

Request for Applications

Maryland Health Care Commission

Rural Health Transformation Program

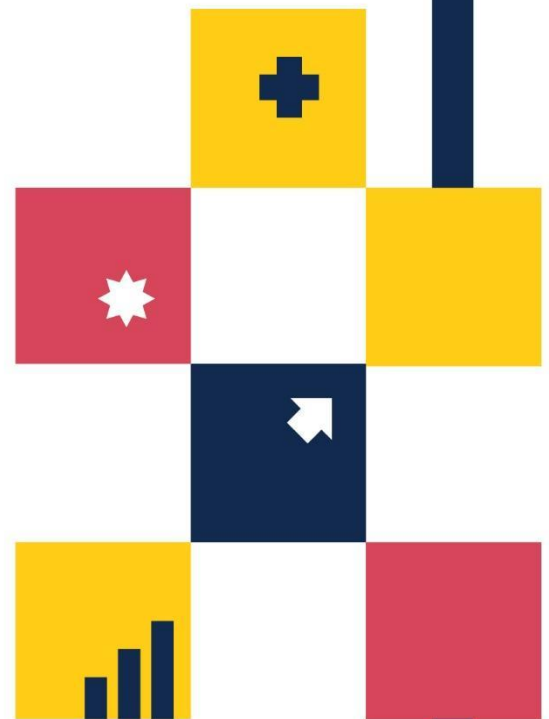
*Grant Funding to Expand Access to
Primary Care in Rural Maryland*

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Funding Announcement

The Maryland Health Care Commission (MHCC) is seeking applications from eligible organizations to participate in a Grant Program (or Program) designed to support the development and expansion of advanced primary care practices (or practices) within designated rural areas of Maryland.¹ This grant funding opportunity is provided under the [Maryland Rural Health Transformation Program](#) (RHTP)² and will provide infrastructure and resources to help practices build capacity to strengthen access to high-quality, whole-person care with a focus on prioritizing preventive care services, enhancing chronic disease management, and reducing avoidable hospitalization. Eligible organizations include existing or newly established primary care practices, Federally Qualified Health Centers (FQHCs), and organizations such as employers or local governments willing to sponsor an advanced primary care practice.

This one-year Program will allocate approximately \$6.3 million made available via the Maryland RHTP's cooperative agreement with the Centers for Medicare & Medicaid Services (CMS) with priority given to applicants that demonstrate readiness to establish or expand primary care services in underserved rural communities. The MHCC has proposed a Program start date of August 1, 2026. Additional grants beyond the first year may be available contingent on Program performance and available funding. The RHTP is a federal initiative administered by CMS. CMS provides oversight and funding to state agencies who are responsible for local implementation. The Maryland Department of Health (MDH) has delegated funding to MHCC for this Grant Program. The MHCC will provide Program oversight to awardees in accordance with CMS and MDH requirements.

Award amounts may vary based on need and scope of the proposed project, with a maximum of \$1.6 million for a single award. Grant funding can be used to strengthen personnel, technology, and operational capacity needed to start up or expand primary care in rural communities. The Program will assist rural communities that face provider shortages, delayed diagnoses, and higher burdens of chronic disease, and will ultimately strengthen Maryland's rural primary care infrastructure. The Program will support entry into and advancement in programs under the [Achieving Healthcare Efficiency through Accountable Design \(AHEAD\) Model](#), including Primary Care AHEAD (PC AHEAD), Maryland Primary Care Program AHEAD (MDPCP-AHEAD), and Maryland Medicaid Advanced

¹ Advanced primary care is a practice that shifts the focus of primary care toward quality. Advanced primary care practices offer care that is person and family-centered, relationship-based, accessible, comprehensive, team-based, integrated, and coordinated. Adapted from: Pacific Business Group on Health. *Advanced Primary Care: Defining a Shared Standard*. Published June 2020. Revised April 2022. Accessed April 30, 2026. <https://www.pbgh.org/wp-content/uploads/2022/04/advanced-primary-care-shared-standard.pdf>

² The Maryland RHTP is part of the federal RHTP framework established by the Centers for Medicare & Medicaid Services. More information is available at: <https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview>

Primary Care Program, as well as Accountable Care Organization (ACO) programs, such as the Medicare Shared Savings Program and Long-term Enhanced ACO Design (ACO LEAD).

