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Massachusetts Rural Health Transformation Program – Application Package

Funding Opportunity Number: CMS-RHT-26-001

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A. Project Summary (Executive Summary)

Applicant: Commonwealth of Massachusetts (Governor’s Office, in coordination with Executive Office of Health and Human Services). Subrecipient partners include the Massachusetts Department of Public Health (Office of Rural Health), MassHealth (State Medicaid Agency), and a consortium of rural hospitals, community health centers, and technology partners.

Project Goal: Transform rural health care delivery across Massachusetts to improve access, outcomes, and sustainability for the ~680,000 residents living in rural and small-town communities (roughly 10% of the state’s population)[1]. The program will invest in

innovative, evidence-based initiatives to address critical rural health challenges – from provider shortages and hospital financial distress to chronic disease burden and behavioral health needs – while strengthening local healthcare infrastructure and workforce. By 2031, Massachusetts aims to **"Make Rural Massachusetts Healthy Again"** by ensuring every rural resident can access high-quality care as close to home as possible.

Funding Request: $500 million over FY2026–FY2030 (base allocation of $100M per year for five years, as authorized under the $50B Rural Health Transformation Program[2][3]). This budget will be allocated across multiple initiatives (described below) in at least three of the statutorily approved use-of-funds categories[4]. Massachusetts will also pursue competitive funding (up to an additional ~$500M) by meeting or exceeding CMS's technical scoring criteria, potentially bringing the total award to $1 billion[5]. All funds will be used for permissible activities and **not** for any prohibited expenditures (e.g. no supplanting of Medicaid/Medicare payments). Administrative costs are capped at <10% of the award in compliance with federal requirements[6].

Summary of Proposed Use of Funds: Massachusetts will implement a **portfolio of six initiatives** targeting rural health priorities: (1) *Telehealth and Specialty Care Access* – expanding telemedicine and virtual specialty consults in underserved rural areas; (2) *Rural Hospital Stabilization and Transformation* – investing in facility upgrades, new service delivery models, and value-based payment reforms to keep essential hospitals open; (3) *Behavioral Health and Substance Use Outreach* – increasing access to mental health and opioid use disorder treatment in rural communities; (4) *Workforce Development and Training* – recruiting and training clinicians to practice in rural areas (with incentive programs and expanded scopes of practice); (5) *Health IT and Data Integration* – building rural health data exchange, analytics, and remote monitoring capabilities; and (6) *Community EMS and Mobile Health* – strengthening emergency medical services and deploying mobile clinics. These initiatives align with CMS's five strategic goals of Sustainable Access, Workforce Development, Innovative Care, Technology Innovation, and making rural communities healthier[7]. Each initiative's design is evidence-based and **leverages "shovel-ready" solutions** from public-private partners to ensure rapid deployment[8]. The attached **Portfolio Summary Table** (Table 1) provides a high-level overview of all initiatives, and the **Crosswalk to Scoring Table** (Table 2) maps each initiative to the authorized use-of-funds categories A–K[9][10], relevant technical scoring factors, outcome metrics, and any required state policy actions.

Outcomes: By the end of the funding period (FY2031), Massachusetts expects measurable improvements in rural health: increased access points (e.g. more primary care visits and telehealth utilization), improved health outcomes (e.g. lower uncontrolled diabetes rates, reduced hospital readmissions), a larger and more distributed rural workforce, modernized facilities, and financially stronger rural providers. Key performance objectives include, for example, **a 20% reduction in avoidable rural ER visits**, **a 15% improvement in chronic disease control rates**, and **an X% increase in the rural primary care provider-to-population ratio** (specific targets will be set per initiative). Robust monitoring and an independent evaluation (in collaboration with a Massachusetts academic institution) will

track these metrics annually. Massachusetts is committed to sustaining successful programs beyond the grant period, by integrating them into state policy and financing (see Sustainability Plan).

Public Benefit: This transformational investment will ensure that the Commonwealth's rural residents – from the Berkshires to Cape Cod's island communities – enjoy equitable health care access and outcomes. It aligns with the intent of Congress's One Big Beautiful Bill Act in establishing the Rural Health Transformation Program: to **"support rural communities across America in improving healthcare access, quality, and outcomes"**[11]. Massachusetts's application represents a comprehensive, stakeholder-driven plan to fulfill that mandate, tailoring federal support to the unique needs of our rural towns while serving as a model for sustainable rural health innovation.

Note: This Project Summary contains no proprietary information and may be shared publicly[12].

B. Project Narrative (Max 60 pages, double-spaced)

B1. Rural Health Needs and Target Population

Rural Landscape in Massachusetts: Although Massachusetts is often perceived as an urban state, a majority of its municipalities are classified as rural. **Over 52% of the state's land area – including 56% of cities and towns – is considered rural**, encompassing diverse regions from the mountains of the Berkshires to the Cape Cod islands[1]. Under Massachusetts's definition (communities with <500 people per square mile[13]), approximately **680,000 residents** live in rural areas, about 9–10% of the state's population[1]. (By traditional federal "non-metro" county definitions, the rural population is smaller – around 106,000 or 1.5%[14][15] – reflecting the fact that even rural towns in Massachusetts often lie within metro-county boundaries. For the purposes of this program, Massachusetts will use a granular, intra-county definition to ensure all high-need rural communities are included.) The rural population skews older (median age in many rural counties is mid-40s) and faces socioeconomic challenges. Key demographics include lower population density (dozens per square mile vs. >800 statewide), an aging cohort with a higher proportion of seniors, and pockets of poverty amid otherwise moderate incomes. Rural areas of the Commonwealth tend to be less racially diverse than urban centers (with predominantly White non-Hispanic populations, though some rural towns host immigrant farmworker communities and two federally recognized Tribal communities). Educational attainment is slightly lower in rural regions, and many young adults leave for urban areas, contributing to workforce shortages[16][17].

Health Outcomes: Rural Massachusetts residents experience disparities in certain health outcomes compared to their urban counterparts. Chronic illnesses are prevalent – rates of hypertension, diabetes, and obesity are higher in many rural counties, partly due to older age profiles and barriers to preventive care. For example, in Western MA's rural

communities, the prevalence of diabetes and cardiovascular disease exceeds state averages (public health data shows some rural counties have diabetes rates ~10% higher than Boston). Maternal and child health outcomes also lag: rural areas report higher maternal morbidity and infant mortality relative to state benchmarks, though absolute numbers are small. The ongoing opioid overdose crisis has hit rural Massachusetts hard – communities in Franklin and Barnstable counties have among the highest per-capita opioid overdose death rates in the state. Mental health outcomes are concerning as well, with higher suicide rates in rural regions. These disparities underscore the need for targeted interventions in chronic disease management, preventive care, maternal health, and behavioral health[18][19].

Healthcare Access and Infrastructure: Access to care is a fundamental challenge. Rural residents often must travel long distances for hospital or specialist services. The *average distance to the nearest acute-care hospital* can exceed 30–50 miles in parts of Western Massachusetts and Cape Cod islands, and **ambulance transport times** are significantly longer than in urban Boston. Primary care and dental services are limited in many small towns; approximately one-third of rural towns are federally designated Health Professional Shortage Areas. Public transportation options are sparse to nonexistent, leaving many without reliable means to reach care[20][21]. **Healthcare facility distribution:** Massachusetts currently has **4 Critical Access Hospitals (CAHs)** and a handful of small rural community hospitals serving these areas[22]. Examples include Fairview Hospital (25-bed CAH in Great Barrington) and Martha's Vineyard Hospital. Several rural hospitals have struggled financially; notably, North Adams Regional Hospital closed in 2014, illustrating rural financial vulnerability. (It later reopened as a satellite emergency facility). In total, there are **7 Rural Health Clinics (RHCs)** and **15 Federally Qualified Health Center** sites in rural Massachusetts providing primary care and behavioral health services[23]. Many of these clinics operate on thin margins and have limited capacity. Specialty care (e.g. cardiology, psychiatry) is largely absent locally, forcing referrals to urban centers. Pharmacies are also fewer; some communities lost their only pharmacy, complicating medication access. **Workforce shortages:** Rural provider shortages are acute – some towns have no practicing physicians. Statewide, the *ratio of primary care providers to population* in rural areas is far below urban ratios (e.g. ~0.5 per 1,000 in certain rural counties vs. ~0.9 in metro areas). Recruitment and retention of clinicians in remote areas is difficult due to isolation, lower salaries, and lack of professional support. These gaps in healthcare infrastructure contribute directly to poorer outcomes and patient experiences.

Rural Facility Financial Health: Rural hospitals and clinics in Massachusetts face financial distress. Low patient volumes, high fixed costs, and unfavorable payer mix (higher Medicare and uninsured rates) result in operating margins that are often negative. In the past decade, Massachusetts saw at least one rural hospital closure (North Adams) and several service cuts (e.g. birthing unit closures at critical access hospitals). Rural hospitals rely on Medicare Dependent Hospital or low-volume adjustments and modest state subsidies, but many remain at risk. Utilization data show declining inpatient volumes – many rural residents bypass local facilities for perceived higher-quality urban hospitals

("patient bypass"). This exacerbates financial woes[24][25]. Additionally, some facilities are physically aging and need capital improvements (e.g. 1950s-era buildings in need of renovation to meet modern standards). Without intervention, more rural facilities could reduce services or close, which would be devastating for local access.

Target Populations and Geographic Areas: Massachusetts will target **all rural residents and communities statewide** with an emphasis on high-need populations and regions. Specifically, the program prioritizes: **(a)** Residents of the *~20 highest-need rural counties and towns*, identified via a composite of health metrics (e.g. highest chronic disease rates, opioid mortality, and provider shortages). For example, Franklin County (northwest MA) and parts of Worcester County have substantial need. **(b)** Populations experiencing health inequities within rural areas, such as Tribal communities (e.g. members of the Wampanoag Tribe on Martha's Vineyard), older adults living alone, low-income farming communities, and immigrant or non-English speaking pockets (like Brazilian immigrant communities in rural southeastern MA). **(c)** All rural healthcare providers and facilities (hospitals, RHCs, FQHCs, EMS agencies) that serve these communities. In practice, the geographic focus will span western Massachusetts (Berkshire, Franklin, western Hampden and Hampshire counties), parts of central MA, and selected towns in Plymouth, Barnstable, Dukes/Nantucket (Cape and Islands). *Example target statement:* "Rural residents in 20 high-need towns across Franklin, Worcester, and Barnstable counties, including significant older adult and Tribal populations"[26]. A full list of impacted counties by initiative is provided in each initiative description (with FIPS codes for reference). Notably, **all 4 CAHs and 7 RHCs in Massachusetts are within the scope** of this plan.

Summary – Case for Change: Rural Massachusetts faces a convergence of challenges: *access gaps* (long travel times, provider shortages), *quality issues* (worse chronic disease outcomes, limited specialty care, high avoidable ER use), and *unsustainable financing* (hospitals on the brink). These issues persist despite Massachusetts's generally strong healthcare system, because past reforms often bypassed rural needs. **There is a clear need and opportunity for transformation.** This application establishes the context and urgency: our rural communities are **economically distressed, underserved in healthcare, and in need of innovative solutions to thrive**[16][17]. The RHT Program funding will enable Massachusetts to address root causes – like lack of preventive care infrastructure and workforce shortages – and create lasting improvements in rural health. In short, our rural residents deserve the same access and outcomes as those in Boston, and this plan will help bridge that gap.

B2. Rural Health Transformation Plan: Goals and Strategies

Vision: Massachusetts envisions a future where **every rural resident has sustainable access to high-quality, preventive and specialty healthcare within their community**. The Rural Health Transformation Plan will reimagine service delivery through innovation and collaboration, ensuring that rural healthcare is **modernized, financially viable, and integrated** into the broader health system. Our plan is built around the five strategic objectives mandated by statute[27] and CMS's priorities: improving access, improving

outcomes, leveraging technology, fostering partnerships, enhancing workforce, and data-driven solutions for rural care. We articulate below our goals and strategies for each element, as required by 42 U.S.C. 1397ee(h)(2)(A)(i)[28]:

- **Improving Access to Care:** Massachusetts will undertake specific actions to expand rural residents' access to hospitals, primary care, specialty care, behavioral health, and other essential services[29]. **Key strategies include:** establishing telehealth specialty consultation programs linking rural primary care sites with urban specialists (e.g. tele-cardiology and tele-mental health programs in all 4 CAHs)[30], investing in mobile clinics to bring preventive services (vaccinations, screenings) to remote villages, and *keeping critical emergency departments open* through financial stabilization and new delivery models. For instance, we plan to designate at least one struggling rural hospital as a pilot **Rural Emergency Hospital (REH)** with 24/7 ED and primary care hub services to ensure no community loses emergency access. We will also expand **maternal health services** in rural areas by funding a traveling OB/GYN team and remote prenatal monitoring, so that pregnant women in distant towns receive adequate care[30]. Another example is re-establishing **basic surgical services** one day per week at a CAH via visiting surgeons, so residents need not travel for routine procedures. By broadening service availability through such innovations, we will close access gaps for rural populations that currently must travel an hour or more for specialty or even primary care.

- **Improving Health Outcomes:** Our plan targets measurable improvements in key health outcomes for rural residents[31]. We have identified priority outcomes: reducing risk factors and mortality for chronic diseases (like diabetes, hypertension, heart disease), improving maternal and child health metrics, and reducing overdose deaths. **Strategies to achieve these outcomes include:** implementing community-based chronic disease management programs (e.g. chronic care management for diabetes through rural health clinics, including remote patient monitoring devices for glucose and blood pressure)[32], expanding care coordination and patient navigation via community health workers in rural areas (for example, training local community health workers to do home visits and follow-ups for patients with uncontrolled chronic conditions)[33], and launching healthy lifestyle initiatives (nutrition, exercise programs) in partnership with local organizations. *Examples:* A "Rural Healthy Hearts" program will use evidence-based interventions to improve hypertension control, aiming to reduce related mortality risk[31]. For diabetes, we will deploy remote monitoring patches and telehealth coaching (in partnership with tech firms) to achieve better A1c control. For behavioral health, we plan to integrate **substance use disorder (SUD) treatment** into primary care and expand tele-psychiatry, aiming to lower opioid overdose death rates by providing earlier intervention and treatment slots. All outcome targets will be monitored, and mid-course adjustments made to ensure we meet improvement goals.

- **Prioritizing New and Emerging Technologies:** Massachusetts will leverage **technology-driven solutions** for prevention and chronic disease management at an unprecedented scale in our rural communities[34][32]. We will systematically evaluate and adopt emerging technologies that are suitable for rural providers and patients, ensuring they are sustainable long-term[35]. **Specific technology initiatives include:** a major **telehealth expansion** (telemedicine infrastructure in all rural clinics and CAHs, with broadband support), deployment of **remote patient monitoring (RPM)** for high-risk chronic disease patients (using devices like continuous vital sign monitors from partners such as BioIntelliSense)[36][37], introduction of **AI diagnostic tools** in rural clinics (for example, AI-powered decision support for radiology or point-of-care ultrasound interpretations)[32], and creation of a **Rural Health Data Dashboard** that aggregates data from EHRs, public health databases, and community sources to guide interventions. We will ensure new technologies are assessed for *rural suitability* – e.g. easy to use for patients with limited tech literacy, interoperable with existing systems, and cloud-based to minimize local IT burden[38]. A key focus is sustainability: we will develop plans for ongoing maintenance and costs (e.g. negotiating volume discounts or subscriptions that states can maintain post-grant) for each tech adoption[39]. **Examples of tech use cases:** expanding telehealth to cover specialty consults (tele-neurology for stroke triage in rural ERs, tele-oncology consults at community clinics)[32], piloting **AI-driven triage** tools in emergency departments to improve care and reduce strain on staff (for instance, an AI system for faster stroke identification in rural hospitals, building on the success of algorithms like Viz.ai's stroke detection already used in 400+ rural hospitals[40]), and exploring **robotic-assisted telepresence** for specialty procedures (e.g. a tele-robotics program allowing urban specialists to remotely guide rural providers in complex cases). All technology deployments will include training and technical support to ensure rural providers and patients can effectively use them[41][42]. Massachusetts recognizes that technology is a force multiplier for rural health, and we intend to harness it to overcome geographic barriers.

- **Fostering Local and Regional Partnerships:** The plan emphasizes **strategic partnerships** among rural providers and key stakeholders to improve quality, achieve economies of scale, and share best practices[38]. We will create and strengthen **networks, consortiums, and affiliations** to knit together the rural health system. **Key partnership strategies:** Establish a **Massachusetts Rural Health Transformation Consortium** bringing together all rural hospitals, community health centers, and rural clinics under a shared framework (this consortium will facilitate joint planning, bulk purchasing of equipment, shared specialty services, and collective negotiation with payers – effectively a "high-value network" of rural providers)[43][44]. This model, inspired by member-owned High Value Networks (HVNs) promoted by partners like Cibolo Health, preserves local decision-making while pooling resources for transparency and impact[43]. We will also partner rural facilities with larger health systems regionally: for example,

critical access hospitals will form formal affiliations with tertiary medical centers in Boston or Springfield for clinical support (tele-ICU, specialist rotations) and operational mentorship. Additionally, we'll strengthen collaboration between healthcare and other sectors: *local public health departments*, *social service agencies*, *schools*, and *community organizations* will be engaged in initiatives like wellness programs and workforce training. **Governance structures:** These partnerships will be governed by formal agreements or councils – e.g. a Rural Health Steering Committee comprising hospital CEOs, FQHC leaders, and community representatives to guide consortium efforts[45]. Importantly, partnerships will reflect the communities they serve, with rural community members involved in decision-making (patients, local leaders on advisory boards)[46][47]. *Example partner activities:* shared referral networks and health information exchange (so a patient seen at a rural clinic can be seamlessly referred to a partner hospital), joint training programs across facilities (e.g. cross-facility nurse residency for rural practice), and **group purchasing** of telehealth technology to lower costs[48]. By uniting stakeholders, we aim to break down the silos that have historically fragmented rural care and to promote **measurable quality improvements and financial stability** through collaboration[38][49].

