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Governor

November 5, 2025

Mehmet Oz, MD, MBA
CMS Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Baltimore, MD

Dear Administrator Oz,

On behalf of the State of New Jersey, I am writing to formally endorse the enclosed submission for funding through the Rural Health Transformation Program (Funding Opportunity: CMS-RHT-26-001). I am pleased to express my strong support for and commitment to the proposed Rural Health Transformation plan.

New Jersey is home to over 1 million rural residents, who live in eleven of our twenty-one counties: Atlantic, Burlington, Cape May, Cumberland, Hunterdon, Mercer, Monmouth, Ocean, Salem, Sussex, and Warren. Our rural New Jerseyans live in 40 federally-designated rural census tracts and in seven State-designated rural counties. Rural New Jerseyans are more likely to live in areas facing a health care workforce shortage, are more likely to have experienced a hospital maternity unit closure, are more likely to experience more substance use-related health impacts, and are less likely to have an annual pediatric well-visit appointment.

The New Jersey Department of Human Services' Division of Medical Assistance and Health Service is the State's Medicaid Agency and is applying on behalf of the State of New Jersey to receive $1 billion in federal funding through the Rural Health Transformation Program. Through this letter, I designate the New Jersey Department of Human Services as the lead agency to submit the State's application and as the lead agency responsible for implementation of the proposed Rural Health Transformation plan. The New Jersey Department of Health, and especially the State Office of Rural Health, has co-developed our State's submission with our Department of Human Services. The New Jersey Commission on American Indian Affairs within the New Jersey Department of State was also closely engaged in the development of this application to ensure the health-related needs of New Jersey's three State-recognized tribal nations and inter-tribal peoples in the wider community are reflected in the Rural Transformation Plan. Together, these and other relevant state agencies will work collaboratively to implement the proposed initiatives in the collective effort to improve the health of New Jerseyans in rural communities and transform care delivery.

Recognizing the unique and transformative nature of this funding opportunity, the State of New Jersey undertook an extensive engagement process with rural constituents, health care providers serving rural communities, and other health-related stakeholders to develop this plan. A centerpiece of this effort was a formal process for interested stakeholders to submit written proposals and to testify at a public listening session. Each of the over 200 written proposals and testimonies were carefully reviewed. The diverse perspectives have closely informed the proposed program design, policy decisions, and implementation strategies. To dig deeper, targeted roundtables were conducted with key constituencies like New Jersey's Rural Health Council, New Jersey's federally-qualified health centers, the New Jersey Hospital Association, and New Jersey's Primary Care Association. Additionally, to build out specific initiatives or to learn more about innovative concepts, officials and staff from the Department of Human Services, the Department of Health, and the Office of the Governor undertook meetings with key partners. To hit the ground running once funding is awarded, the State will host a pre-award innovation and technology informational meeting at the Robert Wood Johnson Foundation on December 4 to bring together prospective subawardees and innovation and technology vendors in order to continue strategizing about potential collaborations during Rural Health Transformation implementation. To sustain connectivity and inclusivity with our rural communities and health care partners throughout the course of this funding, the State will leverage ongoing, regularly convening forums such as the New Jersey Rural Health Council and New Jersey Medicaid's Medical Assistance Advisory Council and Beneficiary Advisory Council.

The enclosed plan endeavors to make sustained transformation in health care for rural New Jerseyans through a multi-pronged approach. This includes growing the clinical and nonclinical workforce (RHT 1); bolstering funding for essential emergency, primary care, and behavioral health providers (RHT 2); leveraging regional partnerships and innovative technology to deliver care closer and more conveniently for our rural constituents through tools like telehealth, remote patient monitoring, and mobile health care (RHT 3); investing in upstream prevention to improve outcomes and reduce costs (RHT 4); and modernizing and improving identification and access to chronic disease treatment (RHT 5). New Jersey proposes a hybrid funding approach, where we blend directed funding with competitive funding. This allows New Jersey to jumpstart RHT-funded activities immediately while still preserving our ability to fund the best ideas that can arise from competitive application processes. To support the success of the New Jersey Rural Health Transformation plan, we are enhancing partnerships with innovation leaders (like SciTech Scity, a public-private collaboration to support digital health adoption), hospitals (like University Hospital, which leads statewide emergency response), and academic partners (like Montclair University, a state leader in reflective supervision) to help with key activities. In accordance with the terms of the Notice of Funding Availability for CMS-RHT-26-001, I certify that the State will not spend any award funds on activities prohibited under 42 U.S.C. 1397ee(h)(2)(A)(ii). All projects proposed conform with the allowable uses as outlined in CMS-RHT-26-001.