Awardees will be encouraged to use appropriate billing codes for services related to Advanced Primary Care Management (APCM), Collaborative Care Model (CoCM), Behavioral Health Integration (BHI), Community Health Integration (CHI), and Principal Illness Navigation (PIN) to support care delivery and long-term financial viability (see Appendix A). The billing codes associated with these services enable practices to deliver comprehensive care management, simplify billing and documentation requirements, and provide patients with a broad range of services through monthly bundled billing (see Appendix B for more information). By focusing on initial start-up infrastructure costs through the Grant Program, practices will be prepared to bill for services to achieve long-term sustainability, ensuring Maryland residents in participating rural communities continue to have access to high-quality care.

Grant Period: August 1, 2026 – September 30, 2027 (anticipated)

One-time awards will be made before the start of the grant period and must be fully expended by September 30, 2027. No extensions will be allowed, and any unspent funds will be rescinded.

Overview

Rural communities face distinct challenges, including geographic isolation, an aging population, higher rates of poverty, and limited access to primary care and behavioral health services, all of which contribute to poorer outcomes and greater burdens of chronic disease.³ The Grant Program will respond to these challenges by strengthening the rural health workforce and promoting sustainable access and innovative care. Under the AHEAD Model with CMS, the State assumes risk for the total cost of care.

Several innovative care delivery programs highlighted below provide enhanced funding to Maryland practices in order to strengthen primary care. This funding is intended to improve access and quality through advances in technology, clinical and community-based services, workforce development, and partnerships or sponsorships that align local resources with community needs. Overall, these initiatives promote financial stability through care models that support population health and maintain reliable access to high quality care for rural residents.

Episode Quality Improvement Program - Primary Care

The Health Services Cost Review Commission (HSCRC) and the MDH, Office of Advanced Primary Care, established the [Episode Quality Improvement Program Primary Care \(EQIP-PC\)](#) to support care transformation. Program Year 1 launched in January 2025 and 11 practices were selected for

³ Rural Health Information Hub. Rural Health Disparities. Published 2023. Accessed March 27, 2026. <https://www.ruralhealthinfo.org/topics/rural-health-disparities>

awards and participation in EQIP-PC. The State provides infrastructure funding to support advanced primary care capacity in designated areas of the State. EQIP-PC is intended to supplement AHEAD primary care programs by expanding access to advanced primary care and directing additional resources to underserved areas. EQIP-PC is scheduled to conclude in December 2027.

Maryland Medicaid Advanced Primary Care Program

The [Maryland Medicaid Advanced Primary Care Program](#) aligns with PC AHEAD and MDPCP-AHEAD and serves as the foundation for advancing primary care for Medicaid participants under the AHEAD Model. As of January 2026, 200 organizations participate in the program and are Maryland Medicaid HealthChoice primary care practices. Participating organizations use a team-based approach where a primary care provider leads disease management and medical decision-making, while delegating appropriate tasks to team members such as nurse care managers and medical assistants. The Maryland Medicaid Advanced Primary Care Program was launched in August 2025 and supports growth in alternative payment approaches, care transformation, and the gradual inclusion of additional practices. Beginning January 2027, practices must also participate in the Maryland Advanced Primary Care Program in order to be eligible to participate in MDPCP-AHEAD or PC AHEAD.

MDPCP-AHEAD

[MDPCP-AHEAD](#) is a statewide advanced primary care initiative launched in January 2019 by MDH in collaboration with CMS. As of January 2026, 460 practices participate in MDPCP-AHEAD, which encompasses a coordinated system supported by multiple payers, shared resources, and a unified information network. Participation is voluntary for qualifying primary care providers and offers funding and support to deliver advanced primary care to Medicare Fee-for-Service (FFS) beneficiaries, with a focus on prevention, chronic disease management, and reducing avoidable hospital use.