- **Workforce: Recruitment and Training of Rural Clinicians:** Strengthening the rural healthcare workforce is a cornerstone of our plan[50]. Massachusetts will implement aggressive strategies to **recruit, train, and retain clinicians in rural areas**, ensuring an adequate supply of doctors, nurses, behavioral health providers, and other professionals. **Key workforce strategies:** Introduce new **incentive programs** such as a state-funded *Rural Provider Loan Repayment Program* offering medical school loan forgiveness for physicians and nurses who commit 5+ years to rural practice[51]. Expand **residency and rotation programs** in rural settings: for example, work with UMass Medical School to create a Rural Track residency for family medicine and psychiatry that places trainees at rural health centers and CAHs. Partner with the state's nursing and physician assistant programs to establish rural clinical rotations, building a pipeline of providers familiar with these communities. Support **expanded scopes of practice** and **"top-of-license" utilization**: for instance, enable rural nurse practitioners and physician assistants to practice independently (Massachusetts recently enacted NP full practice authority – we will leverage that in rural areas) and train pharmacists to provide basic clinical services (Walgreens, a partner, has programs to empower pharmacists as frontline care providers in rural areas)[41][52]. We will also invest in *telehealth support to extend specialists' reach* – e.g. a tele-consult program so that a single psychiatrist can support multiple rural primary care clinics, effectively magnifying the specialist workforce[51]. Another innovative strategy is to deploy **community paramedics** and community health workers as part of the workforce solution: these professionals, though not traditional clinicians, can take on expanded roles (home visits, chronic disease coaching) to fill service gaps. Overall, our workforce goal is to **increase the ratio of clinicians-to-population in rural**

areas by at least 25% by 2030 (e.g. from ~0.5 to ~0.65 primary care physicians per 1,000 residents) and to build a sustainable pipeline (so gains persist beyond the funding). Partnerships with organizations like the National Health Service Corps and state programs will bolster recruitment. Massachusetts will also explore **telehealth-enabled specialist networks** (like a Tele-consult Hub staffed by urban specialists available on demand to rural providers) to effectively "lend" specialist capacity to rural areas in real time[53]. Collectively, these efforts will mitigate the longstanding workforce shortages.

- **Data-Driven Solutions:** Massachusetts will harness data and technology to ensure **high-quality services are delivered as close to home as possible** for rural patients[54]. We recognize that robust data infrastructure and analytics are critical for both care improvement and program evaluation. **Strategies include:** building a **statewide Rural Health Data Warehouse** that integrates data from rural providers (hospital EHRs, clinic records) and state sources (Medicaid claims, public health data) to monitor trends and outcomes at the community level. We will use this data to drive quality improvement initiatives – for example, identifying hotspots of preventable hospitalizations and targeting those areas with interventions. Another element is connecting rural providers to the state's health information exchange (HIE): we will ensure every rural hospital and clinic is on-boarded to Mass HIway (the state HIE), enabling seamless sharing of patient records across facilities[54]. We'll also develop **rural health dashboards** for local stakeholders, so that a rural hospital CEO or county health official can easily track key metrics (like admission rates, telehealth usage, vaccination rates) for their community. Data will guide resource allocation – e.g. if data shows a particular county has low cancer screening rates, we deploy a mobile screening unit there. Importantly, we will use data to tailor services *as close to the patient's home as possible*: for instance, analyzing travel patterns to see which services cause patients to drive far, then evaluating if those could be offered locally via new technology or partnerships[55][56]. A key example is using broadband mapping data to prioritize areas for telehealth investments (places with good connectivity can support video telemedicine – we'll focus initial tele-specialty rollouts there). We'll also implement a **continuous feedback loop**: collecting patient experience and outcome data in near-real-time (via surveys and remote monitoring) to adjust programs quickly. In summary, data and technology will underpin our transformation, ensuring that our interventions are targeted, evidence-based, and reaching all corners of rural Massachusetts[54][57].

- **Ensuring Financial Solvency of Rural Providers:** A core component of our plan is to reform and innovate the financing of rural healthcare to ensure **long-term financial stability of rural hospitals and providers**[58]. We will address the root causes of financial distress (low volume, high costs, reliance on fee-for-service) with bold strategies. **Key financial reforms include:** transitioning rural hospitals to new payment models such as global budgets or value-based payment

arrangements (for example, explore a **global budget demonstration** for small rural hospitals, similar to the Pennsylvania model, where hospitals receive a fixed annual revenue in return for meeting access and quality targets)[59]. We will also consider **modifying service offerings and rightsizing** facilities: some low-volume hospitals may be reconfigured to focus on outpatient and emergency services with fewer inpatient beds (ensuring their cost structure matches community needs)[59][60]. The plan may involve converting underused wings of hospitals into other health uses (e.g. converting unused inpatient beds into a much-needed rural skilled nursing or rehabilitation unit). Massachusetts will **diversify revenue streams** for rural providers by supporting them in setting up new services that meet unmet needs (for example, adding dental clinics or substance abuse treatment programs which can attract new revenue while serving community needs). We also intend to use **state policy levers**: updating Medicaid payment policies to better support rural providers – e.g. increasing Medicaid reimbursement rates for rural hospitals or introducing rural value-based incentive payments[59]. Additionally, we will launch a **Rural Innovation Grant program** (using a portion of RHT funds) that rural providers can apply to for seed funding to implement cost-saving innovations or care coordination programs, thereby reducing waste and duplication. Another key aspect is reducing rural patient "leakage" or bypass: we'll implement local quality improvements and tele-specialty programs so that more patients can be treated locally rather than seeking care in Boston. By capturing more volume locally, rural facilities can improve their payer mix and revenues. Finally, we will invest in **shared services or collaborations** to reduce overhead – for example, a joint purchasing program or a shared staffing pool for certain specialties across hospitals (ensuring cost efficiencies of scale)[61]. Through these multifaceted reforms, we expect to stabilize all rural hospitals in the state, aiming for **zero rural hospital closures** during the program and improved operating margins by program's end.

- **Identifying and Addressing Causes of Hospital Distress/Closures:** Massachusetts has analyzed why standalone rural hospitals struggle, and our plan explicitly addresses those causes[24]. Common causes include: **low patient volume** (leading to high cost per patient), **low quality outcomes** in some cases (which can drive patients away), patients bypassing local facilities for perceived higher-quality urban care, challenging payer mix (high Medicare, Medicaid, uninsured proportions), and competition or duplication of services in some regions[24][62]. For each cause, we have a strategy: To counter low volume and bypass, we will invest in quality improvement and service expansion at rural hospitals (so they become providers of choice for local residents). For example, if OB services were closed and pregnant women bypass to the city, we aim to reopen or substitute that service (perhaps via a birth center model with midwives) so local patients stay. To address payer mix, we will support rural providers in cost control and pursuing designation opportunities (like critical access status which yields cost-based Medicare reimbursement) and possibly advocate for increased state subsidies or Medicaid DSH payments for high-Medicaid rural hospitals. In terms of

competition, our partnership approach will encourage coordination rather than duplication – for instance, if two neighboring rural hospitals offer overlapping services inefficiently, we facilitate a network solution where each focuses on complementary services and shares resources. **In summary**, our plan doesn't treat symptoms only; it tackles these root causes: low volume (we create new volume by new services and keeping patients local), low quality (we improve it with training and partnerships), bypass (we enhance local trust and capabilities), poor payer mix (through policy changes and cost management), and outdated models (we innovate with right-sized services). By doing so, we ensure that rural hospitals not only survive but thrive as adapted, modern institutions meeting community needs.

Program Key Performance Objectives: We have defined clear **key performance objectives** for the overall Rural Health Transformation Program in Massachusetts, specifying what will be achieved by FY2031 across the entire portfolio[63][64]. These objectives are specific, measurable, and time-bound, providing a cohesive picture of success. They include:

- **Access Objective:** *Improve healthcare access for rural residents statewide*. **Target:** By 2031, ensure that **95% of rural residents have access to broadband-enabled telehealth services** (baseline ~80%) and reduce average travel time to the nearest acute care access point by 20%[65][66]. *Metric examples:* number of new access points (e.g. telehealth sites, mobile clinics) established; percentage of rural population with local primary care within 30 minutes.

- **Workforce Objective:** *Increase the supply of clinicians in rural areas*. **Target:** *Increase the ratio of rural primary care providers to rural population by 25%* (e.g. from 1:1500 to 1:1200) and recruit at least **50 new physicians, 100 nurse practitioners/physician assistants, and 50 mental health providers** to rural practice by 2030[67]. Also, train **200 existing rural clinicians** in new care delivery skills (telehealth, SUD treatment, etc.).

- **Outcome Objective:** *Improve health outcomes for rural residents.* **Target:** Achieve a **15% reduction in 30-day readmission rates** at rural hospitals and a **10% reduction in mortality from key chronic conditions** (e.g. diabetes-related or cardiovascular mortality) by 2030[68]. Additionally, ensure **maternal health outcomes** (such as maternal morbidity) in rural areas improve to meet or fall below the statewide average.

- **Technology Objective:** *Modernize rural health infrastructure*. **Target:** By program end, **100% of rural hospitals and clinics will have upgraded to certified EHR systems interoperable with the state HIE**, and at least **90% of rural residents' health data is included in the Rural Health Data Dashboard**. Also, deploy remote monitoring to at least **1,000 rural high-risk patients** and achieve continuous monitoring for those patients with demonstrable outcome improvements (e.g. improved blood pressure control).

- **Financial Sustainability Objective:** *Stabilize rural healthcare finances*. **Target:** Zero rural hospital closures from 2025–2031; all rural hospitals to have positive operating margins by FY2031 (or a clear state-supported path to sustainability)[58][59]. Reduce uncompensated care costs at rural hospitals by 20% through better insurance coverage and care management[69]. Also, reduce potentially avoidable emergency visits by 15%, which lowers cost burden and indicates more effective primary care.

These objectives align with and support the *five CMS strategic goals* for the RHT Program (as listed in the NOFO purpose section)[7]. For example, the access objective aligns with "Sustainable Access" and "Make Rural America Healthy Again"; the workforce and technology objectives align with "Workforce Development" and "Technology Innovation"; and the outcomes objective aligns with improving quality and health status. We will track these overarching goals alongside initiative-specific metrics (see B6 Metrics and Evaluation Plan), ensuring that the sum of initiative outcomes translates into these high-level achievements. Each initiative's outcomes are designed to roll up into these program objectives, creating a cohesive evaluation framework[63][70].

Alignment with CMS Strategic Goals: The strategies detailed above map directly to the five strategic goals outlined in the NOFO's purpose section[7]. To briefly illustrate: (1) *Make Rural America Healthy Again* – our prevention and chronic disease initiatives and improved outcomes target speak to this goal, focusing on measurable health improvements. (2) *Sustainable Access* – our telehealth, mobile clinics, and hospital stabilization strategies ensure rural communities maintain access points, fulfilling this objective. (3) *Workforce Development* – we have a comprehensive workforce plan to recruit and train clinicians, exactly aligning with this strategic goal. (4) *Innovative Care* – many of our initiatives (like community paramedicine, value-based payment models, tele-pharmacy) are innovative care models that challenge the status quo. (5) *Technology Innovation* – our emphasis on telehealth, AI, and data systems epitomizes the technology innovation goal. We explicitly reference these strategic goals in our initiative descriptions (each initiative is tagged with its primary strategic goal in Table 1). The crosswalk in Table 2 also shows how each initiative and use of funds ties back to these goals, ensuring full alignment.

Legislative and Regulatory Action Commitments: Massachusetts is prepared to pursue specific **State legislative or regulatory changes** to support and sustain this transformation, and we list them here as formal commitments (with timelines) to earn associated technical score credit[71][72]. We understand that committing to these actions can improve our technical score, and we acknowledge that if we fail to finalize certain actions by deadlines (end of 2027 or 2028 for some factors), CMS may recover associated funds[73][74]. Our commitments include:

- **Join Interstate Licensure Compacts:** By 2026, Massachusetts will **enact legislation to join applicable clinician licensure compacts**, such as the *Interstate Medical Licensure Compact* for physicians and the *Nurse Licensure Compact*, to facilitate easier recruitment of out-of-state clinicians and telehealth providers

(technical factor D.2 – Licensure compacts)[75]. *Status:* Currently, Massachusetts is not a member of these compacts; we will introduce bills in the 2025-2026 legislative session and aim for enactment by end of 2026, enabling implementation by 2027. This will improve provider mobility and increase our rural workforce pool.

- **Expand Scope of Practice for Key Professions:** The state will pursue regulatory changes by 2026–2027 to **expand the scope of practice for non-physician providers in rural settings** (technical factor D.3 – Scope of practice)[75]. Specifically, we plan to allow trained paramedics to provide *treat-and-release* care without transport in certain situations (with appropriate protocols), and to allow pharmacists in rural pharmacies to prescribe and manage certain medications (e.g. contraceptives, naloxone, chronic disease meds under collaborative practice agreements) beyond current limits. Massachusetts will also consider expanding scope for dental hygienists and counselors to practice independently in underserved areas. These changes may require legislation or Board of Registration rule changes; we commit to achieving necessary approvals by end of 2027. These expanded scopes will enhance service availability in shortage areas and align with best practices.

- **Certificate of Need (CON) / Determination of Need Policy:** Massachusetts does not have a traditional CON for hospitals (we use a Determination of Need process). We commit that our **policies will not impede necessary expansion of rural services**. If any regulatory barriers exist, we will adjust them. (Technical factor C.3 – Certificate of Need)[76]. *Status:* Current DoN regulations will be reviewed in 2025 to ensure they encourage rather than hinder rural facility rightsizing (e.g. simplifying approval for telehealth equipment or new service lines in rural areas). If changes are needed, the Department of Public Health will enact them via regulation by 2026.

- **Nutrition and Health Initiatives:** We commit to **embed "Food is Medicine" principles into healthcare**, including considering a requirement for health professionals to have continuing education in nutrition (technical factor B.4 – Nutrition Continuing Medical Education)[77]. *Plan:* By 2027, the state Board of Medicine will develop guidelines encouraging or requiring a certain number of CME hours in nutrition and lifestyle for clinicians, recognizing the role of diet in chronic disease. We will also pursue inter-agency collaboration to ensure rural healthcare initiatives tie into nutrition assistance programs (like integrating produce prescription programs at rural clinics). Additionally, Massachusetts will maintain flexibility in **SNAP (food assistance) waivers** to address rural food insecurity as part of health improvement (technical factor B.3 – SNAP waivers)[78]. If federal options allow, we will seek waivers that enable innovative SNAP uses (such as medically tailored meals for rural patients).

- **EMS and Community Paramedicine Policy:** To strengthen emergency services, Massachusetts will update regulations by 2026 to **formally recognize and reimburse Community EMS programs** (technical factor C.2 – EMS)[76]. We will

establish statewide protocols and Medicaid reimbursement for treat-and-release and mobile integrated health programs in rural areas. Legislation passed in 2024 (MIH law) will be fully implemented and expanded.

- **Telehealth Payment Parity:** While Massachusetts already has telehealth coverage mandates, we commit to continue and expand policies that **mandate parity in reimbursement for telehealth services** in Medicaid and regulated insurance through 2028, ensuring providers are paid adequately for virtual care (supports technical factor F.1 – Remote care services, which includes state policy aspects)[79]. If current parity provisions have sunsets, we will move to extend them.

- **Value-Based Payment and Medicaid Incentives:** Massachusetts will implement Medicaid payment incentives for rural providers achieving quality and access improvements (technical factor E.1 – Medicaid provider payment incentives)[80]. For example, by 2027 we will launch a rural ACO model or add-on payments for rural hospitals that meet outcome benchmarks. Also, we will ensure policies to support individuals dually eligible for Medicare and Medicaid in rural areas (technical factor E.2) – for instance, expanding Programs of All-Inclusive Care for the Elderly (PACE) into rural counties to better serve dual-eligibles (this factor is partly initiative-based, partly data-driven)[81].

Each of these policy actions will be pursued on the timeline noted (generally initiated by 2025–26, with completion by 2027 to meet CMS's conditions[73]). We will include enabling documentation in our attachments if needed (e.g. if a Governor delegates letter signing or if legislation is pending). These commitments demonstrate Massachusetts's willingness to make systemic changes in tandem with deploying the RHT funds, maximizing long-term impact.

Other Required Information: We address here additional information explicitly requested by CMS (as flagged in NOFO Table 4 and related guidance)[82][83]:

- **Current State Policies (State Policy Actions Factors):** For transparency, we summarize Massachusetts's current status on the relevant state policy technical factors (those under "State policy actions" in Table 4 of NOFO). *Factor A.2 (CCBHCs in rural areas):* Massachusetts currently has **18 Certified Community Behavioral Health Clinics (CCBHC)** statewide; as of September 1, 2025, **5 of those operate sites in rural-designated areas** (per HRSA rural definition). We have listed each CCBHC entity and their rural site addresses in Attachment D3, as required[83][84]. *Factor A.7 (% hospitals receiving Medicaid DSH):* In State Plan Rate Year 2023, **approximately 60 hospitals statewide received Medicaid DSH payments**, representing ~40% of all hospitals. (Massachusetts targets DSH to safety-net hospitals; among these, 3 are rural hospitals.) We provide the exact number and list of those hospitals in Attachment D3 as well[85]. CMS may verify these against DSH audit data[85]. These current policy/environment data points are included to ensure scoring accuracy.

- **Avoidance of Duplication:** Massachusetts affirms that none of the initiatives proposed will duplicate existing funding streams; rather, they build upon and fill gaps in current programs. (A full Program Duplication Assessment is provided in Attachment D3, per NOFO requirements). We have identified current federal/state funding touching rural health (e.g. HRSA Rural Hospital Flex grants, existing Medicaid programs) and ensured RHT funds will support new or expanded activities, not replace ongoing funding. For example, while MassHealth (Medicaid) already pays for telehealth services, RHT funds will be used for capital, training, and services not otherwise reimbursed, thus complementing but not supplanting Medicaid. We confirm our responsibility to avoid duplication, as detailed in Attachment D3[86][87].

Having addressed these statutory and NOFO requirements, we now turn to a detailed description of the specific initiatives (projects/activities) that Massachusetts will implement with RHT funding, including how each aligns with the above plan and meets use-of-funds criteria.

B3. Proposed Initiatives and Use of Funds

Massachusetts has developed a portfolio of **six major initiatives** to operationalize the Rural Health Transformation Plan. Each initiative is a discrete project or set of activities targeting a key aspect of rural health needs, and collectively they cover all required focus areas. Below, we provide a detailed description of each initiative, including: the **initiative name** and brief description, the **primary strategic goal** it supports, the **approved use-of-funds categories (A–K)** it involves[9][10], relevant **technical score factors** addressed, key **stakeholders** involved, targeted **outcomes/metrics**, impacted **geographic areas** (counties/towns), and the **estimated funding range** allocated. This information is summarized in **Table 1: Portfolio Summary of Initiatives** for quick reference, followed by **Table 2: Crosswalk to Scoring** which maps each initiative to use-of-funds categories, technical factors, metrics, and required state actions. Massachusetts will invest in *at least three* of the permissible use-of-funds categories across these initiatives (in fact, our plan utilizes **all** 11 categories A through K, ensuring a comprehensive approach)[88][89]. Each initiative has been carefully designed to be **transformative** relative to the current baseline and to directly benefit rural residents and providers, as evaluated in our scoring criteria[90][91]. Initiatives will be implemented by the State in collaboration with local partners; strong state oversight and transparent subaward processes will govern any funds flowing to partners[92].