Over the course of my Administration, we have taken significant policy and regulatory actions that make New Jersey well-prepared for the Rural Health Transformation plan. For example, the State has already implemented certain Certificate of Need exemptions; participates in multiple health care provider interstate licensure compacts; has extended certain scopes of practice, including a temporary extension of scope for advance practice nurses; facilitates remote care through Medicaid flexibilities and state-level parity laws for telehealth payments; and

maintains a robust network of rural health care facilities, including Certified Community Behavioral Health Clinics (CCBHCs), federally-qualified health centers, and 69 acute care hospitals receiving disproportionate share hospital payments. Given that New Jersey is one of two states that will inaugurate a new Governor in January 2026, our ability to make forward-looking policy commitments may be somewhat limited relative to other states. However, over the remaining course of my Administration, we will continue to support policies that grow and empower our health care workforce, strengthen public health, modernize our health care system, and improve affordability for New Jerseyans.

Health care outcomes and access and affordability to health care for rural New Jerseyans were at the core of this proposal and will be centered throughout implementation. Prioritizing sustainability from the start, the plan intends for improvements like data systems that will exist beyond the five-year program period. Investments will work to grow trusted and invested community partners to support the health care workforce and a long-term focus on chronic disease prevention. As reflected in the proposed project milestones, the State will work to reach rural residents across the entire state through targeted outreach and ongoing program evaluations.

Thank you for your consideration. The State of New Jersey looks forward to closely working with the Centers for Medicare & Medicaid Services to achieve this proposal.

Sincerely,

Philip D. Murphy
Governor

NJ RHT Project Summary

New Jersey is home to over 1 million rural residents, who live in eleven of our twenty-one counties: Atlantic, Burlington, Cape May, Cumberland, Hunterdon, Mercer, Monmouth, Ocean, Salem, Sussex, and Warren. Our rural New Jerseyans live in 40 federally-designed "rural census tracts" and in 7 state-designated "rural" counties. Rural New Jerseyans are more likely to live in areas facing a healthcare workforce shortage, experience more SUD-related health impacts, and are less likely to make it to an annual pediatric well-visit appointment.

The Division of Medical Assistance and Health Service (DMAHS) is the State's Medicaid Agency and is applying on behalf of New Jersey to receive $1 billion in federal funding through the Rural Health Transformation Program. If awarded, this funding would strengthen our State's ability to direct resources and focus towards transforming the healthcare of rural New Jerseyans over the next five years. DMAHS has been working closely with NJ's State Office of Rural Health and other stakeholders for this application—and will continue to do so to achieve our goals of building our rural-serving healthcare workforce, and adapting care delivery to be responsive to rural residents' wishes and needs.

We propose directing funding in five Initiatives areas:

1. RHT1 supports recruitment, training, and retention of clinical and non-clinical providers
2. RHT2 provides funding for essential providers of behavioral health (CCBHCs), primary care (FQHCs), and emergency medical services (hospitals)
3. RHT3 encourages regional partnerships to strengthen care delivery outside of brick-and-mortar offices—including telehealth, remote patient monitoring, and mobile care
4. RHT4 funds community-level efforts to promote preventive health
5. RHT5 invests in an array of evidence-based interventions and data integration efforts to improve chronic disease treatment

We will take a hybrid funding approach, where we blend directed funding with competitive funding. This allows us to jumpstart RHT-funded activities immediately when funded while still preserving our ability to fund the best ideas that can arise from a competitive application process. To support the success of NJ RHT, we have sought out partnerships with innovation leaders (like SciTech Scity, a public-private collaboration to support digital health adoption), hospitals (University Hospital, which leads statewide emergency response), and academic partners (Montclair University, a state leader in reflective supervision) to help with key activities. DMAHS will also rely on our strong partnership with public health partners at the Department of Health to leverage RHT funding to adapt our healthcare ecosystem to better meet the needs of rural New Jerseyans and help them thrive.