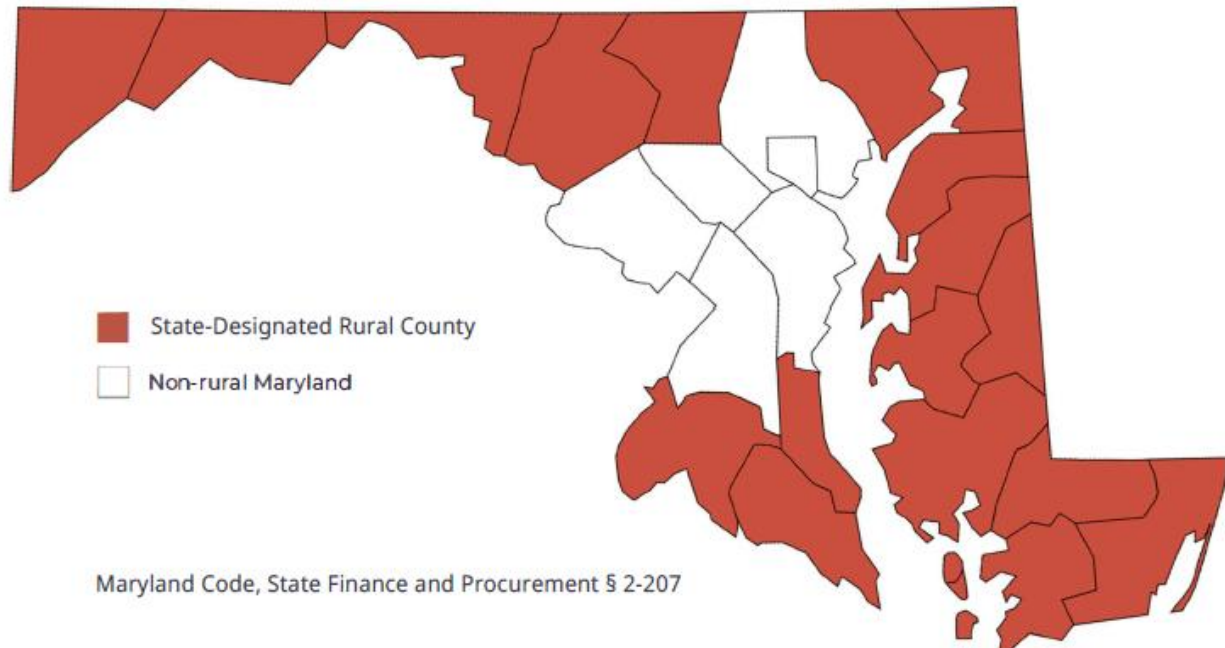
PC AHEAD

[PC AHEAD](#) is a voluntary advanced primary care model that aligns Medicare with state-led efforts and complements Medicaid priorities to expand care coordination, strengthen connections to community resources, improve quality, and support whole person-centered care. Eligible participants include primary care practices, FQHCs, and Rural Health Clinics. PC AHEAD includes care transformation activities, enhanced payments, learning supports, and technical assistance, with expectations for integrated behavioral health, care management, and attention to health-related social needs. PC AHEAD will operate through three cohorts beginning in January 2026 and concluding in December 2034. The first cohort includes 32 practices.

Geographic Focus Areas

Maryland’s designation of rural counties recognizes 18 of 24 counties as rural, representing about 1.4 million residents.⁴ This includes: Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne’s, Somerset, St. Mary’s, Talbot, Washington, Wicomico and Worcester (Figure 1).⁵

Figure 1: Rural Maryland, by State Designation



Participation Requirements and Timeline

To be eligible for a grant, an organization must 1) open a new practice or 2) expand an existing practice located in one or more designated rural areas identified in Figure 1. Participation in other innovative care delivery models does not prevent an organization from taking part in the Program. Practices currently enrolled in AHEAD Primary Care Programs, including FQHCs, are expected to maintain participation in the respective AHEAD program(s). Practices may use grant funds to expand or enhance care delivery, including adding or increasing staffing support or investing in other infrastructure-related resources, such as technology, equipment, and other operational support needed to deliver and sustain services. Organizations must apply for grant funding to be

⁴ Md. Code Ann., State Fin. & Proc. § 2-207 (2025).