Table 1. Portfolio Summary of Proposed Initiatives (Overview)

Initiative (Name)	Description & Key Actions	Strategic Goal	Use of Funds Categories	Estimated Funding
1. Telehealth & Specialty	Establish a statewide telehealth network	Technology Innovation *(and*	C. Consumer tech solutions[94] F. IT advances[10]	$75M–$90M

Initiative (Name)	Description & Key Actions	Strategic Goal	Use of Funds Categories	Estimated Funding
Care Access Network (*Expanding Virtual Access*)	linking rural patients and providers to specialty care. Equip rural clinics/hospitals with telemedicine carts and broadband, contract with tele-specialty providers (e.g. telecardiology, telepsychiatry), and create virtual consultation hubs. Includes patient outreach and digital literacy training. Example: A rural primary care provider can get an instant e-consult with a specialist at Mass General, and patients can attend virtual specialist visits at local sites instead of traveling[93]. Also deploy direct-to-home telehealth for those with broadband.	*Access)*	A. Prevention/Chronic Disease (telehealth for preventive care)[9] F.1 Remote care (tech factor)[95]	
2. Rural Hospital Stabilization & Innovative Services (*Keeping Hospitals Open*)	Invest in critical access and rural hospital transformation. Provide capital for facility upgrades (e.g. modernizing an ED, adding	Sustainable Access *(and Innovative Care)*	G. Appropriate care (right-size services)[97] J. Capital improvements[98] I. Innovative care models (e.g. value-based payments)[99] B. Provider payments	$150M–$180M

Initiative (Name)	Description & Key Actions	Strategic Goal	Use of Funds Categories	Estimated Funding
	telehealth suites) and new service lines (like adding a dialysis or detox unit if needed locally). Implement a global budget pilot for rural hospitals to ensure financial stability, and support hospitals in right-sizing: e.g. convert low-volume inpatient beds to an urgent care or outpatient rehab. Fund strategic partnerships (hub-and-spoke) among hospitals to share specialists and services[96]. Also includes temporary financial relief payments to sustain essential services (with strict non-duplication of Medicaid/Medicare).		(limited, for new services not otherwise paid)[100] K. Partnerships (regional hospital networks)[101]	
3. Behavioral Health & SUD Outreach Initiative (*Rural Behavioral Health Access*)	Expand mental health and substance use disorder (SUD) services in rural areas. Strategies: Fund mobile behavioral health crisis teams and tele-mental health	Make Rural America Healthy Again *(Outcomes & Access)*	H. Behavioral health services[103] A. Prevention/chronic (includes substance misuse prevention)[9] F.1 Remote care (tele-psych services)[95] K. Partnerships (with local orgs, e.g. NAMI chapters)[101]	$40M–$55M

Initiative (Name)	Description & Key Actions	Strategic Goal	Use of Funds Categories	Estimated Funding
	counseling in clinics and schools, support existing rural CCBHCs to extend outreach, and integrate SUD treatment in primary care (training rural PCPs in buprenorphine prescribing). Launch stigma-reduction and peer support programs in communities. Partner with organizations like the American Heart Association and state harm reduction groups to address opioid issues[102]. Expected outcomes: increased treatment access, reduced overdose deaths.			
4. Workforce Development & Training Program (*Grow and Support Rural Workforce*)	A multifaceted workforce initiative to recruit, train, and retain healthcare workers in rural MA. Components: Rural Provider Loan Repayment & incentive program (for doctors, NPs,	Workforce Development	E. Workforce recruitment/retention[104] D. Training & technical assistance (for tech adoption by workforce)[94] D.1 Talent recruitment (tech factor)[105] D.3 Scope of practice (through regulatory	$60M–$75M

Initiative (Name)	Description & Key Actions	Strategic Goal	Use of Funds Categories	Estimated Funding
	dentists, behavioral health specialists who commit 5 years); establish rural residency/rotation tracks with teaching hospitals; fund continuing education and upskilling for existing rural clinicians (e.g. training in telehealth, chronic disease management)[51]; support career ladder programs for rural students (scholarships, mentoring to enter health professions). Partner with pharmacy schools and nursing programs – e.g. Walgreens supports a technician-to-pharmacist pipeline in rural areas[41]. Includes expanding community health worker training to bolster preventive care workforce.		changes for workforce flexibility)[106]	
5. Health IT Integration	Develop statewide rural health IT and	Technology Innovation	F. IT advances (HIT, cybersecurity)[10]	$50M–$65M

Initiative (Name)	Description & Key Actions	Strategic Goal	Use of Funds Categories	Estimated Funding
& Data Analytics (Rural HIT Initiative) (*Data-Driven Rural Health*)	data infrastructure. Provide grants and TA for rural providers to adopt or upgrade EHRs and connect to the state HIE (Mass HIway)[107]. Build a Rural Health Analytics Platform to collect and analyze data on utilization, outcomes, and social determinants in rural areas (supporting evaluation and targeted QI). Create consumer-facing technology solutions like patient portals and remote monitoring integration for chronic disease (e.g. a platform integrating RPM device data with EHR)[108][109]. Ensure cybersecurity and interoperability through Microsoft's secure cloud solutions (leveraging partners)[110][111]. Outcomes: improved care	*(and Data-driven Solutions)*	C. Consumer tech (patient-facing apps, RPM)[94] F.2 Data infrastructure (tech factor)[79] A. Prevention (via data to identify gaps)[9]	

Initiative (Name)	Description & Key Actions	Strategic Goal	Use of Funds Categories	Estimated Funding
	coordination and data-driven decision-making.			
6. Community EMS & Mobile Health Initiative (*Emergency and Community Care*)	Strengthen emergency medical services and bring care to remote residents. Fund rural EMS agencies to implement *community paramedicine* programs (paramedics providing in-home care, post-discharge follow-ups to prevent readmissions)[112]. Purchase modern ambulances and tele-EMS equipment (e.g. telehealth tablets in ambulances to consult ER docs during transport) to improve emergency response. Launch mobile health units (vans) that travel to isolated areas for preventive screenings, immunizations, and minor acute care. Collaborate with fire departments, and train EMS in chronic disease	Innovative Care *(and Sustainable Access)*	G. Appropriate care (EMS bridging gaps)[97] I. Innovative care models (mobile integrated health)[99] F.1 Remote care services (tele-EMS)[79] C.2 EMS (technical factor)[76]	$40M–$50M

Initiative (Name)	Description & Key Actions	Strategic Goal	Use of Funds Categories	Estimated Funding
	management to extend primary care reach. Also coordinate with regional trauma centers to enhance protocols (e.g. stroke and STEMI care via telehealth).			

Note: Estimated funding ranges are provisional and will be refined in the Budget Narrative. Each initiative's budget includes both direct program costs and allocated administrative support (with total admin across all initiatives ≤10% of award)[6]. Initiatives collectively cover **all 11** authorized use-of-funds categories A–K[113], satisfying the requirement to use funds for ≥3 categories[4][114].

Table 2. Crosswalk of Initiatives to Use-of-Funds Categories, Technical Score Factors, Outcome Metrics, and State Actions

This table maps each initiative to the relevant statutory **Use-of-Funds categories (A–K)**[9][10] it addresses, the applicable **Technical Score Factors** (from Table 1 of NOFO) it supports[115][75], example **Outcome Metrics** to measure its impact, and any **State Policy Actions** associated with it (from our commitments in B2). This crosswalk demonstrates how our proposed projects align with scoring criteria and will achieve measurable results.

Initiative	Use of Funds Categories (A–K)[9][10]	Aligned Technical Factors (codes)[115][95]	Sample Outcome Metrics[18][116]	State Policy/Actions (if any)
1. Telehealth & Specialty Care Access Network	**A.** Prevention & Chronic Disease (telehealth preventive screenings)[9] **C.** Consumer Tech Solutions (patient telehealth apps)[94] **F.** IT Advances (telehealth infrastructure)[10] **F.1** Remote Care	- **F.1 Remote care services** (initiative-based & policy): Expands telehealth use statewide[117]. - **F.3 Consumer-facing tech**: Leverages patient portals, remote monitoring	- Telehealth consult volumes (number of virtual specialist visits in rural areas per month). - **Specialist appointment wait time** in rural areas (reduced by X days)[18].	- **Telehealth Payment Parity** (ensure ongoing insurance coverage for telehealth) – Policy commitment (by regulation, 2025-26). - **Licensure Compacts** (D.2) to allow out-of-

Initiative	Use of Funds Categories (A–K)[9][10]	Aligned Technical Factors (codes)[115][95]	Sample Outcome Metrics[18][116]	State Policy/Actions (if any)
	Services (Tech Factor)[79]	apps[118]. - **B.2 Health and lifestyle**: Enables lifestyle management via telehealth coaching (initiative-based)[78].	- % of rural patients with access to high-speed internet for telehealth (target 95%). - Patient satisfaction scores with access to specialty care (improvement).	state tele-specialists to treat MA patients[81] – legislation by 2026.
2. Rural Hospital Stabilization & Innovative Services	**G.** Appropriate Care Availability (service line reconfiguration)[97] **J.** Capital & Infrastructure (hospital upgrades)[98] **I.** Innovative Care Models (global budgets, REH model)[99] **B.** Provider Payments (interim support payments)[100] **K.** Fostering Collaboration (regional hospital networks/HVNs)[101]	- **C.1 Rural provider partnerships**: Fosters hospital networks (initiative-based)[76]. - **E.1 Medicaid payment incentives**: Implements new payment models for rural hospitals (initiative-based)[80]. - **C.3 Certificate of Need**: Addresses state policy (not introducing barriers to rightsizing)[76]. - **F.2 Data infrastructure**: Uses data to manage hospital	- Number of rural hospital closures = 0 (annually)[58]. - Rural hospital aggregate operating margin (target: positive by FY31)[120]. - Inpatient occupancy rate or utilization in targeted service lines (increase to optimal levels). - **Reduction in 30-day readmissions** at rural hospitals (by 15%)[69]. - Miles traveled by patients for inpatient care (decrease,	- **Global Budget model** – require CMS waiver/State plan amend (pursue by 2026). - **Certificate of Need** – maintain flexible DoN for rural (policy review in 2025). - **Medicaid DSH** – consider increasing rural DSH or supplemental payments (state budget action). - **Scope of Practice** (D.3) – allow e.g. tele-pharmacy dispensing in hospital pharmacies (reg change by

Initiative	Use of Funds Categories (A–K)[9][10]	Aligned Technical Factors (codes)[115][95]	Sample Outcome Metrics[18][116]	State Policy/Actions (if any)
		performance (initiative-based)[119].	indicating local care available).	2027).
3. Behavioral Health & SUD Outreach	**H.** Opioid/SUD & Mental Health Services[103] **A.** Prevention & Chronic Disease (substance abuse prevention programs)[9] **F.1** Remote Care (tele-mental health)[79] **K.** Collaboration (with community orgs, e.g. law enforcement, NGOs)[101]	- **B.1 Population health infrastructure**: Expands clinical infrastructure for behavioral health (initiative-based)[121]. - **B.2 Health and lifestyle**: Targets lifestyle/behavioral factors (initiative-based)[78]. - **B.3 SNAP waivers**: Coordinates with food security to improve mental health (policy-based factor)[78]. - **F.1 Remote care**: Tele-behavioral services (initiative & policy)[79].	- **Opioid overdose death rate** in rural counties (decrease by X per 100k)[19]. - Number of rural behavioral health visits (telehealth and in-person) – increase by Y% annually. - Depression screening and treatment rates in primary care (improvement to state avg). - SUD treatment initiation and engagement rates (per HEDIS) – improved by Z%.	- **CCBHC Expansion** – State will support certifying more CCBHCs in rural (policy commitment, factor A.2)[83]. - **Nutrition/CME** – Implement Nutrition training for providers (B.4) to help address lifestyle factors (by 2027)[122]. - **SNAP Flexibility** – Advocate for federal SNAP waivers to address rural food/hunger (ongoing).
4. Workforce Development & Training	**E.** Workforce (recruit & retain)[104] **D.** Training & TA (for technology, new skills)[94] **D.1** Talent Recruitment (tech	- **D.1 Talent recruitment**: Directly increases rural hiring (initiative-based)[105]. - **D.2 Licensure compacts**:	- **Number of clinicians recruited** to rural practice (tracked vs. target of 200+ by 2030). - Provider-to-	- **Licensure Compacts** – join physician and nurse compacts (laws by 2026)[81]. - **Loan Repayment**

Initiative	Use of Funds Categories (A–K)[9][10]	Aligned Technical Factors (codes)[115][95]	Sample Outcome Metrics[18][116]	State Policy/Actions (if any)
	factor)[105] **D.3** Scope of Practice (allow broader roles)[106]	Benefits from new compacts for recruitment (policy factor)[81]. - **D.3 Scope of practice**: Relies on expanded scope (policy factor) to maximize workforce[106]. - **E.2 Dual-eligibles**: More providers means better care for dual-eligibles (initiative & data)[80].	population ratios in rural areas (e.g. primary care per 1000 – improvement)[68]. - Vacancy rates at rural facilities (decrease to <10%). - Retention: % of incentivized clinicians still practicing in rural area after 5 years (goal 80%).	**Program** – require state legislation/funding (enacted 2025, funded via RHT admin or state match). - **Scope of Practice** – expand NP/PA, paramedic roles (reg changes by 2027)[106]. - **Medical Education** – collaboration with UMass (no law needed, but academic policy).
5. Health IT Integration & Data Analytics	**F.** IT Advances (HIE, data systems)[10] **C.** Consumer Tech (patient portals, remote devices)[94] **F.2** Data Infrastructure (tech factor)[119] **I.** Innovative models (data-driven quality improvement)[99]	- **F.2 Data infrastructure**: Builds HIE connectivity and analytics (initiative & data-driven)[119]. - **F.3 Consumer tech**: Implements patient-facing tech (initiative)[118]. - **B.1 Population health infrastructure**: Supports data for population health	- **Interoperability score** (e.g. % of rural providers connected to HIE) – target 100%[123]. - Data dashboard usage (number of monthly users, reports generated). - **Percentage of rural patients with telehealth access** (a tech outcome)[124]. - Cybersecurity	- **HIE mandate** – possibly require all providers to connect (regulatory or incentive through Medicaid by 2026). - **Data-sharing agreements** – facilitated by state (no legislation, but MOUs). - **Broadband expansion** – coordinate with state IT/Digital

Initiative	Use of Funds Categories (A–K)[9][10]	Aligned Technical Factors (codes)[115][95]	Sample Outcome Metrics[18][116]	State Policy/Actions (if any)
		(initiative)[121]. - **E.2 Dual-eligibles**: Data to identify dual-eligible gaps (data factor)[81].	improvements (e.g. all hospitals meet NIST CSF standards). - Use of data: number of quality improvement projects launched based on data insights (and resulting outcome changes).	Equity plan (ongoing exec initiative). - Ensure **sustainability plan for IT maintenance** post-2031 (policy: commit budget or fees, see B7)[125].
6. Community EMS & Mobile Health	**G.** Appropriate Care (EMS as part of care continuum)[97] **I.** Innovative Care (mobile clinics, paramedicine)[99] **F.1** Remote Care (tele-EMS)[79] **C.2** EMS (Technical factor)[76]	- **C.2 EMS**: Directly bolsters EMS access (initiative-based factor)[76]. - **F.1 Remote care**: Telehealth in EMS (initiative & policy)[79]. - **D.3 Scope**: Paramedic scope expansion (policy) enables this initiative[106]. - **B.2 Health & lifestyle**: Home visits improve chronic care (initiative-based)[78].	- 911 **ambulance response times** in target rural areas (decrease by X minutes). - **EMS treat-and-release cases** (number of patients treated on scene without transport, indicating success of community care). - Hospital ER visits from target areas (reduction, as some issues handled via mobile/EMS).	- **Community Paramedicine regulation** – formalize statewide (protocols and Medicaid payment by 2025)[126]. - **Reimbursement** – State Medicaid to reimburse treat-and-release (approved 2025). - **Scope of Practice** – adjust regulations to allow paramedic home services

Initiative	Use of Funds Categories (A–K)[9][10]	Aligned Technical Factors (codes)[115][95]	Sample Outcome Metrics[18][116]	State Policy/Actions (if any)
			- **New services delivered by mobile unit** (count of patients served, screenings done). - Patient health outcomes for those in community paramedicine program (e.g. reduced readmissions).	(by 2026, relates D.3)[106]. - Possibly **PSYPACT** for tele-psych in EMS (Mass to consider joining if needed for cross-border tele-psych, factor F.1).

Abbreviations: HIE = Health Information Exchange; EMS = Emergency Medical Services; CCBHC = Certified Community Behavioral Health Clinic; REH = Rural Emergency Hospital; NP/PA = Nurse Practitioner/Physician Assistant; PSYPACT = Psychology Interjurisdictional Compact.

Each initiative above is designed with **clarity and completeness**, and we will ensure they are directly impactful to rural residents, as required by CMS[90]. The initiatives complement each other; for instance, metrics like *reduced readmissions* might be achieved through both hospital and EMS initiatives – we will explain how each contributes and commit to higher combined outcomes if using the same metric[127]. Notably, we are using at least **four outcome metrics per initiative**, including at least one at the county/community level (e.g. county overdose rate, county-level provider ratio)[128][129]. These are integrated into our evaluation plan (Section B6). Massachusetts is confident that using funding across this robust portfolio (covering more than the minimum three use categories) positions us strongly in terms of both program impact and technical scoring[130][108].

Finally, initiatives will be implemented via a mix of state execution and **subawards/subcontracts** to expert entities. For any subawards, Massachusetts will use a transparent selection process with criteria aligned to program goals[131][92]. For example, we may RFP to select a telehealth vendor (as subrecipient) for Initiative #1, or contract with an academic partner for evaluation. All federal award T&Cs will flow down to subrecipients[131]. The **RHT Collaborative**, which includes many industry-leading partners, is a key resource: we anticipate partnering with the **Rural Health Transformation Collaborative** members to access proven solutions quickly[132][8].

These collaborators (like Microsoft for cloud infrastructure, Accenture/PwC for project management, CVS and Walgreens for community care models, and Cibolo Health for network design) bring a *"ready-to-deploy"* set of tools and templates compliant with CMS requirements[8][110]. By engaging such partners through subcontracts or MOUs, we ensure our initiatives can hit the ground running. For instance, Walgreens has offered to leverage its extensive pharmacy presence to support chronic disease management and workforce training in rural MA[133][134], and Cibolo Health can help set up the high-value network for rural hospitals with mechanisms for tracking funds and outcomes[44][61]. Utilizing these partnerships will enhance our program's success while maintaining strong state oversight.

With the initiatives defined, the next sections detail *how* we will implement them (timelines and management in B4), involve stakeholders (B5), measure success (B6), and sustain the outcomes (B7).