NJ Rural Health Transformation Project Narrative

NJ's Rural Health Needs and Target Population

Rural Health Transformation (RHT) funds would strengthen New Jersey (NJ)'s ability to improve healthcare in our 11 rural counties, home to nearly 11% of the state's population. Rural New Jerseyans face unique access challenges and carry a disproportionate burden of health conditions—making targeted investment essential.

NJ RHT's Target population—Rural residents

New Jersey is home to almost 150,000 residents who reside in 40 federally recognized rural census tracts (RCTs). Our RCTs are distributed across the state's 7,000 square miles. NJ's RCT residents live in eight of our 21 counties: Atlantic, Burlington, Cumberland, Hunterdon, Mercer, Monmouth, Ocean, and Warren. Together, these RCTs include an area of 309 square miles, with an average density of 445 people per square mile (range of 0.2-28,644 residents per square mile). 80% of NJ's RCT residents, and most RCTs, are located in three NJ counties: Burlington, Cumberland, and Hunterdon.

NJ's State Office of Rural Health (SORH, housed within the Department of Health [DOH]) has developed, and uses, a state definition of rurality[i] that includes counties with population densities below 500 residents per square mile. SORH developed our state definition to more fully acknowledge the unique challenges NJ's rural residents face—challenges that are not currently captured by the standard federal definition. Although NJ is not commonly perceived as a rural state, the state's unique geography—where small urban centers and rural communities sit side by side—means that proximity to out-of-state metropolitan areas (like Philadephia and New York City) does not necessarily translate into access to care or services. In recognition of these challenges, our incorporation of SORH's state definition of rurality ensures that programs and

investments address the needs of our residents who experience rural barriers, despite living in a densely populated state. This definition supports our inclusion of residents in the following counties: four that also include RCTs (Atlantic, Cumberland, Hunterdon, Warren) and three that do not (Cape May, Salem, and Sussex).

Thus, NJ RHT plans to use the complementary federal and state definitions of rurality to define our target population: All residents in counties meeting the state definition of rurality, plus the residents in RCTs in Burlington, Mercer, Monmouth, and Ocean. Together, this represents over 1 million rural New Jerseyans living in 3,045 square miles (for a map of NJ, see Figure A).