⁵ Maryland Department of Health Office of Population Health Improvement . *Maryland Rural Health Strategic Plan, 2025-2030*. Maryland Department of Health. Accessed April 13, 2026. <https://health.maryland.gov/pophealth/Documents/Rural%20Health/Rural%20Health%20Strategic%20Plan/ONLINE-Rural-MD-Strategic-Plan-2025-2030.pdf>

considered by MHCC, which requires completion of the [Application Template](#) and [Financial Worksheet Template](#). Applicants are required to follow the required format when preparing their responses. Responses that do not adhere to the Application and Financial Worksheet Templates will be considered incomplete, which could affect scoring. **A complete application and all supporting documentation must be submitted to mhcc.grants@maryland.gov no later than June 1, 2026.**

The MHCC anticipates competitively awarding up to 15 grants based on available funds. Award decisions will prioritize applicants that demonstrate readiness to establish or expand primary care services in rural communities, with a focus on operational capacity, workforce planning, and timely implementation. Grant funding is intended to support defined project activities and may not substitute for practices' existing billing and collection processes. Practices are expected to continue billing and reimbursement activities with all payers, which include commercial insurance plans, Medicaid HealthChoice (managed care), Medicaid FFS, and Medicare FFS, as appropriate.

Building Primary Care Capacity

The Grant Program is designed to increase access to new, high-quality care delivery by supporting increased capacity and enhancing advanced primary care services. Applicants must describe their intended use of funds and how it supports access to advanced primary care. Table 1 (provided as an example only; not reflective of all eligible activities) lists potential grant-funded infrastructure elements that could provide pathways to sustainable primary care. Many of these listed activities are required or supportive of joining value-based care (VBC) models or billing advanced primary care codes. The billing codes listed in Appendix A promote sustainability through reimbursement for comprehensive care management (codes are paid for by Medicare; policies may differ among Medicaid and commercial payers).

Table 1. Infrastructure Pathways to Sustainable Primary Care Funding

Note: The examples that follow are for illustrative purposes and are not exhaustive. Some categories include more examples; some cells are intentionally left blank.

| APCM, PC AHEAD, MDPCP AHEAD, or Maryland Medicaid Advance Primary Care Program | CoCM or BHI | CHI or PIN |
|--|---|--|
| Hiring or otherwise supporting staffing of care coordinators, care managers, or other members of the care team | Hiring or otherwise supporting staffing of behavioral health care managers or psychiatric consultants | Hiring or otherwise supporting staffing of Community Health Workers (CHWs), patient navigators, or peer-support workers, or partnering with community-based organizations (CBO) that |

| APCM, PC AHEAD, MDPCP AHEAD, or Maryland Medicaid Advance Primary Care Program | CoCM or BHI | CHI or PIN |
|--|--|---|
| | | employ these workers |
| Answering services for 24/7 access for patients to contact members of care team | Developing workflows to use validated rating scales, registries, or deliver brief psychosocial interventions | Implementing technology to link primary care practice with CBOs to address upstream drivers of health |
| Implementing electronic medical record upgrades to allow for care planning and consent | Implementing technology to track time, perform regular caseload reviews | Implementing technology to track time, ensure that CHWs, patient navigators, or peer support workers can operate under general supervision and document notes |
| Timely exchange of health information among nearby emergency departments and hospitals | Implementing technology to track patient consent | Implementing technology to track patient consent |
| Implementing secure messaging or patient portals | | |
| Implementing telehealth technology for virtual visits | | |
| Implementing solutions to be able to analyze patient panels to identify gaps and risk stratify | | |
| Implementing technology to report primary care quality measures | | |

Primary care serves as the patient's usual, accessible entry point into the health system, providing person-centered, long-term care for most health needs, including acute illness, chronic disease management, and preventative screenings. Applicants are encouraged to propose an innovative approach that demonstrates measurable impact on rural communities and efficient use of resources. The approach should support the development, expansion, and sustainability of primary care services with a focus on improving timely access to care.