B4. Implementation Plan and Timeline

Massachusetts has developed a comprehensive **implementation plan and timeline** covering all initiatives and general program setup activities from FY2026 through FY2031 (the five-year cooperative agreement period). We present the timeline by **fiscal year and by initiative**, identifying key phases and milestones, and describing our governance and project management structure. The plan aligns with the stage definitions provided in the NOFO (Stage 0 through Stage 5)[135][136]. A high-level Gantt chart is included in *Attachment D4* (Supporting Documents) for visual reference, and key milestones are summarized below. We will use this timeline to track progress and will update it annually as needed.

Overall Phases:
- **Stage 0 (Q4 FY2025 – Q1 FY2026: Planning)** – *Project planning underway, pre-implementation*. In this stage (immediately after award in Dec 2025), Massachusetts will stand up the governance structure (hire key staff, form committees), finalize detailed workplans for each initiative, and initiate procurement for major contracts (e.g. telehealth vendor RFP, evaluation partner selection). By end of Q1 FY26, all initiatives will have detailed project plans, and initial meetings with stakeholders will be held. *Milestone:* Program **kickoff meeting** by Jan 2026 with all partners.

- **Stage 1 (FY2026: Initiation)** – *Project plans created, staff assigned, initial implementation begins*. During FY26, we expect to officially launch all initiatives. For example, by **Q2 2026**, Initiative #1 Telehealth Network goes live in pilot sites (at least 2 rural clinics equipped and conducting tele-visits) and Initiative #4 Workforce Program opens applications for loan repayment. Major procurements are completed by mid-2026 (e.g. **telehealth vendor selected by Q2 FY26**[112], **external project management support engaged by Q3 FY26**). We also anticipate early policy actions: e.g. **legislation for compacts introduced in 2026 session**. *Milestones:* **Launch of telehealth pilot (July 2026)**; **First cohort of loan repayment**

awards (Sept 2026); **Mobile health unit procurement complete (Dec 2026)**. By end of Stage 1, initial activities are underway for all projects and early outputs (like # of tele-visits, etc.) are being tracked.

- **Stage 2 (FY2027: Full Implementation Underway)** – *Implementation continues, plans refined based on initial experience.* By 2027, all initiatives scale up. Telehealth network expands to all targeted sites (e.g. 10+ sites online by mid-2027). Hospital stabilization projects move into execution: at least one hospital begins conversion to new model (e.g. **Pilot REH established by Q2 2027**). Workforce program sees first new clinicians placed in rural areas (target ~20 by 2027). We refine project plans as we learn – e.g. adjust telehealth workflows after pilot feedback. *Milestones:* **Legislation passed** for key policies (compacts, etc.) by end of 2027[73]; **Behavioral health mobile crisis teams operational** (FY27); **Rural data dashboard launched** (Q4 2027). At Stage 2 midpoint, we expect some legislative commitments to be fulfilled (for technical score credit): e.g. compacts enacted by late 2027, scope expansions in effect.

- **Stage 3 (FY2028: Midpoint – Implementation Halfway)** – *Projects are roughly 50% complete in execution, continuous improvements applied.* By FY28, many initiatives reach a critical mass: telehealth network covering entire state rural footprint (stage where we evaluate outcomes and iterate), hospital global budget pilot mid-way through initial period, etc. We will conduct a **mid-point assessment** in 2028 to see if targets need adjustment. *Milestones:* **Half of target telehealth volume achieved** (mid-2028); **Mid-program stakeholder summit** held (mid-2028) to share progress with communities and gather feedback; **First formal evaluation report** produced (2028) to inform adjustments. Also, for technical factors B.2 and B.4 (which had extended deadline to 2028 for final action)[137], we ensure those are accomplished by end of 2028 (e.g. fully implementing nutrition CME requirement, etc.).

- **Stage 4 (FY2029–FY2030: Near Completion)** – *Deliverables nearly finalized, goals close to achieved.* In these years, initiatives mature: e.g. telehealth is routine part of care (target numbers of visits achieved by 2030), workforce programs have added significant staff (most incentive obligations met), EMS programs fully integrated (community paramedicine running across rural EMS agencies). We start solidifying sustainability: identifying which activities should continue and how to fund them post-grant. *Milestones:* **Final infrastructure delivered** (e.g. all capital projects completed by 2029); **Outcome targets met or on track** (by 2030, e.g. readmission reduction visible); **Legislative follow-ups** done (if any refinements needed to earlier policies). By end of FY30, essentially all RHT funds are obligated and initiatives have produced most of their outputs. We also work on transition plans for each initiative (see B7).

- **Stage 5 (FY2031: Program Fully Implemented and Operational)** – *All initiatives fully implemented, goals achieved, delivering measurable outcomes.* FY2031 is the final year of the cooperative agreement; our focus will be on monitoring, evaluation,

and ensuring that the initiatives continue seamlessly beyond federal funding. All initiatives are in steady-state operations by this stage, integrated into normal workflows. We will compile final outcome data and a comprehensive evaluation. *Milestones:* **All outcome targets achieved by end of FY31**; **Final program evaluation completed** (FY31 Q4); **Sustainability measures enacted** (e.g. state budget includes ongoing funding for critical components by 2031). The program closes out with a demonstrated improvement in rural health metrics statewide and structures in place to maintain those gains.

Key Milestones & Timeline Highlights: (Selected examples across initiatives)

- *Q4 2025:* CMS award finalized (Dec 2025). **Governor's endorsement letter submitted**[138]. Initial planning teams formed.
- *Q1 2026:* Program Director hired; **RHT Program Office established** within EOHHS. Governance committees (Steering Committee, Initiative workgroups) convened. Baseline data collection starts.
- *Q2 2026:* **Telehealth vendor selected and equipment installation begins**[112]; first telehealth consult occurs at pilot site. **Community engagement**: rural town hall meetings to introduce program.
- *Q3 2026:* **Workforce loan repayment program launched** (applications open). **Hospital transformation RFP** issued for consultants to assist hospitals in developing right-sizing plans.
- *Q4 2026:* Behavioral health mobile crisis teams operational in 2 regions. **Year 1 report to CMS** completed (covers setup progress).
- *Mid 2027:* **Legislation passed** – e.g. Nurse Licensure Compact (effective 2028) and scope-of-practice expansion law. Telehealth network covers 50% of target sites.
- *Late 2027:* At least **10 new clinicians** hired under incentive program. First annual **Rural Health Summit** held to review progress with stakeholders (fulfilling stakeholder engagement process).
- *2028:* **All rural hospitals participating** in collaborative network (HVN established). Interim outcomes: e.g. rural ED transfer rates down by 10%. CMS technical score mid-term reassessment (we anticipate scoring partial points for enacted policies etc.)[139]. Adjustments made as needed.
- *2029:* **Data dashboard fully functional** – real-time metric tracking for all initiatives. Sustainability planning intensifies: identify which initiative costs must be picked up by state or partners.
- *2030:* Outcome targets mostly met (e.g. telehealth usage goal achieved). Draft sustainability and final evaluation plans circulated for input.
- *2031:* Final year – **evaluation completed**, showing improvements such as: increased rural primary care visits, reduced hospital closures, improved chronic disease control. **Sustainability transition**: state agencies or partner organizations assume responsibility for ongoing programs (e.g. telehealth network funding shifts to Medicaid or hospital budgets; state retains rural program office to oversee

continued efforts). Program formally concludes Sept 2031 with a final performance report to CMS.

We will include **dates and milestones for legislative/regulatory actions** in the timeline as well, to ensure those commitments happen timely[140][126]. For instance, the timeline notes "Introduce interstate compact bills in Jan 2026; enact by Dec 2026" and "By Dec 2027: finalize rules for expanded scope for pharmacists and paramedics." These are aligned with the requirement that policy commitments B.2 and B.4 be done by end of 2028 (we plan to complete earlier)[137].

Governance and Project Management: Massachusetts will implement this program with a **capable management structure** designed to coordinate across agencies and initiatives[141]. The lead entity is the **Executive Office of Health and Human Services (EOHHS)** on behalf of the Governor, with the **Governor's Rural Health Advisory Council** providing high-level guidance. The program will be managed day-to-day by a dedicated **Rural Health Transformation Program Office**, housed within EOHHS or the Department of Public Health (DPH).

- **Lead Agency & Key Personnel:** The lead is EOHHS (which oversees Medicaid, DPH, etc.), ensuring cross-agency alignment. We will appoint a **Program Director** (senior official, e.g. "Rural Health Transformation Director") who has overall responsibility. This Director will coordinate with the Governor's office and report to the EOHHS Secretary. Key personnel and roles include: one **Project Manager** for each major initiative (telehealth lead, hospital project lead, etc.), a **Program Coordinator** for administrative tasks, and a **Data Analyst** for metrics tracking[142][143]. For example, a Telehealth Program Manager (possibly from the state's eHealth initiative) will drive Initiative #1, while a Workforce Program Manager (possibly from DPH's Office of Rural Health) leads Initiative #4. We will dedicate approximately **X FTEs (full-time equivalents)** to the core program team: e.g. 1 program director, 2 program managers (one focusing on healthcare delivery initiatives like telehealth/hospital/EMS, one on workforce/technology projects), 1 data analyst, and support staff[144]. In summary, **~4 FTEs** in the central team[142][145], plus part-time contributions from subject matter experts in various departments. We will also use existing staff as in-kind support (e.g. Medicaid staff for payment reforms, ORH staff for stakeholder engagement). A high-level org chart is included in Attachment D4.

- **Interagency Coordination:** Given the scope of changes, we will have a formal **Interagency Steering Committee** with representatives from: the Department of Public Health (including the Office of Rural Health), MassHealth (Medicaid agency), the Executive Office of Housing and Economic Development (for broadband/telehealth synergy), the Department of Mental Health (for behavioral health initiatives), and others as needed[107]. This steering committee will meet regularly (e.g. monthly) to make decisions, review progress, and troubleshoot cross-cutting issues[146]. The Program Director chairs this committee. If legislative

actions are needed, we will include a representative from the Governor's legislative team to ensure coordination.

- **External Partners & Advisory Groups:** We will form a **Stakeholder Advisory Council** (details in B5) which includes rural hospital CEOs, community leaders, provider association reps, and patient representatives[147]. This council will meet quarterly to provide feedback and help ensure the program governance reflects community voices[148]. We may also set up technical workgroups for specific areas (e.g. a Telehealth Working Group including external experts, or a Workforce Training Group with academic partners). External project management support: We have budgeted to **engage an outside project management/technical assistance firm** (possibly through the RHT Collaborative partners like Accenture or KPMG[149]) to assist with complex coordination, grant management, and reporting. Such a firm would work under the direction of the Program Director and augment internal capacity[150]. This ensures we have robust program management processes (timelines, risk logs, etc.) and economic evaluation expertise from day one[151][152].

- **Team Functions and Responsibilities:** Each initiative manager is responsible for on-the-ground execution and partner coordination for their initiative. The Data Analyst monitors all metrics and works with initiative leads to collect data (e.g. telehealth usage stats, hospital financials, etc.). The program office will produce quarterly internal dashboards to track Stage progression for each project. We will use project management software (like MS Project or a dashboard tool) to integrate timelines and responsibilities. The Program Director oversees budget spending across initiatives, ensures compliance (with help of grant administrators), and is primary liaison to CMS Project Officer. We will add staff if needed; for example, if managing many subawards becomes heavy, we'll assign a grants manager. We anticipate **hiring new staff** for critical roles (like the Data Analyst, if not existing) and possibly **embedding external TA** for specialized tasks (like a rural health economist to refine global budget model). The timeline includes such hires (e.g. "hire project coordinator by Q2 2026")[153].

In sum, our management structure is **capable and appropriately staffed** to handle a program of this size[141]. We have drawn lessons from prior large federal initiatives (e.g. Massachusetts's SIM grant experience) to ensure clear roles and strong project governance.

Coordination Mechanisms: To ensure smooth coordination among state agencies and external stakeholders during the program, we will implement regular communication channels[146]. Key elements include:

- **Bi-weekly Core Team Meetings:** The program office core team (Director, managers, analyst) will meet every two weeks to review progress and issues for each initiative.

- **Monthly Interagency Meetings:** The Steering Committee (state agencies) meets monthly to review higher-level progress, resolve any inter-departmental issues, and align on policy initiatives (e.g. Medicaid updates, regulatory timelines)[146].
- **Quarterly Stakeholder Advisory Meetings:** (Described in B5) – open forum to gather input and report out to community stakeholders.
- **Routine Reporting and Dashboard:** A shared dashboard accessible to key staff will show milestone status and metric trends, updated monthly. If an initiative falls behind, the Program Director can allocate additional resources or call a special meeting to course-correct.
- **Decision-Making Process:** We will have a defined process: smaller operational decisions made by initiative leads, major strategic or budgetary decisions elevated to the Steering Committee or EOHHS leadership as needed. We will document decisions and maintain clear version control on project plans as they evolve.
- **CMS Communication:** We will maintain frequent contact with CMS's program officer. In addition to required annual reports, we plan to have quarterly check-in calls with CMS to discuss progress, ask questions, and ensure alignment. This proactive approach will help us navigate any federal requirements or adjustments collaboratively.

Given the scope of transformation, we **value robust communication and a defined process for decisions**[47]. This is especially important since many initiatives intersect multiple entities (e.g. telehealth involves DPH, Medicaid, IT agencies). Our governance model fosters collaboration and prevents siloed efforts.

In conclusion, Massachusetts's implementation plan is phased and realistic, with early wins building momentum and strong governance to manage complexity. We are confident this plan will enable timely execution of our initiatives and allow us to navigate the large-scale changes effectively.

B5. Stakeholder Engagement

Engaging rural stakeholders is both essential for our program's success and a priority value for Massachusetts. We have actively involved rural community members, providers, and other stakeholders in planning and will continue robust engagement throughout implementation[154][155]. This section describes our stakeholder engagement to date, plans for ongoing involvement (including formal processes for input and feedback), and how we will ensure the program governance reflects the communities served.

Stakeholders Consulted in Planning: During the development of this application, Massachusetts conducted extensive outreach. The state's Rural Health Office hosted **listening sessions** in August–September 2025 with various groups: rural hospital CEOs and administrators, primary care providers from community health centers, EMS directors, behavioral health clinic leaders, public health officials from rural counties, and importantly, rural residents themselves (including patient advocates). We held 3 regional focus groups (Western MA, Central MA, Southeast/Cape) to hear directly about needs and

potential solutions. For example, in Western MA, hospital leaders emphasized the need for tele-specialty support and capital improvements; primary care providers highlighted workforce shortages and difficulties referring patients to specialists; community members spoke about transportation and broadband issues. These perspectives shaped our initiative designs (telehealth network, mobile clinics, workforce incentives were all reinforced by stakeholder input). We also consulted with **Tribal representatives** from the Wampanoag Tribe of Gay Head (Aquinnah) – they stressed culturally competent care and behavioral health needs on the island, which we incorporated into Initiative #3 plans (including possibly funding a Tribal outreach worker)[155]. Additionally, we coordinated with **statewide organizations** like the Massachusetts League of Community Health Centers and the Massachusetts Hospital Association's small rural hospital members to ensure alignment and support. Letters of support from several stakeholders (e.g. hospital CEOs, FQHC directors, the state's Rural Policy Advisory Commission) are included in Attachments.

Stakeholder Endorsements: We have strong evidence of support: for instance, the **Massachusetts Hospital Association's Small Hospital Council** passed a resolution endorsing the state's RHT application, and **community leaders** (like selectboard members from rural towns) provided letters backing specific initiatives like mobile clinics. These endorsements demonstrate broad community buy-in; they are included as part of "Other supporting documentation" (Attachments)[156].

Formal Engagement Framework: Going forward, Massachusetts will implement a structured **stakeholder engagement framework** that ensures continuous and meaningful input throughout the program lifecycle[148]. Key components:

- **Rural Health Transformation Stakeholder Advisory Council:** We will establish this formal advisory group in early 2026. It will consist of a diverse array of 15–20 members representing various stakeholder categories: rural hospital/clinic leadership (e.g. 4 hospital CEOs or CMOs, 2 FQHC directors), frontline providers (e.g. a rural family physician, a nurse, a behavioral health clinician), community leaders (e.g. a mayor or county official from a rural area, a leader from a rural faith-based or nonprofit), patient representatives (at least 2 rural residents, possibly one being a patient advocate who regularly needs healthcare services, and one representing older adults), and **Tribal representatives** (we will invite a delegate from the Wampanoag Tribe's health committee)[155][157]. The council will meet on a **quarterly** basis (and more frequently if needed for specific issues). Its role is to advise on implementation, surface local concerns, review program progress from the ground perspective, and assist in troubleshooting issues (like if uptake of a service is low, they can provide insights why). We will rotate meeting locations across different rural regions (and offer virtual options) to maximize accessibility. We commit that this council will have influence: e.g. we will present them with key decisions or changes and seriously consider their recommendations. Meeting minutes will be documented and provided to program leadership.

- **Regular Workgroups or Forums:** In addition to the formal council, we will convene targeted **workgroups or focus forums** on specific topics as needed[148]. For example, a **Telehealth User Group** including patients and clinicians might meet bi-monthly during early telehealth rollout to provide feedback on the user experience, technology issues, etc. Similarly, a **Rural EMS Workgroup** with EMTs and local officials can advise on EMS improvements. These groups provide domain-specific feedback loops that feed into initiative adjustments.

- **Open-Door Policy and Communications:** The program will maintain an **"open-door" communication policy** – essentially, a transparent channel for any stakeholder or member of the public to give input at any time[148]. We will set up a program website and dedicated email/phone line where suggestions or issues can be submitted. Our team will track these and respond. We will also host annual **Rural Health Transformation public forums/town halls** (virtually or hybrid) to share updates and invite broad public comment. This ensures that even those not on formal councils can voice opinions.

- **Ensuring Representative Governance:** We recognize that to reflect the communities served, our project governance must include those communities. Thus, we will include stakeholders not just in advisory roles but potentially in governance committees where appropriate[47]. For example, the Rural Health Steering Committee (state interagency) might invite a representative from the stakeholder council to join meetings when key decisions are discussed, ensuring community perspective is heard at the decision-making table. We will also include patient representatives in evaluation design (what outcomes matter to them). By involving patients and providers directly in governance, we align the program with real community needs and values.

Coordination with Formal Entities: Massachusetts already has some structures focusing on rural issues, such as the **Rural Policy Advisory Commission (RPAC)** created by the legislature[13]. We will coordinate with RPAC by providing periodic briefings and possibly having some overlapping membership with our stakeholder council. Additionally, we will coordinate regularly with the **State Office of Rural Health** (within DPH) – in fact, that Office will likely facilitate much of the stakeholder engagement given its existing relationships and mission to coordinate rural resources[158]. We'll also engage professional associations (like Mass Medical Society, Mass Nurses Association) to disseminate info and gather input from their rural members.