Table: NJ RHT's Target Population

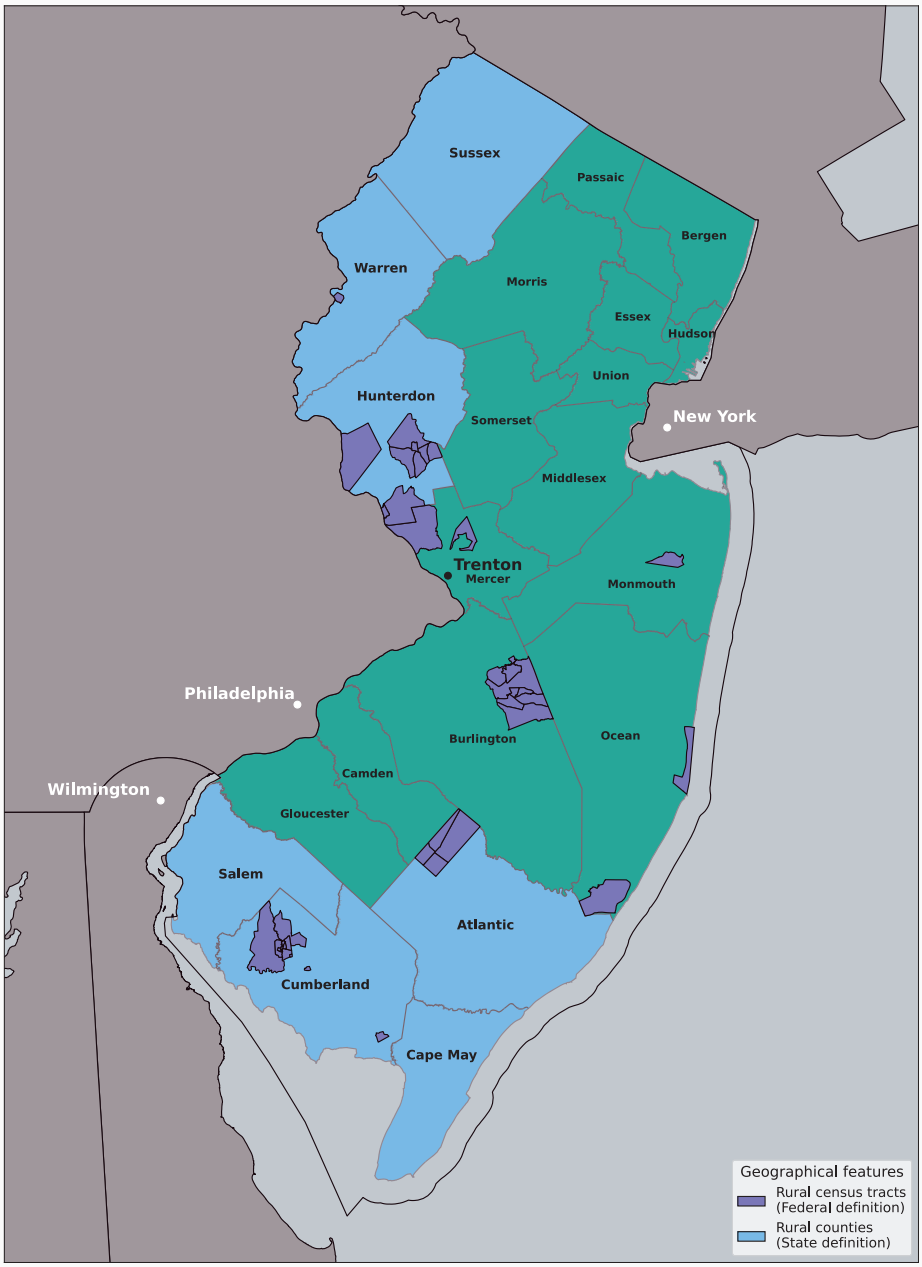
County	Has RCT? [# RCTs]	Population in RCT(s)	State Rural County?	NJ RHT Rural population	Population calculation method	Medicaid Rural population	% Medicaid
Atlantic	Yes [4]	14,711	Yes	279,114	County	97,136	35%
Burlington	Yes [9]	31,314	-	31,314	RCT	7,180	23%
Cumberland	Yes [12]	39,620	Yes	155,678	County	68,716	44%
Hunterdon	Yes [9]	40,639	Yes	131,708	County	15,313	12%
Mercer	Yes [2]	8,786	-	8,786	RCT	1,173	13%
Monmouth	Yes [1]	194	-	194	RCT	0	0
Ocean	Yes [2]	8	-	8	RCT	0	0
Warren	Yes [1]	2,520	Yes	112,031	County	23,748	21%
Cape May	-	-	Yes	93,875	County	22,822	24%
Salem	-	-	Yes	65,874	County	20,894	32%
Sussex	-	-	Yes	147,444	County	21,673	15%
TOTAL	40 RCTs	**137,792**	7 counties	**1,026,026**	-	**278,655**	**27%**

Data source: "Rural population #" from *County-wide* from 2024 ACS. "RCT population #" from *RCT* from 2020 Census from US Bureau of the Census. "Medicaid subset of rural population #" based on member zip code for 2024 NJ Medicaid eligibility data.

NJ RHT's Target population—Geography (Counties)

Consistent with our definition of our target population, NJ RHT's target counties are those where our rural New Jerseyans live: Atlantic (001), Burlington (005), Cape May (009), Cumberland (011), Hunterdon (019), Mercer (021), Monmouth (025), Ocean (029), Salem (033), Sussex (037), and Warren (041) Counties. The 3-digit Federal Information Processing Standard

Figure A: Map of NJ's Rural Geography



codes are provided as requested by the RHT Notice of Funding Opportunity (NOFO) to specify the counties impacted by the *Initiatives* described later in this Narrative.

NJ RHT's Target population—Healthcare Facilities

NJ RHT will focus primarily on healthcare facilities located in NJ RHT's target counties, but may also include additional rural-serving facilities located in rural-adjacent counties if they serve a substantial portion of rural New Jerseyans. In addition, NJ RHT plans to fund other healthcare organizations – such as community-based organizations, technology companies, and others contributing to our rural healthcare ecosystem.