Program Monitoring

The MHCC will offer technical guidance to awardees, track and monitor progress towards creating

new or expanded upon primary care access points, and ensure that all funded activities address the community needs outlined in the applicant's response to this Request for Applications (RFA). To assess performance and ensure ongoing compliance, MHCC will implement program monitoring controls that include but are not limited to:

- Monitoring the net increase in primary care capacity within targeted geographic focus areas
- Assessing progress toward the process measures (Appendix C)
- Conducting periodic reviews to ensure Program integrity
- Verifying that expenditures remain within the approved budget

Awardees will be requested to submit updates on process measures as outlined in the Appendix C. Awardees must demonstrate fidelity to their approved proposal.

The MHCC will work closely with grantees to minimize administrative burden while ensuring compliance with Program and reporting requirements. Failure to comply with the requirements in this RFA will result in either a corrective action plan, reduction of funding, return of funding, and/or elimination from the Program.

Grant Timeline

The MHCC anticipates the following timeline of activities for this RFA. The timeline is not comprehensive, and all dates are subject to change.

| Date | Activity |
|---------------------------|---|
| May 4, 2026 | MHCC releases RFA |
| May 11, 2026 | Q&A – RFA informational webinar will provide an opportunity for potential applicants to clarify program requirements, application procedures, and expectations for grant activities |
| June 1, 2026 | Submission deadline |
| June - July 2026 | Evaluation Committee reviews all applications |
| July 2026 | MHCC notifies applicants about award decisions (after MDH and CMS review and approval) |
| August 1 2026 | Grant commences |
| September 30, 2027 | Grant ends – close out and final reporting |

As indicated in the timeline above, MHCC will offer an opportunity for potential applicants to ask questions about the RFA. Late or incomplete applications will not be considered. Submitted applications will be evaluated based on the criteria outlined in this RFA. The MHCC reserves the right to request additional information or clarification from applicants during the review process. Failure to provide the requested information may result in disqualification. Award decisions will be based on the merit of applications and alignment with Program objectives.

Evaluation and Award Process

An MHCC-convened Evaluation Committee will review and score all grant applications. The MHCC may engage external subject matter experts to provide technical input and assist in the evaluation process. The Evaluation Committee's recommendations will guide award decisions. The following conditions apply to the grant evaluation process:

- Applicants must meet and maintain all eligibility requirements throughout the review and award process
- The Evaluation Committee may request clarifications, additional information, or revisions to the proposed scope or funding amount requested before making an award decision
- The Evaluation Committee may require an applicant to modify its application to ensure compliance with federal, State, and Program-specific rules and other award limitations described in this RFA
- Members of the Evaluation Committee must disclose any conflicts of interest and recuse themselves from related discussions
- Determinations made by the Evaluation Committee are final and not subject to appeal

Application Questions and Scoring

Applications will be reviewed based on six criteria. The guidance specifies key domains and expectations for each. The total possible points noted will be used by the Evaluation Committee to guide award decisions and ensure a transparent, objective review process.

