1. Establish Regional Planning Councils

Health care delivery in Maryland is often planned on a jurisdictional basis. A county-specific planning approach is not well aligned with how health care is organized in rural communities in Maryland given that large health care systems are focused on a regional approach. A Regional (Cross Jurisdictional) Health Planning Council should be created and charged with developing a regional health care master plan. The regional master plan should address somatic, behavior, and dental care needs in acute, post-acute, and community-based care settings. The master plan should take into account infrastructure, capacity, and population health needs of the region. The Council shall use community needs assessments, existing Department of Health information, and other data sources in developing the Master Plan. The Council shall comment on the alignment of project proposals with the master plan from health care organizations. The Council shall review all projects covered in the CON law if those projects are located in their region. The Council may hold public hearings on the projects and may make non-binding recommendation to the MHCC. The Council may be organized in each of the rural regions: Mid Shore, Lower Eastern Shore, Southern Maryland, and Western Maryland. Each council would be broadly representative of the region, including the community, health care professionals, and local officials. One member of each Council should be knowledgeable about veterans' health issues. Another member should knowledgeable about transportation issues that affect residents' access to care.

Yes	Yes with Modifications	No
7	4	2

Comments:

- Another layer of unnecessary regulation/ interaction with MHCC CON authority unclear
- Look to old health planning council of the Eastern Shore as a model
- Still would need a local hospital board at each facility/ fear of larger county-centric regional board.

2. Create a special hospital designation for Rural Communities

The General Assembly should create a special designation, beyond the freestanding medical facility, that would allow for a small hospital to retain limited inpatient capacity. These "micro hospitals" may require a limited rate adjustment in their global budget to support patient needs that might not be optimally delivered, but must be accessed by the community in that hospital because of distances to a full service inpatient acute care hospital.

Yes	Yes with Modifications	No
8	3	0

Comments:

- Should include considerations for the Maryland All-Payer Model Contract
- Hospitals need to keep med/surg and ICU beds
- The ability and feasibility of keeping inpatient beds might become too expensive

3. **Establish a rural Maryland Health Communities Grant Program that would enable rural communities to establish health improvement programs**

Yes	Yes with Modifications	No
9	3	0

Comments:

- Use the Community Health Resources Commission
- Basic funding needs of each hospital/facility need to be met
- Could be assigned to regional health councils

4. ***Extend and Expand Enterprise Zones with a health system focus for rural communities***

Yes	Yes with Modifications	No
9	2	0

Comments:

- Needs more discussion

5. ***Develop Apprenticeships***

Yes	Yes with Modifications	No
7	2	1

Comments:

- Needs more discussion/Not sure how "apprenticeship" is defined
- Develop free on the job CEU programs for clinicians on the Shore
- Could work in a rural setting

6. ***Establish a Rural Scholarship for Maryland Medical Students***

The General Assembly should establish a scholarship program that incentivizes students that serve in a rural designated jurisdiction for the following health care occupations: Physicians, RN/NPs, PAs, EMT/Paramedics (at rural Community Colleges), and Dentists/Dental Hygienists. Eligibility would be open to all students admitted to health services programs in the State. Although the scholarship program would be open to all admitted to recognized programs in public and private higher education institutions, the program would give a preference to students that originated from the specific region. A region would be able to designate the health

occupations that would be eligible based on supply due to the limited level of scholarship funds. Regions would be required to match funds committed by the State on a 1 for 1 basis. Students awarded a scholarship would have a specified amount written off for a year of service. Repayment formulas would be back loaded to incent students for fulfilling their commitments. The number of scholarships would be dependent on the funding available.

Yes	Yes with Modifications	No
9	2	0

Comments:

- Unclear funding
- Has been tried and doesn't work well
- Great idea/strongly in favor

7. Establish a Rural Residency Program

There is strong evidence that many physicians opt to practice in close proximity to their final residency program. Research suggests that residents who train in rural areas and whose training emphasizes services necessary for rural practice are more likely to practice in rural areas. Rotating residents from urban hospital residency programs into rural areas, while helpful, does not expose residents to the benefits and challenges of practicing in a rural areas. A Residency Program at one or more rural hospitals would better serve the objectives of preparing residents to practice rural primary care medicine and to experience the benefits of this type of practice. Residency programs should be established at one or more rural hospitals in Western Maryland and the Eastern Shore. HSCRC should provide support through an adjustment to a hospital's global budget revenue to support a rural residency program. At minimum, each residency program should support 6 residency slots. The workgroup believes that Peninsula Regional Hospital and University of Maryland Shore Medical Center at Easton are reasonable candidates to host a program. It maybe that a joint-program would be most beneficial to residents and the people of the Eastern Shore. In Western Maryland, Frederick, Meritus and the Western Maryland Regional Medical Center are all positioned to support a residency program. Like the Eastern Shore, it may be that a collaborative program among the three systems would generate the most benefit. The Trivergent cooperative arrangement that already exists among the three hospitals may provide the framework for such an initiative.

Yes	Yes with Modifications	No
8	3	1

Comments:

- Need to consider All-Payer-Model growth limits
- Funding Issues
- Need to include AHEC and FQHC program

8. Modernize and expand the Maryland Loan Assistance Repayment Program (M-LARP)

The General Assembly should enact legislation to reform the M-LARP program in the following ways;

a. Change the definition of eligible field of employment in Education Article § 18-1501 to include for-profit physician settings. (Note that under the current Federal LARP program, this is not possible due to federal funding restrictions.) The State-only program does not have to impose such a restriction. This modification would allow new physicians to quality for the State-only program to qualify.
b. Expand the scope of specialties that can qualify for loan assistance in underserved areas. Currently the federal and State LARP are limited to primary care, behavior health, and dentists That change would allow other physician specialties to participate in loan forgiveness as long as the specialty has been identified by the Department of Health as being in shortage in the area.
c. Streamline the management of State LARP by centralizing oversight of the program in the Maryland Department of Health

Yes	Yes with Modifications	No
9	1	1

Comments:

- Emphasis on primary care providers
- Funding will be problematic

9. Realign the prioritization of the J-1 Visa program

The Maryland J-1 Visa Waiver Program offers a J-1 Visa waiver to foreign physicians who commit to serving for 3 years in an underserved area of Maryland, waiving the foreign medical residency requirement and allowing them to remain in the United States. The program is intended to provide physician services in areas that typically have difficulty attracting and retaining physicians. The Maryland program should prioritize applicants who are willing to work in rural areas for a limited number of state slots.

Yes	Yes with Modifications	No
11	0	1

Comments:

- Will not answer the rural healthcare shortage problem

10. Create and Extend Tax credits, loan or grant opportunities for Practitioners to Practices in Rural Communities

The General Assembly should establish tax incentives for providers willing to practice in rural areas. Examples of these include the HEZ personal tax credit, HEZ hiring tax credits, tax credits for near retirement providers who move to rural communities, and state backed small business loans for practitioners to establish a practice in a rural community. The Department of Commerce should be directed to use its existing economic development funds to fund this program.

Yes	Yes with Modifications	No
11	0	0

Comments:

- Need to discuss effectiveness of existing programs

11. Develop a nurse practitioner program on the Eastern Shore

Yes	Yes with Modifications	No
8	4	0

Comments:

- Salisbury University has a program. A PA program on the Shore is needed
- Need for public service and health department employment