NJ's Rural residents' healthcare-related demographics

The following demographics of our rural residents highlight the unique healthcare challenges rural New Jerseyans face[ii]:

(1) *Median household income*[iii] impacts one's ability to afford healthcare costs*:* Cumberland County (the county with the largest number of RCTs) has a lower median household income of $64,908 (as compared to the statewide median of $99,781).

(2) *Employment*[iv] impacts one's access to employer-based healthcare coverage*:* Cumberland County has a higher unemployment rate of 8.5% (as compared to the statewide average of 5.6%). Its neighbor, Atlantic County, has a rate of 6.5%. The most common employment sectors statewide are: leisure, hospitality, and retail; healthcare; technology; and education services.

(3) *Educational attainment*[v] impacts one's health literacy and the ability to get higher paying jobs to help with healthcare costs*:* For Cumberland County, only 17.9% of residents have a bachelor's degree (as compared to the statewide average of 42%).

(4) *Internet access*[vi] impacts one's access to online health information, health digital tools, and telehealth*:* For Cumberland County, 7.7% of households lack internet access (as compared to 6.3% statewide). For one RCT located in Cumberland, the rate is 28.6%.

(5) *Public transit* impacts one's ability to make healthcare appointments and seek care if they do not have personal access to a vehicle: Together, our counties with RCTs only have an All Transit Performance Score[vii] of 1.3 (as compared to 3.7 statewide). The Score uses a 10-point scale with 10 corresponding to the highest transit connectivity.

NJ's Rural residents' healthcare needs—Healthcare coverage

The following healthcare trends impacting rural healthcare highlight the coverage and access challenges our rural residents face, and the difficult financial environment within which our rural facilities operate:

(1) *Healthcare coverage*[viii]*:* For Cumberland County, a higher portion of residents are uninsured—43.6% as compared to 10.1% statewide. Cumberland County has the highest percentage of rural residents covered by Medicaid (44%) relative to other rural geographies in New Jersey.

(2) *Healthcare access—Health Professional Shortage Areas*[ix]*:* These Shortage Areas are federally-designated geographic areas determined based on high population-to-provider ratios, among other metrics. For primary care, Cape May, Cumberland, and Salem all contain Shortage Areas. For mental health, Cape May, Cumberland, Salem, and Sussex all contain Shortage Areas. For dental care, Cumberland and Mercer contain Shortage Areas.

(3) *Healthcare access—Financial solvency:* NJ hospitals have faced financial challenges in recent years that have impacted their ability to stay in business and serve rural residents. Specifically, Cape Regional Medical Center in Cape May county merged with another

health system (Cooper) last year after two years of significant operating losses and closure of maternity services in 2022.

NJ's Health Care Facilities Financing Authority recently reported on the financial health of the state's hospitals and FQHCs relative to national medians[x]: NJ hospitals have relatively higher debt and lower days cash on hand, higher accounts payables, and older facilities. NJ FQHCs also have lower days cash on hand and higher accounts payables. They also have lower operating margins and higher accounts receivables.

(4) *Healthcare access—Primary care visits:* When DMAHS looks at Medicaid claims data, we observe visit utilization differences between rural and non-rural Medicaid members: While 39% of non-rural Medicaid members have had at least one well visit in 2024, only 32% of rural Medicaid members have had one. When focusing specifically on the pediatric Medicaid population, the difference is even more pronounced: 65% of non-rural children have had at least one well visit, as compared to 58% of rural children.

(5) *Healthcare access—Dental care visits*[xi]: The rate of dentist visits in the prior year are lower in three of our target counties—Salem (62%), Cumberland (62%), Atlantic (64.1%)—when compared to 67.6% statewide.

NJ's Rural residents' healthcare needs—Conditions and disease

The following highlight some key healthcare needs of our rural residents:

(1) *Disease and infant health—Substance Use Disorder (SUD)*[xii]*:* Atlantic has the highest drug death crude rate in the state (92.7 per 100,000). We can also see the burden of SUD through its impact on infant health: Three of our target counties have higher rates of neonatal abstinence syndrome prevalence—Atlantic (103.7 per 10,000), Cumberland (68.8 per 10,000), Mercer (53 per 10,000)—when compared to 31.9 per 10,000 statewide.