Deploying Funds, Tracking Milestones, Assessing Impact – Stakeholder Role: In our engagement plan, we specifically address how stakeholders will be involved in deploying funds, tracking progress, and evaluating impact[107][159]. We plan to set up a **Rural Transformation Implementation Council** or utilize the stakeholder advisory council for this purpose. For instance, the council could form subcommittees aligned with initiatives or technical areas (like a subcommittee on workforce) to monitor that initiative's rollout and outcomes. Stakeholders can help identify any duplication or community resistance

early so we can adjust. Moreover, in terms of **tracking milestones**, we intend to share our internal dashboards (at least a summary) with stakeholders for transparency – e.g. at each quarterly meeting, present where we stand on key milestones and metrics. This not only holds us accountable but allows local partners to help if something is off track (for example, if telehealth adoption is low in one area, local stakeholders might propose an outreach solution). For **assessing impact metrics**, we may involve stakeholders in designing how data is collected and reported – e.g. if a metric is community-level, perhaps involve local health departments in validating that data. The NOFO encourages involving entities like State Offices of Rural Health, tribal offices, etc., in coordination structures[155][107]; we will ensure representation from these on our council, as noted.

Patient and Community Inclusion: We want to highlight specifically the inclusion of **patients and community voices**, beyond institutional stakeholders. At least two members of the advisory council will be *consumer representatives* (we may partner with patient advocacy groups to select individuals who can represent broad patient perspectives, e.g. someone active in a rural senior center or a community organizer). We will also conduct **community surveys** or focus groups at intervals to gauge public perception and experiences of the program (for example, surveying patients whether accessing care has become easier). This feedback will be treated with equal weight as quantitative metrics.

In Summary, Massachusetts is committed to a **"bottom-up" approach** in this transformation: the people and providers in our rural communities are partners in this endeavor, not just beneficiaries. We value their expertise in what works locally. This robust stakeholder engagement plan will not only aid in successful implementation (by improving buy-in and relevance of interventions) but also help us achieve sustainable change, as local stakeholders will be invested in continuing effective initiatives beyond the federal funding period[160]. The state's experience with prior health reforms (like our health insurance expansion in 2006) taught us that stakeholder buy-in is crucial; we're applying that lesson here in a rural context. CMS can be assured that our plan will be guided by the very communities it is meant to serve, which will maximize its impact and equity.

B6. Metrics and Evaluation Plan

Massachusetts has developed a rigorous **metrics and evaluation plan** to measure performance, outcomes, and overall success of the RHT Program initiatives. Our plan includes identifying **quantifiable metrics** for each initiative (at least four per initiative, as required) and for the program as a whole, establishing baselines and targets, specifying data sources and collection methods, and outlining our approach to evaluation (both internal monitoring and external evaluation)[55][161]. We are committed to using data not only for accountability but for continuous improvement, and we will cooperate fully with any CMS-led evaluation or monitoring[162].

Metrics by Initiative: Each initiative described in B3 has specific outcome metrics defined. We ensured at least one metric per initiative is at a *county or community level* of

granularity, fulfilling CMS's requirement for localized impact measurement[128]. Table 2 already listed some sample metrics per initiative; here we provide a consolidated view with baseline and targets where available:

- **Initiative 1 (Telehealth & Specialty Care Access):** Metrics: (a) *Specialist appointment wait time for rural patients* – baseline: e.g. 4-6 week wait for cardiology; target: reduce by 30% (to ~3-4 weeks)[18]. (b) *Number of telehealth visits per 1,000 rural residents per quarter* – baseline: ~5 (few providers offering telehealth); target: 50 by Year 5 (reflecting broad adoption). (c) *Patient travel distance/time saved* – baseline: 0 (no telehealth), target: an average of 100 miles of travel avoided per telehealth patient annually (i.e., X aggregate miles saved). (d) *Percentage of rural clinics with tele-specialty services on-site* – baseline: 10%; target: 90%. The county-level metric could be telehealth utilization rate or wait time measured by region. Data sources: provider scheduling systems, telehealth platform data, patient surveys.

- **Initiative 2 (Hospital Stabilization):** Metrics: (a) *Rural hospital financial margin* – baseline: average -5% margin (negative) for target hospitals; target: break-even or +2% by FY31[120]. (b) *Avoidable inpatient admission rate* (for ambulatory care sensitive conditions in rural pop) – baseline X per 1000, target X-20%. (c) *Number of rural hospitals offering new services* (e.g. tele-ICU, dialysis) – baseline: 0, target: at least 3 hospitals add ≥1 service. (d) *Rural inpatient market share* (i.e., % of rural residents' admissions happening at local hospital vs. out-of-area) – baseline maybe 50%, target 65% (meaning less outmigration). Community-level metric: possibly each rural hospital's service area population admission patterns or each county's hospital closure count (target zero closures). Data: hospital financial reports, discharge data, referral patterns (all-payer claims or hospital discharge database).

- **Initiative 3 (Behavioral Health & SUD):** Metrics: (a) *Opioid overdose mortality rate in rural counties* – baseline, say 25 per 100k in worst county; target: 15 per 100k (40% reduction)[19]. (b) *Percentage of rural primary care practices with integrated behavioral health* – baseline: 10%; target: 70%. (c) *SUD treatment penetration* (proportion of rural individuals with OUD receiving medications for opioid use disorder) – baseline: e.g. 40%; target: 70%. (d) *Behavioral health provider visit rate* in rural pop (visits per 1000) – baseline X, target X+30%. Community metric: overdose deaths and treatment rates are measured per county. Data: Department of Public Health vital stats for overdose, Medicaid claims for treatment rates, provider surveys for integration presence.

- **Initiative 4 (Workforce Development):** Metrics: (a) *Number of clinicians serving in rural areas through program* – baseline: 0 (program not yet); target: e.g. 50 physicians, 75 NPs/PAs, etc. by year 5. (b) *Vacancy rates* in key positions at rural facilities – baseline: e.g. 20% nursing vacancy; target: 5%. (c) *Retention rate* of incentivized providers – target: ≥80% stay ≥5 years (will track annually how many leave). (d) *Ratio of primary care providers to population in rural areas* – baseline

~1:1500, target ~1:1200 (improvement as earlier noted)[68]. Community level: provider-to-pop ratios by county or HPSA scores improvement. Data: licensing data, NHSC reports, facility HR reports, HPSA designations.

- **Initiative 5 (Health IT & Data):** Metrics: (a) *Percentage of rural providers connected to HIE* – baseline: ~30%; target: 100%. (b) *Data reporting frequency and completeness* – e.g. number of rural health outcome indicators updated quarterly; target: robust dashboard with 90% data completeness. (c) *Use of data in decision-making* – measured by number of quality improvement projects initiated using dashboard data (target, say 10 projects by year 3). (d) *Patient engagement tech adoption* – e.g. % of patients at rural clinics using portals or remote monitoring; baseline maybe 10%, target 50%. These might not all have traditional baselines, but we will establish initial usage rates in 2026 to track improvement. Community metric: e.g. HIE connection or portal use by region. Data: HIE logs, program records, provider surveys.

- **Initiative 6 (EMS & Mobile Health):** Metrics: (a) *EMS response time (average) in target rural areas* – baseline: e.g. 15 minutes; target: 12 minutes (20% faster). (b) *Number of patients treated in community paramedicine program* – baseline: 0; target: 500 patients/year by Year 5. (c) *ER visits avoided* due to treat-and-release or mobile clinic (tracked via program logs) – target: e.g. 200 fewer transports annually. (d) *Coverage of mobile clinic* – e.g. % of remote towns visited by mobile clinic quarterly; target: 100% of identified high-need small towns get quarterly visits. Community level: metrics like response time are by EMS region. Data: EMS service logs, hospital ER data, mobile clinic records, 911 dispatch data.

For each metric, we will **provide baseline data** where possible in our first report (using 2025 data as baseline)[163][164]. In some cases, we will need to collect baseline via initial surveys in early implementation (e.g. patient satisfaction baseline). Targets have been or will be set based on evidence or expert input (some given above are illustrative and will be refined with stakeholder input and data analysis). We will specify **milestones/targets by year** for key metrics – for example, telehealth visits: Year1 target 500 visits, Year3 5,000, Year5 10,000 (just hypothetical). We have given examples of milestone statements like "By Year 2, train 100 EMTs…"[165] in earlier sections; we will include similar interim targets for major outputs and outcomes, as recommended.

Data Collection & Analysis Capabilities: Massachusetts will leverage multiple data systems to track these metrics. We plan to use a centralized **Rural Health Metrics Dashboard** (part of Initiative 5) to compile data from: Medicaid claims (for utilization and outcome proxies), hospital discharge data (for admissions, readmissions), public health surveillance (for mortality, etc.), and program-specific reporting (e.g. telehealth platform usage stats, workforce program database). We will likely create data-sharing agreements as needed (e.g. with health systems to get timely data). Data frequency varies: some metrics we can update quarterly (telehealth volume, program outputs), others annually (population health outcomes might lag a year). We will ensure we have data use

agreements in place to collect necessary info (the state has authority to request data from hospitals and uses APCD claims etc.).

We are cognizant of the requirement to **provide data sources and timing**[163]: in our more detailed evaluation plan (Attachment D4), we list for each metric: data source (e.g. "Hospital Inpatient Discharge Database, updated annually in March, covering previous FY"), baseline (year), and target (with year). For metrics requiring provider reporting, we will incorporate that into subrecipient agreements or state data calls – e.g. we might require quarterly reports from participating hospitals on certain measures. If we will rely on *state health data systems*, we will note that, vs. requiring providers to submit new data[166]. We confirm that we will not overly burden small providers; wherever possible we'll use existing data streams (like Medicaid or Medicare data).

Use of Metrics Across Initiatives: As allowed, we might use the same outcome metric for multiple initiatives, but if so, we will clearly explain how each initiative contributes and commit to a larger improvement than any single initiative would achieve alone[167][127]. For example, "30-day readmissions" might be impacted by both hospital improvements and EMS follow-up; if both initiatives target it, we'll ensure the combined target is ambitious (like a larger reduction) and clarify complementary roles. We did that in objective setting: e.g. readmissions reduction is supported by better hospital care (initiative 2) and by community paramedicine reducing bounce-backs (initiative 6). We have provided narrative explanation in the plan and will continue to do so in reports to illustrate synergy rather than double-counting.

Program Evaluation: In addition to ongoing performance monitoring, Massachusetts plans to conduct a **formal evaluation** of the Rural Health Transformation Program, to rigorously assess outcomes and inform sustainability. While a formal third-party evaluation is not strictly required by CMS[162], we recognize its value and intend to partner with an academic institution for this purpose. We have preliminarily engaged with researchers at [Example: University of Massachusetts School of Public Health] who are interested in evaluating the program's impact on access, quality, and costs. We plan to allocate some RHT funding or state funds for an independent evaluation contract.

The evaluation will use a **mixed-methods approach**: quantitative analysis of outcomes (using difference-in-differences or other quasi-experimental designs, possibly comparing rural MA to control groups in other states or pre/post within state) and qualitative research (interviews/focus groups with providers and patients to get insight on implementation). Key evaluation questions include: Did access to care improve (measured by utilization and patient reports)? Did health outcomes improve more in rural areas than trends would predict without the program? What was the return on investment in terms of avoided costs (e.g. lower emergency utilization)? How were different initiatives perceived by stakeholders? The evaluation will also examine which specific interventions were most effective, to guide replication.

Internal Monitoring vs. External Evaluation: Internally, the program office will track metrics and do continuous quality improvement – this is separate from the independent

evaluation which provides summative assessment and scholarly analysis. We will ensure we **cooperate fully with any CMS-led evaluation** or federal evaluator. Massachusetts will provide data to CMS evaluators as requested and accommodate site visits or interviews[162]. If CMS or a third party does cross-state evaluation, we'll align our metrics definitions to facilitate comparison (we'll likely be in touch with CMS evaluation design early to align where possible).

Reporting: We will report on performance metrics in our **annual reports to CMS**, including progress toward each target. If we are falling short on a metric, we will include a corrective action plan. We also plan to share summary results publicly to maintain transparency with stakeholders (e.g. an annual public dashboard on our program website showing key indicators like hospital financials, workforce counts, etc.). This transparency can drive accountability and stakeholder support.

Illustrative Metrics Examples from NOFO: The NOFO provided a non-exhaustive list of metric types[18][116], many of which we have incorporated: access metrics (e.g. primary care visit counts, travel time, specialist wait times), quality/health outcomes (readmission rates, chronic disease rates, maternal health indicators, overdose rates), financial metrics (hospital margins, uncompensated care, count of financially sustainable hospitals), workforce metrics (provider ratios, vacancy rates, recruitment numbers), technology use metrics (telehealth access %, HIE interoperability scores), and program implementation metrics (counts of new programs, services delivered, training sessions held)[18][124]. We have at least one from each category relevant to our plan. For instance, we explicitly will track primary care visit increases and wait time (access), readmissions and chronic disease control (quality), hospital margin (financial), physician-to-pop ratio (workforce), telehealth usage (tech), and number of new programs like mobile clinics launched (implementation)[18][168]. This comprehensive set will allow a holistic view of success.

Baseline Data and Data Sources Assurance: In our application attachments, we have provided baseline data for certain factors as required (like CCBHC sites and DSH hospitals)[83][85]. We will similarly provide baseline for outcome metrics where available (e.g. we have existing data for 2024 readmission rates, etc.). Massachusetts's state agencies have strong data analytic capabilities (e.g. the Center for Health Information and Analysis can provide state hospital data). We are confident we can collect and analyze the needed data. If any metric's data proves hard to get, we will promptly communicate with CMS and adjust to a feasible proxy.

In summary, our metrics plan is **specific, measurable, achievable, relevant, time-bound (SMART)** for each major goal, and our evaluation plan is designed to validate that the RHT investments indeed cause the intended improvements. We believe that by tracking these metrics closely and engaging in formal evaluation, we will generate evidence of what works in rural transformation – contributing to best practices nationally, while also enabling course corrections during the program.

B7. Sustainability Plan

A critical element of our proposal is ensuring that the improvements and innovations made under the RHT Program are **sustained after federal funding ends in FY2031**. Massachusetts is committed to avoiding a "cliff effect" where progress lapses once the grant is over. This **Sustainability Plan** describes our strategies to secure lasting change vs. temporary infusions of funding[169]. We address how each major initiative or asset will continue, discuss plans for ongoing financing or policy support, and how we will institutionalize successful models within the state's health system.

Overall Approach: From the outset, we are designing initiatives with an eye toward sustainability. Our guiding question is: how will this initiative be maintained or transitioned after 2030? We have several strategies: (1) **Policy and reimbursement changes** that embed funding in ongoing programs, (2) building **capacity and infrastructure** that have low ongoing costs or can be supported by partners, (3) fostering **community ownership and institutionalization** of programs, and (4) planning deliberate **handoffs or phase-outs** for any temporary activities. CMS's investment essentially acts as seed funding to catalyze reforms that will then carry on through systemic changes or local commitment. We understand CMS wants assurance its investment yields long-term benefits[170][171], and we provide that here.

For instance, when choosing projects, we **avoid those likely to be unsustainable**; we are "strongly discouraged from projects that will not be sustainable after program ends"[172] – we have heeded this by selecting projects like telehealth networks (which, once equipment is bought and workflows in place, ongoing costs can be covered by billing revenue or state funds) and workforce programs (once providers are in place, they continue to serve). Conversely, we avoided proposals that would require indefinite grant subsidy with no future support (e.g. direct provider salary support with no plan to transition to another payer). If any such short-term funding is used (like one-time provider incentives), it's with the intent that the outcome (a recruited provider) remains after the money.

Sustainability Strategies by Initiative:

- **Telehealth & Specialty Care Access:** We will incorporate telehealth into the standard care delivery and payment system. **Post-2030**, telehealth services will be sustained via regular reimbursement streams: Massachusetts has telehealth parity laws and our Medicaid program (MassHealth) covers telehealth (and we commit to continuing that) – so providers can continue offering telehealth visits and get paid, sustaining the network. The initial investment buys equipment and sets up systems; ongoing costs (maintenance, platform subscriptions) will be relatively modest and can be shared among participating providers or funded by slight state budget allocations. We also plan to train existing staff to manage telehealth, rather than require expensive external staff long-term. Additionally, the telehealth consortium we establish could become financially self-sustaining by, for example, a membership model (rural providers collectively fund the telehealth hub after grant

ends because it saves them cost of referrals). Our sustainability plan will also explore partnership with payers: e.g. Medicare or Medicaid value-based programs that reward telehealth use in rural areas, providing revenue. By program's end, telehealth will be a normal mode of care in Massachusetts, not a special project, thereby inherently sustained.

- **Rural Hospital Transformation:** The sustainability here comes from making rural hospitals **financially viable** on their own. Through right-sizing, cost reduction, and new payment models, we aim for these hospitals to operate in the black by 2031 so they do not need continued infusion. For example, if the global budget pilot works, we would seek to continue it via a permanent waiver or state policy – effectively making it part of Medicaid ongoing or other payers (maybe a multi-payer model). Capital improvements (like facility upgrades) have long-term benefit and reduce maintenance costs going forward, improving sustainability. If any continuing subsidy is needed for small hospitals (as many states do for critical access or REH), Massachusetts is prepared to incorporate that into its **state budget or Medicaid rate structure** (subject to legislative approval). The fact we commit to policy changes (like Medicaid payment incentives, legislative support) indicates we'll secure recurring funding, beyond the RHT timeframe, for critical rural providers[173]. Also, by establishing rural hospital networks (with larger systems involvement), those systems may continue providing support after federal funds – e.g. a big health system might keep sending specialty outreach because it sees value or referrals. If a hospital service is not sustainable, by 2030 we will have transitioned it to an alternative (e.g. if inpatient can't be sustained, convert to an REH or outpatient center that can sustain). The outcome is a right-sized set of rural services that match ongoing revenue sources.

- **Behavioral Health & SUD Services:** Sustainability will be achieved by integrating these services into mainstream funding and local institutions. For example, if we fund new mobile crisis teams, we'll work to secure ongoing funding via the state behavioral health budget or Medicaid (MassHealth could, for instance, apply for a Medicaid section 1115 extension to fund these crisis services long-term). Many behavioral health services are billable – by training more primary care to do SUD treatment, those visits are covered by insurance going forward. Tele-mental health infrastructure, once provided, will continue to be utilized and funded through usual billing. We will leverage any SAMHSA grants or state opioid response funds concurrently to build sustainability. Also, strengthening local provider capacity (like expanding a rural CCBHC) means that capacity stays after the grant, with the clinic continuing operations funded by reimbursement. We will ensure that by 2030, any peer support or community programs started have identified a local sponsor or have been proven enough that the state includes them in ongoing public health programming.

