admin; pre-clear with CMS. (cms.gov) | State+PMO |
| Retail scope-of-practice limits | Medium | Medium | Use pharmacist protocols allowed by law; refer as needed; pursue policy options. | State+Boards |
| AHEAD/TCOC alignment risk | Medium | Low | HSCRC/MDPCP coordination; multi-payer steering. (cms.gov) | HSCRC+MDH |
| Workforce burnout persists | High | Medium | Ambient documentation; tele-mentoring; phased deployment. | Sites+PMO |

# 11. Draft RFP Response Language (insert-ready)

## 11.1 Project summary (abstract)

Maryland proposes to advance a Rural High-Value Network model that connects rural hospitals, clinics, EMS, and retail access points through tele-specialty coverage, remote monitoring, multilingual consumer tools, and cybersecurity modernization. The program integrates with CRISP and aligns with the AHEAD Model to improve access, outcomes, and sustainability for rural residents. The State will coordinate implementation via a PMO and evaluate results using standardized measures and dashboards. (crisphealth.org)

## 11.2 Rural health needs & target population (excerpt)

Census-defined rural residents totaled 333,237 in 2020 (~5.4%). Rural jurisdictions (18 of 24) account for approximately a quarter of residents by state designation. Elevated overdose mortality (39.3/100,000 in 2022) and perinatal risks (preterm birth 10.2% in 2023) underscore the need for tele-behavioral, chronic, and maternal initiatives. Maryland lacks CAHs, increasing the importance of tele-enabled stabilization. (richmondfed.org)

## 11.3 Rural Health Transformation plan: goals & strategies (excerpt)

We will (a) extend 24/7 tele-specialty access to select rural EDs; (b) deploy remote physiologic monitoring for chronic and maternal cohorts; (c) expand tele-behavioral/care coordination; (d) modernize cyber defenses; and (e) establish CRISP-based dashboards for outcomes and spend. Strategies leverage partners documented in the Collaborative catalog and will be phased by readiness and broadband availability. ; (ntia.gov)

## 11.4 Proposed initiatives & use of funds (abbrev.)

- Tele-ER/ICU and stroke AI notifications; outcomes include transfer rate reduction and timeliness of definitive care.
- Chronic and maternal RPM; outcomes include BP/HbA1c/control, postpartum follow-up, and readmission reductions.
- Behavioral health access (tele-psychiatry, crisis support); outcomes include follow-up after ED and MOUD engagement.
- Data and cyber modernization; outcomes include MFA adoption, vulnerability reduction, and reporting timeliness. (news.microsoft.com)

## 11.5 Implementation timeline & governance (excerpt)

Year 1 emphasis on PMO, site selection, credentialing, cyber baselines, and wave-1 tele/RPM deployments; Year 2 expansion and optimization; governance via State-led PMO, HVN councils, and CRISP data governance. ; (crisphealth.org)

## 11.6 Metrics & evaluation (excerpt)

We will report quarterly on access, quality, financial, workforce, technology, and program metrics using CRISP and partner data; we will cooperate with CMS and third-party evaluators per the cooperative agreement. (cms.gov)

## 12. References


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## 13. AI Generation Notice

This guide was generated by the gpt-5 model on 2025-10-14. The content is AI-generated and may contain errors or omissions. All facts, figures, and citations—especially references to CMS-RHT-26-001 NOFO sections, funding limits, scoring tables, and Maryland administrative data—must be independently validated against official sources before use in planning or submission.