Within the Medicaid population, we correspondingly observe a higher prevalence of diagnosis codes for claims related to Mental Illness and SUD for rural members, as compared to non-rural Medicaid members: 17% vs 13% for Mental Illness and 6% vs 4% for SUD (when looking at 2024 claims data).

(2) *Disease—Cancer*[xiii]*:* Cancer is the second leading cause of death in our state, contributing to 20.3% of all deaths. Two of our target counties have the highest rates of cancer-related death in the state—Salem (191.9 per 100,000) and Cumberland (169.1 per 100,000). Cumberland has the highest age-adjusted case incidence of several cancers in the state. Hunterdon has the highest age-adjusted case incidence of breast cancer in the state (155.9 per 100,000).

(3) *Chronic disease—Diabetes*[xiv]: Cape May has the highest rate of age-adjusted prevalence of adults diagnosed with diabetes in the state (16.9%, as compared to 9.2% statewide). Hunterdon has the highest age-adjusted rate of adults with a history of pre-diabetes or borderline diabetes in the state (17.3%, as compared to 12.2% statewide).

(4) *Chronic disease—Asthma*[xv]: Three of our target counties have higher rates of age-adjusted asthma prevalence—Salem (15.4%), Cumberland (13%), and Atlantic (12.5%)—when compared to 8.9% statewide. Cumberland has the highest age-adjusted asthma-related hospital emergency department visit rate of 83.6 per 10,000 in our state.

(5) *Chronic disease—Chronic Obstructive Pulmonary Disease (COPD)*[xvi]: Three of our target counties have higher age-adjusted prevalence of COPD—Cumberland (7.7%), Atlantic (6.6%), Cape May (6.2%)—when compared to 4.6% statewide. Atlantic has the highest age-adjusted COPD-related hospital emergency department visit rate of 46.2 per 10,000 in our state.

(6) *Chronic disease—Obesity*[xvii]*:* Three of our target counties have higher age-adjusted prevalence of adult obesity—Cumberland (42.8%), Salem (42.1%), and Cape May (40%) —when compared to 29.4% statewide.

(7) *Condition—High cholesterol*[xviii]: Three of our target counties have higher age-adjusted rates of high cholesterol—Cape May (36.7%), Salem (36.4%), and Atlantic (35.8%) —as compared to 33.4% statewide. Cholesterol screening rates are also lower in two of these counties—Salem (79.3%), Atlantic (87.8%)—when compared to 91% statewide.

NJ's Rural Health Transformation Plan: Goals and Strategies

NJ RHT Plan—Goals

Our NJ RHT Plan is aligned with the federal RHT Program's strategic goals to prioritize healthcare workforce growth to meet demand, to improve access through strategic partnerships and infrastructure investments, and to invest in innovation and technology. The NJ RHT Plan synthesizes feedback received through statewide stakeholder outreach and cross-agency consultation during the design phase of our application:

(1) *Goal #1: Improve availability of healthcare in rural New Jersey.* Availability of providers was the most prevalent community challenge identified by our stakeholder process. Our Plan will therefore employ a strategy that directs investments that are inclusive of the specialists and specialized facilities needed to address chronic disease, the primary care providers that are critical to offer preventive care and screen for disease, the healthcare extenders in non-clinical professionals that bridge the gap between clinicians and patients, the community partners that support health literacy, and the innovation partners who develop the tools we can use to improve care.

(2) *Goal #2: Make investments that are responsive to community input.* We acknowledge that the best areas to direct funding may come from outside government. Health technology companies, non-profits, and providers were the most common respondents to our stakeholder process. Our Plan will therefore employ a strategy that leverages competitive processes to surface their best solutions to problems and to give providers choice in directing funds where they need it most.

(3) *Goal #3: Foster a flexible healthcare system that can rapidly adapt to address rural New Jersey communities' needs.* We acknowledge that we need to better understand the specific needs of rural New Jerseyans to be responsive to them. Our stakeholder process identified there is a mismatch in care desired and care available and that transportation to brick-and-mortar care is a key challenge. Our Plan will therefore employ a strategy that strengthens the financial sustainability of brick-and-mortar care, while also investing in expanding access to mobile, in-community, and telehealth.