Funds may not be used to replace payment for clinical services that could be reimbursed by insurance. Funds also may not be used for payments to clinical services if they duplicate billable services and/or attempt to change the payment amounts of existing fee schedules. Supplanting (not supplementing) non-federal funds that have been budgeted for the same purpose through non-federal sources including existing State, local, tribal, or private funding is also not allowed under this grant.

| Criteria | Guidance | Possible Points |
|---|---|-----------------|
| <p>1. Discuss how the organization’s background, experience, qualifications, and proposed grant-funded activities demonstrate its ability to improve access to high-quality primary care in a VBC arrangement or within an advanced primary care model.</p> | <p>Include relevant expertise and operational experience, prior participation in either a VBC arrangement or in a Patient-Centered Medical Home (within the past three years). Describe any relevant experience with opening a new practice/location and/or expanding operations, which may be through a partnership or sponsorship with an organization with comparable experience. If the organization’s ability to participate in these models or arrangements is heavily influenced by grant funding, please discuss.</p> | <p>20</p> |
| <p>2. Describe how the proposed grant-funded activities will increase access to primary care in rural areas of Maryland. Include a well-supported, quantitative estimate of how many rural residents are expected to be newly served. Demonstrate how the organization’s understanding of the population’s needs and history of community engagement within the defined geographic area will reduce barriers and expand access to care.</p> | <p>Indicate whether the proposed new or existing practice has relevant experience in the defined geographic area or a similar environment. Include past partnerships with local organizations, initiatives to address social needs, and programs that have improved access to care and health outcomes in the community. Demonstrate a clear understanding of the health and social needs of the target population and/or provide experience working within the defined geographic focus area.</p> | <p>25</p> |

| Criteria | Guidance | Possible Points |
|---|---|-----------------|
| <p>3. Explain the organization’s ability to oversee an interdisciplinary care management team that will be fully prepared to provide comprehensive care management services to patients attributed to the practice.</p> | <p>Discuss strategies the organization would use, including with grant funds, to support staffing, training, workflow integration, continuous quality improvement, and ongoing performance monitoring to ensure the care team can effectively manage and coordinate patient care across primary, specialty, and behavioral health services. Describe the oversight provided by experienced clinical and administrative leaders related to monitoring team performance and adherence to established care management protocols, coaching, and ongoing performance feedback.</p> | <p>10</p> |
| <p>4. Detail the organization’s projected costs for Year 1, including anticipated operational, staffing, technology, and administrative expenses, along with supporting justification for all cost estimates.</p> | <p>Provide a detailed and reasonable projection of Year 1 costs, including any upfront investments, such as minor renovations or build-out needs, and operational, staffing, technology, and administrative expenses. The proposed budget must align with requirements outlined in the RFA and describe the connection between proposed expenditures and Program goals.</p> | <p>15</p> |

| Criteria | Guidance | Possible Points |
|---|---|-----------------|
| <p>5. Outline a clear and feasible approach for establishing or expanding access to primary care, including strategies for recruitment, hiring, and retention, increasing provider and care team capacity, improving appointment availability, and enhancing service delivery to meet community needs within a defined geographic area to ensure services remain accessible and responsive.</p> | <p>Include a workplan to recruit, hire, and retain providers and care team members that aligns with the requested budget and Program goals.</p> | <p>20</p> |
| <p>6. Discuss how a portion of start-up costs can be sustained through reimbursement using billing codes related to APCM, CoCM, BHI, CHI, or PIN, and participation in VBC models, and how reimbursement will support the long-term implementation of advanced primary care and whole-person care delivery.</p> | <p>Demonstrate how the proposed model will be sustained beyond the end of the Grant Program through ongoing billing or participating in VBC models.</p> | <p>10</p> |

The Maryland RHTP is supported by the CMS of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$168,180,837.61 with 100 percent funded by CMS/HHS. The contents of this RFA are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Appendix A – Advanced Primary Care Billing Codes (Grouped by Service Category)