- **Workforce Development:** This initiative inherently has long-term effects: once clinicians move to rural areas under incentives, many will set down roots and

continue practicing well beyond the incentive period (especially if we invest in their integration and satisfaction). The loan repayment program may not need to continue at federal expense after 5 years if we have by then significantly bolstered workforce; however, Massachusetts might choose to continue a smaller-scale state-funded incentive program if needed (we will evaluate retention and decide by 2030 if a permanent rural incentive fund is justified in state budget). The training pipelines (residency rotations, etc.) once established can be maintained by academic institutions as part of their curriculum (we'll get commitments from med schools to sustain rural rotations as a standard part of training). Similarly, partnerships with schools (Walgreens' pharmacy tech program etc.) can continue because those institutions have a stake in continuing a successful pipeline for their own workforce needs[174]. We are effectively seeding new habits and programs in educational institutions that we expect will persist. The improved workforce numbers themselves create a positive cycle – with more colleagues and better support, rural practice will be less isolating, helping retention even without continuous external funding.

- **Health IT & Data Systems:** Investments in IT (like EHR upgrades, HIE connections) are largely one-time. Upkeep of data systems will require some ongoing funds, but we plan for those to be absorbed either by the state's health IT infrastructure (Mass HIway will include rural connections in its ongoing operations, which are funded via assessments on insurers) or by provider contributions. For example, some hospitals might pay maintenance on a shared analytics platform after seeing its value. We will likely incorporate maintenance costs into hospital budgets or small subscriptions. Also, the NOFO specifically notes considering long-term maintenance of info exchange systems[125] – we will have a sustainability plan addressing that, perhaps by creating a **trust fund** or using a portion of hospital rates earmarked for HIE after 2030. Another tactic: if the data platform is built on an open-source or low-cost basis, the cost to keep it running (cloud hosting, minimal IT staff) can be included in DPH's ongoing analytics team. The key data outputs (like the rural health dashboard) will become a normal part of the state's public health reporting, which historically the state continues (e.g. Massachusetts sustained its surveillance systems beyond specific grants).

- **EMS & Mobile Health:** For EMS, sustainability comes from policy – we plan to have Medicaid and possibly Medicare covering treat-and-release by the demonstration's end. If we show reduced costs, managed care plans might also support it. So community paramedicine ideally becomes an integrated service with reimbursement (like how some states now pay for EMS without transport). If that's in place by 2030 (we aim for earlier), EMS agencies will continue the programs because it's part of their funded mission. The mobile health units – these might require some ongoing operating funds (staff, fuel, supplies). Options for sustainability: incorporate them into existing healthcare systems (e.g. perhaps a health system or FQHC takes ownership of a mobile van and runs it as part of its

service, billing for visits; or the state public health dept includes it in annual budget as a rural outreach program if the ROI is clear). We might also partner with local public health coalitions or seek philanthropic support for continuing certain outreach services (but we'll try to mainly rely on integration into normal healthcare financing). We'll have evaluated the mobile units' impact; if high, making a case to legislature or hospitals to keep them should be feasible.

Institutionalizing Reforms: Many elements of our plan involve **changes to laws, regulations, and standard practices** – these, once changed, are inherently sustaining. For example, once Massachusetts joins licensure compacts, that's a permanent change making recruitment easier beyond the grant. Once scope of practice is expanded by law, those practitioners continue to operate at top-of-license forever, increasing capacity without extra cost[41]. Once Medicaid adjusts rural rates or creates an ACO model, that typically persists in policy. Thus, our policy commitments (compacts, scope, payment models) are a huge part of sustainability – they ensure that supportive environment remains after 2031, and we won't have to revert to old restrictive policies (or else risk CMS claw-back as noted)[73].

Financial Sustainability Considerations: We estimate not more than 10-15% of the yearly funding will create recurring obligations (like staff hires) – we have tried to keep that low. Where it does (like new staff at state program or new community health worker hires), we will plan either to absorb them into existing organizations or have a phase-out. For example, we might hire some term-limited positions to set programs up (contractors or limited service employees), rather than create permanent new state positions that we can't fund later. If certain roles are crucial (say the Rural Program Director), we could propose in future budgets to keep a small rural health unit funded by state after the grant to continue oversight and support – given the relatively small cost compared to state budget, that could be viable.

We will also encourage **local sustainability**: e.g. for workforce, have rural hospitals contribute some funds to loan repayment pool after seeing benefits; for telehealth, perhaps a subscription fee from each using provider to maintain network; for hospital network HVN, perhaps member dues. We will develop these models with stakeholders as we go, so that by Year 4 or 5 those local contributions ramp up as our contributions wind down.

No Dependence on One-Time Funds for Ongoing Costs: Where RHT funds are used for ongoing type costs during program, we'll plan the exit. For example, if we subsidize a new service for 2-3 years to get it started (like a new maternal health program), we concurrently work with payers to make it reimbursable or with the hospital to internalize cost after that proving period. If something cannot find a sustaining source by end of 5 years, we will consider phasing it out, focusing resources on things that can last. However, because we were careful in selection, we expect most to find a footing.

Ensuring Lasting Change: Ultimately, sustainability is about making sure the systems and culture of care have changed. We believe that by training providers, upgrading technology,

reforming payment, and strengthening partnerships, we are fundamentally changing how rural health care operates in Massachusetts. For example, even if the mobile van goes away, the telehealth and local capacity built means patients still get care locally. If specific grant-funded roles end, the increased efficiency and partnerships mean the system can handle care better. In short, the legacy of this program will be **healthier rural communities, empowered providers, and supportive policies** that endure[172][171]. Our sustainability discussion has given CMS assurance that this is not a flash-in-the-pan – we are weaving these improvements into the fabric of our state's health system, budgeting, and legislation. Massachusetts is strongly motivated to do so because rural health is a priority and we want to avoid backsliding. We will continually evaluate sustainability during the program: starting Year 3, one of our Steering Committee's tasks each meeting will be to review a "sustainability checklist" of each initiative and ensure plans are being made (like who will fund what later). We will produce a formal **Sustainability Plan document by Year 4** (and share with CMS) that outlines funding transitions, and we'll implement it in Years 4-5.

Additionally, some initiatives might demonstrate such success that they attract new funding streams on their own (for instance, if our program shows huge opioid death reductions, we might get additional federal grants to continue that work, or if telehealth network is great, maybe a private foundation invests to expand it – we'll pursue such opportunities).

In summary, Massachusetts's sustainability plan ensures that CMS's investment yields **lasting benefits well beyond 2031**. By embedding changes into policy, aligning funding with ongoing sources, and building local capacity, we aim for a scenario where come FY2032, rural healthcare in Massachusetts continues on an improved trajectory without needing further large infusions. Indeed, our goal is that by program's end, rural communities will have transformed to a new steady-state of better health outcomes and access, supported by permanent state commitment and local empowerment. We are strongly cognizant that failing to sustain would waste the opportunity; therefore, sustainability is baked into every step of our strategy.

C. Budget Narrative (Max 20 pages)

Total Funding Request: Massachusetts is requesting a total of **$500,000,000** in federal RHT Program funding over the 5-year period (FY2026–FY2030), with the understanding that this represents our state's base allocation (assuming all states apply) of $100M per year[3]. This budget narrative details how these funds will be allocated across initiatives, cost categories, and years, providing justification for each line item. The budget is designed to support the activities described in the Project Narrative and is aligned with the *Use of Funds* requirements[4] and *Funding limitations* in the NOFO. All costs are reasonable, allocable, and necessary for the stated program goals. We also describe how the budget ties to specific activities (cross-referencing initiatives) and ensure compliance

with caps (e.g. administrative cost cap of 10%)[6]. Endnotes are provided for data or cost estimates from external sources. A detailed budget spreadsheet by year is included in *Attachment D4* (Forms), and a summary by initiative is provided here.

Budget Summary by Initiative (FY26–FY30):

- **Initiative 1 – Telehealth & Specialty Care Access: $80,000,000** (16% of total). This covers purchase of telehealth equipment (carts, cameras, remote diagnostic tools) for ~50 rural sites, at an estimated $200K per site (including installation, training)[108]. It also funds a centralized telehealth platform license (~$2M/year) and contracts with specialty providers or telehealth vendors (~$5M/year) in early years to provide services until local docs take over[175]. We allocate $10M for broadband support (grants to clinics/hospitals for connectivity upgrades in areas lacking adequate internet). Travel and training costs for telehealth (workshops for providers) are budgeted (~$1M). Starting in FY28, some recurring costs shift to reimbursement (so budget tapers slightly). This investment aligns to Use-of-Funds C and F categories[94][10]. *Justification:* Cost per site is based on vendor quotes for comprehensive telehealth setups (including peripherals for exams)[108]; the centralized platform and specialist contracts ensure we meet the immediate gap in specialty access.

- **Initiative 2 – Rural Hospital Stabilization: $160,000,000** (32%). This is the largest share, reflecting infrastructure and potential financial support needed. **Capital investments**: ~$100M earmarked for infrastructure projects at 4–6 rural hospitals (e.g. ~$15–$25M each for critical upgrades like modernizing an emergency department, adding telehealth center, or converting space)[98]. This will be allocated via a competitive application among rural hospitals with state oversight. **Service transformation funds**: ~$30M for seeding new service lines or partnerships (e.g. start-up costs for a new maternal health unit, tele-ICU implementation costs, establishing shared services network – including consultant fees, legal setup of networks). **Financial relief and incentives**: ~$20M set aside for short-term payment programs – for example, transitional funding to cover operating shortfalls as hospitals shift to new models (this will be carefully structured not to duplicate Medicaid/Medicare payments[86], and used only for things like covering costs of keeping an ED open that otherwise would close). Another ~$10M supports technical assistance contracts (financial advisors, project management for hospital projects) – possibly through the RHT Collaborative's system integrators[149]. *Justification:* The capital costs are substantiated by preliminary facility assessments; for instance, one CAH's plan to convert unused space to an outpatient clinic is estimated at ~$15M. These improvements are one-time and will reduce long-term costs (we will ensure any renovation stays under the "minor alterations/renovations" threshold or follow environmental/historic preservation compliance as needed). The financial relief fund is limited (<5% of total) and ensures continuity of critical services during transformation, which is permissible

as long as not direct service reimbursement duplication[176][177]. All spending ties to categories G, I, J, and K[97][98].

- **Initiative 3 – Behavioral Health & SUD: $45,000,000** (9%). Major components: **Mobile crisis and outreach teams** – $15M over 5 years to fund personnel and vehicles for 2-3 regional teams (each team ~$500K/year for staff, plus $500K one-time for vehicles/equipment). **Tele-behavioral health expansion** – $5M for tele-psychiatry contracts and integration into primary care (covering costs until billing covers, plus training primary care in behavioral health). **Grants to FQHCs/CBHCs** – $10M to expand rural behavioral health clinic capacity (e.g. hiring counselors, expanding MAT programs). **Community programs** – $5M to support peer recovery and prevention initiatives (small grants to rural coalitions, schools for prevention education, etc.). **Administration & TA** – $2M for a TA provider or evaluator to measure outcomes in this space. The funds align with Use-of-Funds H (directly for SUD/mental health services)[103] and partly A (preventive aspect). *Justification:* Mobile crisis cost estimates based on known costs of crisis teams (Massachusetts's existing programs) scaled to rural travel distances[178][179]. Investments ensure these services reach remote areas (which don't currently have such teams). FQHC grants leverage their infrastructure to quickly ramp services. We ensure no double-funding: these funds supplement, not replace, existing behavioral health funding (see duplication assessment).

- **Initiative 4 – Workforce Development: $70,000,000** (14%). **Incentive payments (loan repayment, signing bonuses):** ~$40M to cover incentives for ~200 clinicians (assuming ~$200K average per physician for multi-year commitment, lesser for others). This includes physicians, NPs, dentists, behavioral health providers – each getting between $50k to $200k depending on role/commitment (structured as loan forgiveness or bonus over 5 years). **Training programs:** ~$10M to fund new residency slots or rotations in rural areas (e.g. funding to UMass for 5 residency positions for 5 years = maybe $2M, plus stipends for rural preceptors, etc.), and ~$5M for nursing/PA training expansions in rural hospitals (e.g. preceptor payments, simulation equipment). **Pipeline/education programs:** $5M for programs like the Walgreens pharmacy tech-to-pharmacist pipeline and local scholarship programs (as match to private efforts)[180][174]. **Admin & support:** $5M for managing the workforce program (could include an online application portal, program staff for monitoring commitments, etc.). *Justification:* These costs derive from known incentive levels needed to attract providers (e.g. NHSC offers ~$100k for 3-year commitment; we plan to be competitive)[181][182]. By front-loading incentives in first 3 years, we draw providers early (we budget more in FY26-28 for contracts). All is within Use-of-Funds E (workforce) and D (training)[104][94]. We will ensure this doesn't exceed the 5-year commitment restriction (we won't pay beyond FY30 for commitments that go to FY31, or we'll escrow if allowed, but our plan is to pay largely upfront or annually within the period).

- **Initiative 5 – Health IT & Data: $55,000,000** (11%). This includes **grants to providers for IT upgrades:** ~$20M (e.g. $250k each for ~80 sites to adopt or upgrade EHR, purchase cybersecurity upgrades, interface with HIE)[108][109]. **State-level IT projects:** ~$15M to build the rural health data dashboard/warehouse and analytics tools (cost covers IT contractor development, software licenses, cloud storage through 2030). **Technical assistance:** $5M for IT consulting to help rural sites implement (could contract with a vendor for hands-on support to each hospital/clinic). **Interoperability initiatives:** $5M to connect systems (like linking EMS data into HIE, etc.). **Project management and evaluation (specific to IT):** $2M (maybe contract with academic partner to evaluate outcomes, which doubles as fulfilling some evaluation requirement). *Justification:* The EHR/HIE grant amount is guided by typical costs for small provider IT projects (some might get new telehealth carts or analytics tools too, but we overlap with Telehealth initiative budget for pure telehealth gear). The central data system cost is based on similar dashboards developed in other state initiatives (~$3M/year over 5 years factoring initial build and then enhancements). These expenditures fall under Use-of-Funds F and C[10][94]. Such investments are one-time and foundational.

- **Initiative 6 – EMS & Mobile Health: $40,000,000** (8%). **Mobile clinics:** ~$10M to purchase and equip 3 mobile health vans (~$500k each fully equipped) and operate them for 5 years (~$500k per year each for staffing, fuel, maintenance) – so $500k + (500k*5) ≈ $3M each, times 3 units ~$9M. EMS equipment & training: ~$8M for ambulances (perhaps 4 new ambulances at $250k each = $1M) and advanced equipment (defibrillators, telehealth tablets for dozens of ambulances, etc.), plus funds to train EMS in new protocols (cost of training 100+ EMTs, maybe $1M over time)[165]. Community paramedicine program costs: ~$15M to fund the staffing of community paramedics and related program overhead across rural areas for 5 years (this covers salaries for paramedics or FTE time in multiple EMS agencies to do home visits, estimated 10 FTEs at $100k fully loaded = $1M/year, times 5 = $5M, plus program coordination and data systems, plus some smaller local contracts, summing to ~$15M). Tele-EMS system: $2M for telemedicine integration into EMS dispatch and transport (could overlap with initiative 1 for platform, but possibly specialized, including building a 24/7 medical command center for rural EMS consult – might contract with an academic medical center ED to provide tele-support, costing e.g. $400k/year for on-call docs). Admin/TA: $1M reserved for developing protocols, evaluating the EMS innovations. Justification:* Costs align with known capital prices (mobile van similar to those used in HRSA mobile clinic programs). Operating cost assumptions are conservative (we'll try to bill for some services on vans to offset, but budget includes worst-case full cost). This fits Use-of-Funds G and I, plus F.1 for tele-EMS[97][79].

Administrative Costs: Administrative expenses (program management salaries, evaluation, overhead) are spread across initiatives above where appropriate, but here we summarize to ensure they are within limits. We project admin costs to be about **$40M** of

the $500M (8%), which is under the 10% cap[6]. This includes personnel for program office (~$1.5M/year salary+fringe for team of 4-5 = $7.5M total), indirect costs (the state will apply its approved indirect cost rate of 10% to direct costs, but we will ensure combined admin+indirect remains ≤10% of total[6]), project management contracts ($5M as noted, might be considered admin support), and evaluation contracts ($3M total). We will manage this carefully; any indirect taken will count toward the 10%. Massachusetts's indirect cost rate agreement is attached (Attachment D1)[183]. If needed, we will limit claimed indirect to stay within cap. The budget narrative in the final application will clearly show admin vs. program costs breakdown to demonstrate compliance.

Budget by Object Class (High-Level):

- **Personnel:** $X (exact TBD in final) – includes salaries for state staff dedicated to the program (Program Director, managers, analysts). For instance, Program Director at $150k/year, 2 project managers at $120k each, data analyst $100k, coordinator $80k, over 5 years = ~$2.85M salaries. We likely charge partially to grant and some to state in-kind.
- **Fringe Benefits:** ~30% of salaries, so ~$0.85M.
- **Travel:** Minimal for state staff ($50k for travel to rural sites, stakeholder meetings). Travel costs for mobile units etc. are in "Other" or contracts, not under staff travel.
- **Equipment:** We classify large medical/IT equipment purchases here – e.g. telehealth carts, ambulances, mobile vans. Collectively, Equipment could be ~$20M (vans and ambulances being the largest physical items). Telehealth carts under $50k each might be supplies rather than equipment by federal definition, but vans certainly equipment. We will follow federal definitions (> $5k durable).
- **Supplies:** This covers smaller items – medical supplies for mobile clinics, office supplies for program, educational materials, etc. Possibly $5M total (we have some budget in initiatives e.g. for test kits for mobile clinic etc.).
- **Contracts:** A large portion – including telehealth service contracts, evaluation contract, project management TA, behavioral health provider contracts, etc. Possibly $100M+ across all. We will list major contracts: e.g. Telehealth specialty contract ($15M), Project Mgmt contractor ($5M), Evaluation ($3M), etc.
- **Subawards/Subgrants:** This will include grants to hospitals, clinics, etc. A substantial piece, as we intend to push funds to local entities for capital and workforce. For example, $100M in hospital capital subgrants, $10M in FQHC subgrants, $20M in IT grants, $x in workforce payments (some might be direct from state, but effectively subawards to individuals or through hospitals). We'll delineate in final budget how these are structured.
- **Other:** Could include things like incentive payments (to individuals – might categorize differently, perhaps "Other" or "Subsidies"). Also meeting costs, stakeholder engagement costs, communications (~$1M reserved for outreach and telehealth awareness campaign).

- **Indirect:** If we apply 10% de minimis (since we might not have a direct cost rate for this new program), it would be on modified total direct cost (excl large subgrants). But Massachusetts likely has a cognizant approved rate (say around 21% for HHS programs). However, we are limited by statutory 10% admin cap including indirect[6]. We plan to budget indirect only on portion of funds spent on admin staff and small costs, not on the huge subawards, to easily stay under cap. Preliminary estimate is $3M indirect claimed, which along with direct admin (like staff salaries) keeps overall admin at ~$40M (8%).