If awarded, the NJ RHT team plans to reconvene key stakeholders to develop and formalize a set of "NJ RHT North Star Principles" within 3 months of being awarded so that there is alignment and transparency on the goals and expectations to maximize the transformational impact of RHT funding in New Jersey. The goals and strategies in the Plan described above will be used as a starting place for those discussions. The purpose of these principles would be to guide the oversight work of the state administrative team supporting RHT, the implementation work of the public, private, and community partners implementing RHT, and the engagement work we do with rural communities.

NJ RHT Plan—Key performance objectives

Consistent with the Goals described above, our key performance objectives include:

(1) *Objective #1: Increase the number of rural-serving providers*. This includes primary care clinicians—to close the gap in well-visit care, specialty care—to address behavioral health and SUD needs within rural communities, among healthcare extenders—to maximize the impact of non-clinical professionals in improving the health of rural residents.

(2) *Objective #2: Increase the rates of preventive care among rural residents*. This includes well-visit care and preventive screenings—with a focus on rural children, where the long-term impact of preventive care is the greatest.

(3) *Objective #3: Support sustainability of NJ RHT efforts.* This includes ensuring that our efforts are aligned with Medicaid reimbursement policy whenever possible so that healthcare professionals can continue to serve rural residents after completing training and that NJ RHT-supported expansions (such as for mental health care by CCBHC) can be stabilized for the long-term benefit of rural residents.

If awarded, the NJ RHT team will work collaboratively with CMS to provide updates of more specific and feasible objectives after we are able to determine the scale of investment we are able to make with our RHT funding.

NJ RHT's Proposed Initiatives and Use of Funds

We describe five Initiatives that will support achieving the Goals we described. If awarded, the NJ RHT team will work collaboratively with CMS to rebalance and solidify our efforts within the following five Initiatives depending on the level of RHT funding received—as we have to consider individual activities relative to the scale of investment we are able to make.

Overall, we have proposed a hybrid approach of funding NJ RHT Initiatives. Some Initiatives use directed funding, either by using a funding formula to distribute funds to eligible providers (see RHT 2.2) or with named subawardees. Many others involve a competitive Request for Application (RFA) process. This blended approach is intended to facilitate making some payments quickly on the one hand—so that implementation work can begin, while also allowing for a process of healthy competition on the other—so that the best ideas can surface for funding.

NJ RHT Initiative #1: "Workforce"

RHT1 Name: Building the workforce we need to care for rural New Jerseyans

RHT1 Description: RHT1 funding will support recruitment, training, and retention of the healthcare workforce we need to keep our rural residents healthy. Investments are required to train and recruit a highly-skilled clinical workforce serving NJ's rural residents. Investments are required to recruit and train high-quality non-clinical professionals who can serve as trusted healthcare extenders. These professionals could include community health workers, community dental health coordinators, SUD peers, doulas, and lactation care professionals. Also, we must prepare professionals to work in rural healthcare and then retain these highly-trained professionals in whom we have invested. Provider burnout is common in healthcare—especially among professionals supporting rural New Jerseyans who face significant healthcare access issues. This funding will expand upon the existing reflective supervision activities currently administered by Montclair State University's Center for Autism and Early Childhood Mental Health.

RHT1 Main strategic goal: RHT1 most closely aligns with the *Workforce development* strategic goal described in the RHT NOFO. We are choosing to do this because we anticipate being able to recruit from rural communities and fully train non-clinical workforce in a timely manner that aligns with RHT's goals for high-impact transformation—since non-clinical trainings can be completed

in a shorter time frame. We also believe that non-clinical workforce training investments are more likely to keep the positive impact of these investments within the rural communities where the professionals live and serve. And, there could be an indirect community-level impact on health literacy as residents complete training, and an economic impact of professional advancement and sustainable employment for those who are able to use their training to serve their community.

NJ RHT Initiative #2: "Infrastructure"

RHT2 Name: Targeted infrastructure investments to transform care for rural New Jerseyans

RHT2 Description: RHT2 funding will support stability and capacity building in the rural healthcare ecosystem by prioritizing the following set of providers for strategic, targeted investment given their essential role in offering key areas of care: CCBHCs and their role in access to behavioral health care, Primary care providers / FQHCs and their role in access to preventive care, and Hospitals. RHT2 will fund investments in the University Hospital System to improve rural access to emergency and trauma care. University Hospital is one of NJ's state-owned hospitals and is responsible for statewide Emergency Medical Services (EMS) Helicopter Response Program.