| Service Category | Code | Brief Description <i>This column includes abbreviated code descriptions, which may not reflect all requirements or nuances of each service. Practices should refer to full code descriptors and applicable guidance prior to billing.</i> |
|-------------------|-------|---|
| APCM, Level 1 | G0556 | Patient with one chronic condition expected to last at least 12 months, or until the death of the patient |
| APCM, Level 2 | G0557 | Patient with two or more chronic conditions expected to last at least 12 months, or until the death of the patient |
| APCM, Level 3 | G0558 | Patient that is a Qualified Medicare Beneficiary with two or more chronic conditions expected to last at least 12 months, or until the death of the patient |
| CoCM, APCM add-on | G0568 | Initial month behavioral health/psychiatric collaborative care management in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional |
| BHI; APCM add-on | G0570 | Subsequent monthly behavioral/mental health care management in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional– |
| CoCM APCM add-on | G0569 | Subsequent month psychiatric behavioral health/services collaborative care management |
| BHI | 99484 | Initial month care management services for patients with behavioral health conditions in primary care; includes care plan development, coordination, and monitoring |
| BHI | G0323 | Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist, clinical social worker, mental health counselor, or marriage and family therapist time, per calendar month Medicare only |
| CHI | G0019 | Address a patient’s social drivers of health (e.g., housing, food, transportation, or utilities); delivered by a care team member, such as a community health worker or nurse, and includes assessment, resource connection, and care planning |
| CHI add-on | G0022 | Additional time spent delivering CHI services |

| Service Category | Code | Brief Description <i>This column includes abbreviated code descriptions, which may not reflect all requirements or nuances of each service. Practices should refer to full code descriptors and applicable guidance prior to billing.</i> |
|------------------|-------|---|
| PIN | G0023 | Provides care navigation and coordination for patients with one serious or high-risk condition |
| PIN add-on | G0024 | Additional time spent providing PIN services |
| PIN | G0140 | Principal Illness Navigation-Peer Support services, covering the first 60 minutes of, or more, per calendar month provided by certified/trained peer specialists |

Appendix B – Guidance for Billing Advanced Primary Care Service Codes and Value-Based Care Models

- Advanced Primary Care Management Services

<https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services>

- Behavioral Health Integration and Collaborative Care Management

<https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf>

- Community Health Integration and Principal Illness Navigation

<https://www.cms.gov/files/document/health-related-social-needs-faq.pdf>

- Community Health Integration Services (Rural Health Information Hub)

<https://www.ruralhealthinfo.org/care-management/community-health-integration-services>

- Maryland AHEAD Primary Care Programs (PC AHEAD, MDPCP-AHEAD and Medicaid Advanced Primary Care Program)

<https://health.maryland.gov/mdpcp/Pages/AHEAD-Model.aspx>

- MHCC Learning Network November 2025: *Best Practices for Coordinating Care and Managing Referrals*

<https://www.youtube.com/watch?v=ofRlvBjBsU4>

- MHCC Learning Network September 2025: *Using Advanced Primary Care Management Services and Designing Team-Based Models Tailored to Patient Demographics*

<https://www.youtube.com/watch?v=JN36D6NYCW8>

- Principal Illness Navigation Services (from Rural Health Information Hub)

<https://www.ruralhealthinfo.org/care-management/principal-illness-navigation-services>

- Remote Patient Monitoring Services

<https://www.cms.gov/files/document/mln901705-telehealth-remote-monitoring.pdf>

Appendix C – Grant Process Measures

| Measure | Data Source | Frequency | Rationale |
|--|---|---------------------|---|
| Number of patients served by the practice | Electronic health record (EHR) system | Quarterly | Tracking patients served demonstrates progress in promoting patient-centered care, reducing unnecessary utilization, and expanding access to rural residents |
| Percent of patients screened for unmet social needs | EHR system/ social needs screening tool | Annually (Year 1) | Regular completion of social needs screeners ensures that the practice stays informed about emerging local health challenges and can adjust services and priorities based on current community conditions |
| Percent of care team roles filled to meet the organization’s defined staffing model | HR system or platform | Quarterly | Maintaining a high percentage of filled care team roles demonstrates the practice’s ability to sustain the staffing structure required to deliver advanced primary care and support consistent, high quality patient services |
| Number of VBC models the practice actively participates in, as demonstrated by formal enrollment or participation agreements | Practice management system or other platform that supports administrative and operational functions | End of Grant Period | Participation in VBC models is an integral part of the AHEAD model; the Grant Program is designed to promote practice readiness to begin or accelerate participation in VBC models |