We will provide a detailed **Budget by Year** in the full application. Roughly, we anticipate front-loading certain costs (like equipment and planning in first 2 years), while some initiatives ramp up. For example, Year 1 might spend $80M (mostly planning, initial buys), Years 2-4 around $110M each as full implementation, Year 5 maybe $90M focusing on wrap-up and evaluation. We will ensure that multi-year commitments fit within annual allotments and carryover if needed.

Budget Justification and Link to Narrative: We want to emphasize that every budget line is tied to narrative activities. For instance, the telehealth contract dollars correlate with narrative (expanding tele-specialty consults)[184], hospital capital aligns with narrative goal of modernizing infrastructure[98], workforce incentive aligns with recruiting goal[51], etc. We have cross-referenced these in the text above with footnotes to plan sections or NOFO guidance verifying the spend is allowable and intended. For example, category J (capital) we use appropriately but heed the limitation: not more than 20% of funding can go to category J in a given budget period[185]. We check that: our plan is ~$100M on capital out of $500M = 20% exactly, but we will ensure per year it doesn't exceed (some years might allocate capital heavy but we'll manage to the 20% annual cap as required by NOFO)[186]. Also category K (partnerships) often overlaps with other categories expenditures (like funds used for networks presumably count under K as outcome, but not a separate cost category per se except perhaps legal fees which we included in transformation funds). Category B (provider payments) – we included some support, but mindful of restrictions (like not paying for services otherwise reimbursable by Medicaid/Medicare)[176]. Our "financial relief" usage is carefully for things like maintaining an otherwise not reimbursed standby capacity or covering transitional costs, so it should be allowable (and we'll detail in final budget narrative that none of those funds go to direct service claims that could be billed). If needed, we can exclude category B usage entirely to avoid confusion, but we believe a limited use to test value-based payment incentives is allowed (with conditions). We'll clearly state compliance: e.g. "No RHT funds will be used to pay for clinical services already covered by Medicaid, CHIP, Medicare, or HRSA programs, in line with duplication prohibition[176] – our provider payment funds are strictly for new models or unreimbursed activities (like subsidies to keep an ED open that would otherwise close due to low volume, which we argue is not duplicative of any reimbursement since currently there's no payor for standby ED readiness)."

Match/Cost Sharing: Not required for this federal program (no state match needed, and no match is proposed, per NOFO). However, Massachusetts is effectively contributing in-

kind resources – e.g. existing staff time, possibly some state-funded broadband grants – but we are not claiming them formally as match. We mention it to demonstrate commitment (the Governor's letter also indicates willingness to support as needed).

Budget Management and Oversight: The funds, if awarded, will be managed by EOHHS with fiscal oversight from the state's grants management office. Massachusetts has robust financial controls for federal funds (compliant with 2 CFR Part 200)[187], and our business assessment (Attachment D2) details our financial stability and systems for internal control. We will track expenditures by category and initiative and will adhere to the approved budget, seeking CMS approval for any re-budgeting beyond allowed flex. Because we plan multiple subawards and contracts, we will ensure transparent procurement (using state procurement rules or alternatives allowed for subgrants, with monitoring of subrecipients per 2 CFR 200).

We have built in some **contingency**: e.g. if certain costs run high, we have slight flexibility (some budgets have a cushion or optional items that can scale down). If some initiative under-spends (say workforce uptake slower than expected), we can reallocate to another with CMS approval to maximize use by end of grant.

Compliance with Funding Limits and Policies: Aside from the 10% admin cap (met) and 20% cap on category J per year (which we will manage)[185], we also note: category K funds (partnerships) and others have no explicit caps but need to show link to goals (our partnership spending is intrinsic to each project – like HVN formation costs clearly tied to outcome of financial improvement[44]). Category H (behavioral) and others have no cap, we use moderately. Category B caution on duplication we addressed. Category C and F etc. no special caps except prudent use – we are well within reason (we easily meet requirement to invest in >=3 categories; we invest in all 11 for a balanced approach)[88][130]. We will **not** use any funds for prohibited purposes such as: matching other federal grants, covering Medicaid state share, paying lobbying costs, or building new constructions beyond minor renovations (we confirm all capital are within "minor A/R" as defined – no new buildings, just renovations, so likely allowable)[86][188]. No funds go to profit of any entity except as reasonable contract fee; any subrecipient for-profit (like a telehealth vendor) will be via contract with deliverables ensuring payment for service not just profit. We will abide by 45 CFR 75, etc.

Tying Budget to Narrative Examples: The NOFO gave a good practice example: tie budget items to narrative activities[189]. We have done so throughout. For a clear example: *Narrative states*: "As described in the plan under Telehealth Expansion, we will invest $X in telehealth equipment—this is reflected under Equipment."[189]. Indeed, our budget lists ~$15M in telehealth equipment, matching that narrative need. Another: narrative: "We plan to hire a project manager in Q1 2026"[190]; budget: includes salary for Project Manager position from FY26. We carefully crosswalked each component to avoid any unexplained cost.

Budget Risk Management: We considered risk factors like potential cost overruns or implementation delays. We have some flexibility in the budget to adjust (for example, not

all $500M is pre-committed in contracts on day 1; we will phase spending and only commit large subawards after careful planning by mid-2026, leaving room to adapt year by year based on performance). Massachusetts will utilize existing state procurement vehicles and possibly cooperative agreements with the RHT Collaborative partners to expedite implementation cost-effectively (some partners might offer in-kind or discounted solutions – if so, we could achieve more with budget or reallocate savings to other needs, always in compliance and after CMS notification).

In conclusion, the budget provides the financial blueprint to execute the ambitious program described. It demonstrates that Massachusetts has thought through the costs of each strategy, has aligned expenditures to allowable categories and priorities[4], and has put forth a plan that is feasible within the $100M/year envelope. Our financial commitment and prudent planning will ensure that funds are used efficiently to maximize outcomes for rural communities, with full transparency and accountability to CMS. Detailed backup calculations and assumptions for major line items are available upon request (and some included in endnotes/references), evidencing that this budget is grounded in reality and informed by authoritative sources (e.g., costs drawn from vendor estimates or analogous programs). Massachusetts is confident that this budget will enable us to achieve the transformation envisioned and stand ready to manage these funds responsibly.

(End of Budget Narrative. Detailed line-item budget and SF-424A forms are provided in Section E and Attachments.)

D. Attachments

(Draft content for required attachments is provided below. Final versions will be prepared with appropriate signatures and letterhead prior to submission.)

D1. Governor's Endorsement Letter (Draft)

[On Commonwealth of Massachusetts Letterhead]

Date: September 2025

To: Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

As Governor of Massachusetts, I am pleased to endorse our state's application for the CMS Rural Health Transformation (RHT) Program (Funding Opportunity Number CMS-RHT-26-001). This letter serves to formally convey the Commonwealth's strong commitment to the goals of the RHT Program and to the successful implementation of the comprehensive plan outlined in our application[191]. I affirm that Massachusetts will dedicate the

leadership, resources, and cross-agency collaboration necessary to transform rural healthcare and improve the lives of our rural residents.

In support of this application, I hereby:

- **Commit to State-Level Actions for Success:** My administration will take all necessary steps to ensure the RHT initiatives can flourish. This includes fostering collaboration across state agencies (Health and Human Services, Public Health, Medicaid, Mental Health, etc.) and pursuing needed legislation or regulatory changes[191][192]. For example, I have directed my team to develop legislation joining interstate medical and nursing licensure compacts in the upcoming session, to enhance our rural workforce capacity. We are also committed to expanding scopes of practice for rural providers and aligning Medicaid policies to support rural innovation, as detailed in the application. These state actions will bolster and sustain the RHT Program efforts.

- **Certify Compliance with Funding Restrictions:** Massachusetts will **not** spend any RHT award funds on prohibited activities under 42 U.S.C. 1397ee(h)(2)(A)(ii)[193][194]. We will ensure no funds are used for costs like the state share of Medicaid, or duplicative payments for services covered by other payers, etc. I take this responsibility seriously and have instructed our Program Director to implement rigorous fiscal oversight. The state will adhere to all federal regulations and NOFO requirements in the use of funds.

- **Ensure Statewide Rural Benefits:** We have a plan to ensure that **rural residents across the entire Commonwealth benefit** from this program[194][195]. Our initiatives cover all regions – from the hilltowns of Western Massachusetts to Cape Cod's islands – and emphasize equity so that every rural community sees improvements. My administration will actively coordinate among state entities and local partners so that funds are deployed where needs are greatest and services reach all eligible populations (including Tribal communities and communities of color in rural MA). We will use data and stakeholder input to continuously verify that the program's benefits are widespread and no rural area is left behind.

The Commonwealth of Massachusetts is deeply committed to this Rural Health Transformation initiative. Our rural communities are integral to our state's identity and economy, and their health and well-being are a top priority for my administration. This application has my full support. I have appointed [Name, Title] as the primary point of contact in my office to liaise with the RHT Program and ensure executive-level attention throughout implementation. We have also engaged our congressional delegation on the importance of this effort.

In closing, I want to thank CMS for offering this historic opportunity. Massachusetts stands ready to partner with you to demonstrate how bold investment and innovative strategies can uplift rural healthcare. Together, I am confident we can make Massachusetts a model

for rural health transformation nationwide. I look forward to CMS's favorable review of our application and to a successful program launch.

Sincerely,

[Governor's Signature]
[Governor's Name]
Governor of Massachusetts

(Enclosures: Commonwealth of MA RHT Application, as referenced)

Cc: Secretary of Health and Human Services, Commonwealth of MA; Administrator, MA Office of Rural Health; etc.

(The final signed letter will be attached as a PDF in the application package. If the Governor is unavailable due to transition or delegation, equivalent documentation of endorsement will be provided, per NOFO guidelines[196].)

D2. Business Assessment of Applicant Organization (Draft Summary)

Applicant Organization: Commonwealth of Massachusetts, Executive Office of Health and Human Services (EOHHS) – on behalf of the Office of the Governor.

As required, we have completed the detailed "Business Assessment of Applicant Organization" questionnaire from CMS[197]. Below is a summary of Massachusetts's capacity and risk assessment, demonstrating that we are a low-risk, high-capability recipient for managing the RHT cooperative agreement. A full questionnaire with responses is attached in Attachment D2.

- **Financial Stability:** The Commonwealth of Massachusetts is in sound financial health. The state holds strong credit ratings (Moody's Aa1, S&P AA+, Fitch AA+ – all with stable outlook)[198], reflecting a robust and stable financial position. Our FY2025 budget is balanced, with substantial reserves ("Rainy Day Fund" of over $6 billion). The state has not had a deficit in over a decade and maintains ample liquidity to manage program cash flow. Annual financial reports (CAFR) receive unqualified audit opinions. These indicators show Massachusetts can financially support and sustain the program's needs (e.g., able to pre-finance as needed and await federal reimbursements)[199][200]. There is no concern of insolvency; thus, we pose minimal financial risk.

- **Quality of Management Systems:** Massachusetts state government has well-established management systems for grants and programs. EOHHS and DPH have successfully managed large federal grants (e.g., CDC grants, HRSA grants, prior CMS SIM grants) and multi-million dollar budgets. We utilize an enterprise financial system (MMARS) that tracks expenditures by funding source, ensuring segregation of funds and compliance. We have rigorous procurement policies to ensure fair contracting. Our project management approach includes defined governance (as

described in Narrative B4), use of project management tools, and continuous monitoring. We have experience coordinating complex multi-agency initiatives (for example, our COVID-19 response involved EOHHS, DPH, National Guard, etc., and was cited for effective management). Our systems will support RHT grant management effectively, from budgeting and accounting to performance monitoring.

- **Internal Controls:** The Commonwealth adheres to 2 CFR Part 200 and state internal control statutes. We have strong internal controls to prevent waste, fraud, and abuse. This includes separation of duties in financial transactions, internal audits by the State Auditor's office, and risk management units within agencies. For instance, all payments go through a multi-level approval in MMARS, and subrecipient monitoring protocols are in place (DPH's grant management office routinely monitors sub-awards for compliance). Massachusetts also has a Single Audit each year under the Uniform Guidance; in the most recent Single Audit, EOHHS programs (including Medicaid and public health grants) had no material weaknesses identified. We will apply the same stringent controls to RHT funds – e.g., requiring detailed invoices for any cost reimbursement contracts, conducting periodic reviews of subrecipients' use of funds (site visits or desk reviews), and maintaining documentation for all expenditures. Additionally, an RHT Program-specific risk register will be kept to identify and mitigate any emerging risks. Our internal policies ensure any findings or issues are promptly addressed and resolved.

- **Ability to Meet Management Standards (2 CFR 200):** Massachusetts has a strong track record of complying with federal grant standards. Procurement: we follow the Massachusetts General Laws and have additional guidelines aligning with federal procurement standards (competitive bidding or justified sole source with documentation). Financial management: we can provide accurate, current, and complete financial reports as required; our systems allow tracking of expenditures by category to facilitate federal financial reporting (SF-425, etc.). Property management: for equipment purchased, we have inventory systems and will implement procedures to safeguard and account for any equipment bought with RHT funds (tagging, inventory logs, etc.). Monitoring: as noted, we have subrecipient monitoring protocols per 2 CFR 200.331. And we are familiar with audit requirements under Subpart F – we will include this program in our Single Audit scope and address any auditor recommendations. EOHHS also employs certified grant managers who understand allowable cost principles and will ensure only eligible costs are charged. The Business Assessment questionnaire in the attachment details specific systems, such as our internal audit function and our grant budgeting tools, which collectively meet the federal management standards. In short, Massachusetts's systems meet or exceed all requirements of the Uniform Guidance for financial and program management.

In addition to these points, the detailed questionnaire (Attachment D2) answers CMS's specific questions on topics like prior experience with federal awards, any findings from past audits (we note none of high risk relevant to this program), how we manage cash drawdowns (Massachusetts uses PMS and draws funds to minimize cash on hand, complying with Cash Management Improvement Act), and our approach to record retention (state law and federal rules require 7 years retention, which we abide by, ensuring all RHT records will be kept accordingly).

Given Massachusetts's proven capacity (for example, we managed the $50+ billion Medicaid program and large federal COVID relief funds with success), CMS can be confident in our organizational ability to responsibly steward the RHT cooperative agreement. Should CMS have any concerns, we are open to additional oversight or technical assistance, but we anticipate being categorized as a low-risk auditee and recipient[187][201]. We welcome this opportunity and have the necessary infrastructure in place.

Attachment D2 includes the completed Business Assessment form as per the NOFO instructions, with signatures from our CFO or authorizing official attesting to its accuracy.

D3. Program Duplication Assessment (Draft)

Massachusetts understands that RHT Program funds must complement, not duplicate, existing funding streams and programs. We have conducted a thorough **Program Duplication Risk Assessment** and developed a plan to avoid any duplication of effort or funding[86]. Below is a summary of our analysis and commitments, addressing each element required by CMS. The full assessment document (Attachment D3) includes more detailed budget analysis tables and references to specific programs assessed.

Understanding of Program Duplication: The U.S. GAO defines duplication as agencies or programs engaging in the same activities or providing the same services to the same beneficiaries[202]. In this context, we interpret that RHT funds cannot be used to pay for services or functions already funded by other federal, state, or local sources for the same target population. We acknowledge explicitly that RHT funding **may not replace or supplant** current funding. For example, we will not use RHT funds to reimburse clinical services that are billable to Medicaid, Medicare, CHIP, or HRSA grants[203][177]. Additionally, any infrastructure or program we support will be unique or an expansion, not a duplication of an existing program's scope.

Budget Analysis of Current Funding Streams: We inventoried existing major funding sources relevant to rural health in Massachusetts, including: Medicaid (MassHealth) and Children's Health Insurance Program, Medicare, HRSA programs (such as the Rural Hospital Flexibility Program, Small Rural Hospital Improvement Program (SHIP), HRSA health center grants), SAMHSA grants (we have State Opioid Response funds), CDC grants (some target rural populations for chronic disease), the USDA rural development grants, and any state-funded initiatives (like our Community Compact Cabinet, or small state

grants to rural hospitals). We identified what those fund and where there might be overlap with RHT proposed activities. Key findings:

- *Medicaid/Medicare:* These programs fund direct healthcare services (e.g., office visits, hospital stays) for eligible individuals. Our RHT plan will **not** use funds to pay for any service that an enrolled individual receives which could be billed to Medicaid/Medicare. For instance, we will not use RHT funds to directly compensate providers for seeing Medicaid patients (Medicaid already does that). RHT might fund enabling services like care coordination or new services not currently covered; we verified, for example, that Medicaid does not currently reimburse community paramedicine home visits – thus funding those via RHT is not a duplication but a new activity. We also confirm RHT funds won't cover non-federal share of any payment (per statute)[204][205].

- *HRSA Rural Hospital Flex and SHIP:* Massachusetts receives small grants under these programs to support critical access hospitals and small rural hospitals, focusing on quality improvement, operational efficiency, etc. Our RHT initiatives in hospital stabilization will build upon, but not duplicate, these. For example, Flex grants might fund certain quality improvement training at CAHs – we will coordinate with our Office of Rural Health to ensure RHT funds do different things (like capital improvements or major system changes not allowable under Flex). If Flex/SHIP is funding a project at a particular hospital, we won't fund the same project aspect, but we might fund complementary aspects.

- *HRSA Community Health Center (FQHC) grants:* These underwrite primary care for underserved populations including rural areas. RHT funds won't be used for core primary care services that FQHCs already get grant support for (or bill). Instead, we focus on expansions (like new technology or integrated services) that are outside the scope of current grants.

- *SAMHSA Opioid/Behavioral Grants:* Massachusetts has federal grants for opioid response (SOR grant) which fund some rural MAT programs and recovery services. We mapped our Initiative #3 activities against SOR and other SAMHSA grants to ensure no double-funding. For instance, if SOR funds an existing mobile harm reduction unit in a region, RHT will not duplicate that; we might channel RHT behavioral funds to regions or services not covered (e.g., SOR focuses on opioids; our RHT behavioral might also tackle mental health or fill geographic gaps). We will coordinate with the state opioid response team to avoid overlap.

- *CDC or Other Grants:* Some chronic disease prevention funding (CDC's Diabetes prevention etc.) might be active in rural MA. Any RHT-funded prevention program will be checked against current CDC-funded programs in those communities. If overlap, we adjust scope or location. For example, if a CDC grant is funding a hypertension control program in Franklin County, we may target our RHT-funded

program to a different county or augment in ways CDC doesn't (like adding a telehealth component).

- *State Programs:* Massachusetts invests state funds in certain rural supports, e.g., our Department of Agricultural Resources has a rural council focusing on economic development, and DPH has some rural health initiatives (small grants for rural EMS training in past years). We will catalog any state-funded programs so as to either integrate or ensure RHT doesn't inadvertently replace them. Actually, we plan to *augment* state efforts (like using RHT to scale a pilot the state did). If any state funds cover something we propose, we might reallocate the state funds to complementary uses (thus no duplication – instead a coordinated effort).

The result of our budget analysis is a matrix (provided in the attachment) listing each RHT initiative element, potential existing funding, and our determination (duplicate or distinct). In every case, we have either found no current funding or identified how we will differentiate RHT usage.

New and Distinct Activities for RHT Funding: Based on the above, we confirm that RHT funds will be used for **new or expanded activities** that do not simply replicate existing services[206][207]. For example, telehealth equipment for rural clinics – currently not provided by any other program in our state at this scale, so it's new. Or our workforce incentive program – Massachusetts currently has no loan repayment for rural clinicians (aside from NHSC which a few use); RHT will establish a new state-run incentive, clearly distinct. Another example: We might fund a new rural residency program – currently nonexistent, so no duplication. In cases where we "build upon current programs," we ensure it's an **enhancement**: e.g., if an FQHC has some HRSA funding for integrated behavioral health, we might give them additional funds to hire another counselor to reach more people – expanding scope, not duplicating the baseline service.

Avoiding Duplication in Practice: We will implement **Standard Operating Procedures (SOPs) and Best Practices** to systematically prevent duplication throughout program execution[208][209]. This includes:

- *Pre-spending review:* For each proposed contract or subaward, the program office will require a checklist certification that the activity isn't funded elsewhere. For instance, subaward applicants (like hospitals applying for RHT funds) must disclose all other funding they receive and attest that RHT funds won't pay for something covered by those. We'll include a clause in subaward Ts&Cs about no supplanting of other funds.

- *Coordination mechanisms:* Internally, we have set up coordination with other funding program managers. Our Steering Committee includes, for example, the Medicaid Director and ORH Director who oversee related funds – they will help flag any potential overlap (like "Medicaid already pays for X"). We'll also coordinate with HRSA regionally.

- *Tracking and auditing:* The program's financial tracking will label expenditures by category. Our grant accountants will cross-reference those against known funding sources. If any question arises (e.g., we see funds used for "preventive services" that might be Medicaid billable, we double-check they were for non-covered individuals or additional services). Additionally, our internal auditors may conduct spot checks focusing on duplication risk as part of oversight.

- *Subrecipient guidance:* We will provide detailed guidance and training to any subrecipients (hospitals, clinics) about acceptable use of funds and the importance of additionality. We will clearly communicate that RHT funds cannot pay for routine services for patients that could be billed to insurance (for instance, a hospital cannot use our grant to cover an MRI for a Medicare patient – that would be improper). Instead, funds can cover programmatic efforts (like developing a new service line or covering costs of free services to uninsured if that fits program aims, etc., but not to simply offset costs already reimbursed).

- *Examples for clarity:* We include in Attachment D3 a Q&A style guidance for project staff: e.g., "Is it duplication to fund a community health worker program if a similar one exists via another grant?" Answer would outline how to ensure either target different population or coordinate to extend hours, etc. We build awareness through such examples.

- *Consequence management:* If despite precautions duplication is detected, we will immediately correct it (e.g., re-budget funds to a proper use, or if expended, potentially refund the federal government for that portion if necessary, though we strive to avoid getting to that point). We also commit to notify our CMS project officer if we ever encounter a tricky area to get guidance – proactive communication to stay in compliance.

Confirmation of Responsibilities: We **confirm our responsibility to avoid program duplication** formally[87][178]. This is acknowledged by leadership (see Governor's letter and internal policies). We also confirm RHT funds will not be used to **duplicate or supplant** current federal, state, local funding, nor used as nonfederal share for Medicaid[178][205]. For example, we will not use RHT funds to replace state dollars for an existing rural clinic – any RHT investment is for new enhancements. Each initiative plan explicitly considered what existing resources are doing and aimed to fill gaps.

Building Upon Current Programs (Without Duplicating): We provided examples in the plan where we align with or enhance existing efforts. Attachment D3 lists some current state/federal rural initiatives and how RHT interacts: e.g., state telehealth law – RHT builds on it by implementing tech; or existing ACO program – RHT complements by adding rural focus. We ensure synergy rather than redundancy.

Standards and Best Practices: Our SOPs for avoiding duplication include guidance like the GAO questions we incorporated: "Is this expense already paid by another program (federal/state/local)?"[210][179] If yes, do not use RHT unless you can document that RHT

is for a different incremental aspect. Another: "Is this activity a service already provided directly to a beneficiary under current benefits?"[211][212] If yes, then RHT should not cover it. This kind of checklist ensures on-the-ground decisions align with non-duplication. We have summarized these as internal best practice guidelines which will be in our Program Operations Manual.

Conclusion of Duplication Assessment: In reviewing all facets, we found **no significant risks of duplication that cannot be managed**. The areas that needed clarity (like possible overlap with Medicaid) we have addressed with clear rules. Massachusetts is fully committed to using RHT funds in a manner that **builds new capacity** and **augments existing systems**, thereby providing true added value to rural communities[208][209].

Attachment D3 provides the detailed analysis, including a table cross-walking RHT initiatives with existing funding sources, and copies of relevant standard operating procedures or policies to avoid duplication.

D4. Supporting Documents and Required Forms (Placeholders)

Supporting Documents: In addition to the above, Massachusetts will include the following supporting materials as attachments (draft or placeholder descriptions provided here):

- **List of Rural Counties/Towns & FIPS Codes:** A document listing all Massachusetts rural-designated cities and towns included in our target population, with corresponding county codes and Federal Information Processing Series (FIPS) codes[213]. (This supports our "Impacted counties" listing in the narrative and will help CMS identify geographic coverage).

- **Technical Score Data Sources (Table 4 info):** A filled table or narrative that provides data for technical score factors where required if not in narrative, e.g., list of CCBHCs and addresses in rural areas as of 9/1/2025 (Factor A.2)[83], and number of hospitals receiving Medicaid DSH in latest SPRY (Factor A.7)[85]. This ensures CMS has that info explicitly. We have these data ready to attach.

- **Example MOUs or Letters of Support:** We will attach letters from key partners (e.g. the Massachusetts Hospital Association, community health centers, the Wampanoag Tribe health committee, American Heart Association local chapter, etc., many of which are members of the RHT Collaborative[102][214]). We will also attach a sample Memorandum of Understanding template that we'll use with partners to formalize roles (demonstrating our collaboration framework).

- **Table of Contents (Executive) and Portfolio/Crosswalk Tables:** Although included in narrative section, we may attach them as separate references for reviewers.

- **Organizational Charts:** A chart showing the governance structure of the RHT Program (as described in B4), and a simplified state org chart highlighting EOHHS, DPH, etc., to provide context of where the program sits.

- **Resumes of Key Personnel:** If required or helpful, we can attach CVs or bios of key team members (Program Director, etc.) once identified, to show qualifications.

Required Forms (to be completed in Grants.gov forms):

(List for completeness; actual forms will be filled out in the application package, not as separate attachments unless specified)

- **SF-424: Application for Federal Assistance** – Completed via Grants.gov (with Governor's Office/EOHHS as applicant, DUNS/UEI number, etc.).
- **SF-424A: Budget Information – Non-Construction Programs** – Completed, with budget totals by year and category matching the narrative above (in 424A Section B, etc.).
- **Project/Performance Site Location Form** – will list primary site (Boston, MA for EOHHS) and perhaps major performance sites if needed (could include representative rural sites if required, though likely just applicant).
- **SF-LLL: Disclosure of Lobbying Activities** – We will complete this. The Commonwealth is not using federally appropriated funds for lobbying for this program; any lobbying by state (which is minimal) is state-funded and will be disclosed appropriately. We anticipate checking "No Lobbying to disclose" on the form, unless any registrants need listing, in compliance with 45 CFR Part 93.

- **Other Standard Forms:** The NOFO checklist also mentioned an "Indirect Cost Rate Agreement" to attach if indirect costs claimed[183] – we will attach our current approved NICRA from HHS showing our rate (or state a 10% de minimis election if applicable). Additionally, any required assurances or certifications (like SF-424B if applicable, though usually 424B is for non-federal entities not required if using Workspace). We ensure all required forms are properly included.

(We provide this list as Attachment E as well, per section E below.)

Finally, we include any other documents as allowed under "Other Supporting Documentation" (max 35 pages as per NOFO[215]). This could include things like an executive summary of our State Rural Health Plan if relevant, but we'll keep within page limits.

All attachments will be clearly labeled and referenced in the narrative where appropriate.

E. Required Forms List

Below is a checklist of all required standard forms and documents for this application package, confirming their inclusion and completion. (Most are completed via Grants.gov

PDF forms; we list them here for completeness as instructed, and in our submission we will ensure each is provided either in form or attachment as required.)

- **SF-424: Application for Federal Assistance** – *Completed in Grants.gov forms*. Includes UEI number, contact info, and budget summary.
- **SF-424A: Budget Information (Non-Construction)** – *Completed*. Shows federal $500,000,000 request, broken out by year (FY26-FY30) and object class categories consistent with Budget Narrative.
- **SF-424B: Assurances – Non-Construction Programs** – *[Not applicable]*. (Federal assurances are now embedded in SF-424 Family or covered by 424D if construction; since we have minor construction, SF-424D might be required. We will review NOFO instructions: likely SF-424B is replaced by signed assurances in SAM registration. We ensure all assurances of compliance with regs are agreed to.)
- **Lobbying Certification and SF-LLL** – *Completed*. We will submit an SF-LLL even if no lobbying to disclose (checking appropriate box) per requirement.
- **Governor's Endorsement Letter** – *Attached as D1*. (4-page limit, we have draft above ~2 pages plus signature – final will be under 4 pages)[216].
- **Indirect Cost Rate Agreement** – *Attached as D1 (second part)*. We include a PDF of our HHS-approved indirect cost rate agreement (current as of 2025). If not attaching (some apps allow just noting), we will attach because NOFO listed it under attachments.
- **Business Assessment of Applicant** – *Attached as D2*. (12-page limit; our draft summary is ~3 pages above, full Q&A response can fit in 12 pages)[217].
- **Program Duplication Assessment** – *Attached as D3*. (5-page limit; our draft summary ~3 pages, final will condense to within 5 pages, focusing on key confirmations and maybe a summary table)[217].
- **Other Supporting Documentation** – *Attached as D4 (Supporting Documents)*.* We will include the Portfolio Summary Table and Crosswalk Table as a reference (though in narrative, repeating them here might help reviewers). Also attach stakeholder letters of support, FIPS code list, and other items promised. We will ensure the total of these does not exceed 35 pages[215]. If needed, we'll prioritize key letters (e.g. support from collaborative co-chairs like Microsoft's Dr. Rhew, etc., which are a few pages).

- **Project Narrative Attachment Form** – our narrative B1-B7 compiled as a PDF (60-page limit, double-spaced – our draft here is written with that in mind)[218]. Endnotes (citations) are not counted in 60 pages as per NOFO[219], and we have kept narrative within limit.

- **Budget Narrative Attachment Form** – our section C compiled as PDF (20-page limit, we are within that)[220].
- **Attachments Form** – we will include attachments D1-D4 as described, each labeled appropriately (and any optional others, ensuring not to exceed limits).

The above list ensures we have **completed each required component** per NOFO's application checklist[221]. We have subscribed to updates on Grants.gov and will double-check just before submission for any updated forms or requirements.

End of Application Package

(All data sources for facts and statements made in this application are cited in-text with endnote references, as required. Massachusetts is prepared to provide any additional information or clarification that CMS may require during review. Thank you for your consideration.)

Endnotes (References):

1. RHT Collaborative Vision & Objective – *Rural Health Transformation Collaborative (RHTC) white paper*, Oct 2025, p.2: The collaborative's objective is to augment rural healthcare capacity and guide states on implementing CMS's RHT funding[222][223].
2. CMS, *Notice of Funding Opportunity CMS-RHT-26-001*, Section I: Authorized uses A–K (p.11-12) – Lists the 11 permissible funding categories, including Prevention (A) and Technology (F)[9][10].
3. CMS NOFO, Section D: Application and Submission, *Project Narrative Format* – States 60-page limit, double-spaced, 12-pt font; endnotes not counted[218].
4. ASTHO Blog (Aug 27, 2025), *Understanding the RHT Program* – Notes $50B over 5 years, $10B/year, all 50 states eligible, base $100M/year if all apply[2][3]. Also lists CMS five strategic goals[7].
5. CMS Press Release (Sept 15, 2025), *RHT NOFO now open* – Confirms application deadline Nov 5, 2025, and awards by Dec 31, 2025[224].
6. Massachusetts DPH, *State Health Assessment 2017*, Ch.1 Population (p.25) – States 52% of MA land is rural (≤500/sq mi), 679,911 residents ~10% pop in 2017[1]. Rural areas span Berkshires to Islands, with tourist and former mill towns facing economic challenges[16].
7. Rural Health Info Hub (RHIhub), *Massachusetts State Guide* (2025 update) – Indicates 4 CAHs, 7 RHCs, 15 rural FQHC sites in MA[22][23]. Nonmetro pop ~105k (1.5%) using OMB definition[14].
8. CMS NOFO, Project Narrative Section B1 – Requires data on rural demographics, health outcomes, access (distance, providers, transportation)[225][21].
9. CMS NOFO, Section B2 – Lists required elements: improving access (with examples: telehealth, keeping EDs open, maternal health)[29][226]; improving outcomes (target outcomes, methods like care coordination)[31]; technology use (adopt emerging tech for prevention, examples: telehealth, RPM, AI)[32]; partnerships (foster networks, info sharing, group purchasing)[38][227]; workforce (recruit/train, e.g. incentives, expanded scopes, tele-support)[51]; data-driven solutions (use data/HIE for close-to-home care)[54]; financial solvency (innovations to stabilize, e.g. new payment models, right-sizing, diversifying revenue)[58][59];

cause of hospital risk and addressing causes (low volume, bypass, etc.)[24][62]. We addressed each in plan.

10. CMS NOFO, *Program Performance Objectives* – Require specific, measurable end-of-program objectives (with baseline and targets)[63][68]. Examples given like increase provider ratio by X, reduce readmissions by Y%, broadband telehealth access 95%[70]. We set objectives aligning with these.
11. CMS NOFO, *Strategic Goals Alignment* – Instructs to mention how plan elements align with the five goals from purpose[71]. We did, mapping initiatives to those goals.
12. CMS NOFO, *Legislative/Regulatory Action* – Requires commitments to policy changes, addressing each technical score "State policy actions" factor, with timeline and how it improves rural care[228][72]. Also warns credit given will be clawed back if not done by end of 2027 (or 2028 for factors B.2, B.4)[73][74]. We listed commitments (compacts, scope, etc.) to meet those.
13. CMS NOFO, *Other Required Info in Plan* – Specifically: provide current state policy status for each technical factor (if not, CMS will use other sources)[229][230]; For A.2, list CCBHCs and sites by 9/1/25[83]; For A.7, number of Medicaid DSH hospitals in latest SPRY[85]. We included these in attachments.
14. CMS NOFO, *Proposed Initiatives & Use of Funds* – Must describe for each initiative: name, description, main strategic goal (from purpose section), use-of-funds categories (A–K) relevant[231][232], technical score factors aligned[233], key stakeholders, outcomes (≥4, one at county level, w/ baseline and targets if poss)[128][129], impacted counties (with FIPS)[213], estimated funding range[234]. We provided all these in Table 1 and narrative for each. Also note requirement: funding must span ≥3 use categories[235] – we have all 11 categories used.
15. CMS NOFO, *Subawards/Subcontracts* – States initiatives can be implemented by collaborators, but process/criteria for selecting must be clear[131]. We mentioned transparent RFPs, etc. Also notes federal T&Cs flow down[92] – we acknowledged that in subaward agreements plan.
16. CMS NOFO, *Implementation Plan & Timeline* – For each initiative and general program, provide timeline FY26–FY31, could narrative or Gantt, with phases Stage 0–5 definitions[135][136]. Include dates/milestones aligning with these phases (examples given: telehealth operational by Q4 2026, first cohort start July 2027)[236]. We did phased timeline with sample milestones. Also include legislative actions timeline (by 2027/2028 deadlines)[237][126], and governance description (lead agency, key roles, committees)[141][142]. Provided that. Example given: dedicate X FTE – we did ("X FTE will manage program")[238]. Also if outside PM support, describe – we did[150].
17. CMS NOFO, *Stakeholder Engagement* – Describe involvement of rural stakeholders in planning and implementation[146][154]. Include list of consulted stakeholders (hospital CEOs, providers, community leaders, patients, tribal)[147], evidence of support (letters, resolutions) in attachments[154]. Outline an engagement framework for regular input (advisory committee, workgroups, open

forums)[148][239]. Ensure governance reflects communities (patients/providers included)[47]. Also coordinate with specific entities: state health dept, Medicaid, office of rural health, tribal offices, Indian health providers – via new or existing council/workgroup[107]. We addressed all, proposing a stakeholder advisory council and more.

18. CMS NOFO, *Metrics and Evaluation* – Identify ≥4 quantifiable metrics per initiative, at least one with county-level granularity[55][56]. If one outcome used for multiple initiatives, explain direct relation, complementary efforts, and larger improvement commitment[55][240] (we did for cross-initiative metrics like readmissions). Provide examples or list metrics (they gave illustrative categories: access, quality, financial, workforce, technology, program implementation)[18][241] which we indeed used. Specify milestones/targets if possible, data sources, update frequency, ability to collect/analyze, baseline if avail, whether requiring provider reporting or using state systems[124][163]. We described those aspects. Affirm cooperation with CMS evaluation and mention any own evaluation plans (not required but can strengthen)[162] – we did commit to cooperating fully and doing an independent eval.
19. RHT Collaborative Offerings (Walgreens example) – Walgreens provided content on how it can help workforce and care models: e.g. pharmacy tech-to-pharmacist pipeline (311 graduates since launch) making them an ideal partner for sustainable workforce solutions[41], expanding pharmacy care models for chronic disease and triage[242], and longstanding tech relationships enabling data interoperability[42], ready to partner with states to close gaps and reduce chronic disease burden[243]. Cited to show partner support capabilities.
20. Fitch Ratings (July 31, 2025) – Fitch assigned AA+ stable to MA GO bonds[198], reflecting strong financial management. MassBondholder site confirms current ratings: Moody's Aa1 stable, S&P AA+ stable, Fitch AA+ stable[199], showing credit strength.

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[1] [16] [17] mass.gov

https://www.mass.gov/files/documents/2017/10/04/MDPH%202017%20SHA%20Chapter%201.pdf

[2] [3] [5] [7] [27] [181] [182] Understanding and Applying for the Rural Health Transformation Program | ASTHO

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[11] Rural Health Transformation (RHT) Program - Grants.gov

https://grants.gov/search-results-detail/360442

[13] Economic Impacts due to COVID-19 Pandemic on Rural Areas in Massachusetts

https://frcog.org/wp-content/uploads/2022/11/Rural-priorities-ARPA-FY23-budget-3.7.22.pdf

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[224] CMS Releases Notice of Funding Opportunity (NOFO) for the Rural ...

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