RHT2 Main strategic goal: RHT2 most closely aligns with the *Sustainable access* strategic goal described in the RHT NOFO. RHT2 will help grant-funded CCBHCs transition to full Medicaid funding, while simultaneously increasing rural residents' access to behavioral health needs—an identified area of increased need for rural New Jerseyans. Similarly, RHT2 will provide critical primary care providers with funding to help build provider capacity, such as FQHCs expanding into providing dental care..

NJ RHT Initiative #3: "Technology"

RHT3 Name: Investing in technologies that bring care to where people live

RHT3 Description: RHT3 funding will support innovative strategies for care delivery at sites that aren't brick-and-mortar offices. We plan to fund technology-supported digital health services across the spectrum—from periodic telehealth to ongoing remote patient monitoring, for preventive care and mental health treatment to ongoing management of chronic disease, and for patients across the digital literacy continuum. We are also interested in mobile care solutions that bring care from the office into the community. While many digital technologies have potential to improve rural care offerings and capacity, ensuring their responsible deployment is essential to ensuring that they truly benefit our rural residents without introducing harms or vulnerabilities. RHT3 will fund pilots of rural-serving health technology innovations through the state's recently established Healthcare Innovation Engine ("the Engine"). The Engine was recently recognized by the World Economic Forum as a promising state-level model for collaborating across government, health systems, academia, and industry to accelerate responsible digital health adoption. The Engine convenes startups, health systems, payers, and agencies to co-design and evaluate solutions in real-world settings.

RHT3 Main strategic goal: RHT3 most closely aligns with the *Tech innovation* strategic goal described in the RHT NOFO. Rural New Jerseyans face unique challenges in accessing care because they live in more remote areas, with more limited provider networks, and uncertain internet access. As a result, rural residents are less able to add and use digital health tools as part of their healthcare toolbox.

NJ RHT Initiative #4: "Prevention"

RHT4 Name: Focusing on preventive health interventions for rural New Jerseyans

RHT4 Description: Investing in strong, evidence-based activities focused on prevention maximizes the impact of available resources to drive long-term health improvement. Preventive

health interventions will strengthen rural health systems by supporting community-based organizations, healthcare providers, and public health partners to expand outreach, education, and access to care, including data modernization of systems that support those activities. Additional activities will improve and expand the operational capacity of EMS.

RHT4 Main strategic goal: RHT4 most closely aligns with the *Make rural America healthy again* strategic goal described in the RHT NOFO. RHT4 is intended to give rural residents access to more coordinated and accessible preventive healthcare services and information. Outcomes of RHT4 focus on prevention through expanded healthcare access, increased community outreach and education, enhanced data capabilities, and improved operational capacity of rural EMS. Expanding access to direct healthcare services, outreach, and education is essential to improving the overall health of NJ's rural communities.

NJ RHT Initiative #5: "Chronic disease"

RHT5 Name: Helping rural New Jerseyans improve chronic disease outcomes

RHT5 Description: The RHT5 initiative aims to strengthen chronic disease prevention, management, and wellness in rural communities through innovative data integration, community partnerships, and evidence-based interventions. Funding will support the development of integrated data systems and public-facing dashboards, as well as competitive grant opportunities that will enable healthcare providers and community and faith-based organizations to implement and expand programs addressing chronic diseases and promoting wellness through healthy lifestyles, physical activity, and nutrition.

RHT5 Main strategic goal: RHT5 closely aligns with the *Make rural America healthy again* strategic goal. The proposed collaborative efforts would lead to more efficient data monitoring,

enhanced EHR capabilities, improved care coordination, improved patient outcomes, increased operational efficiency, and more targeted care and intervention of chronic disease in rural NJ.

NJ RHT Initiatives—Use of Funds

The Table summarizes how RHT1-5 are intended to support progress towards at least one of NJ RHT Plan's Goals, and how the activities above relate to the allowable uses in the NOFO. Given our goals to be responsive to community input and to support an adaptive healthcare system, our Initiatives permit funding to be directed towards multiple, related uses depending on the expert judgement of the funded entity.

Table: NJ RHT Initiatives and Use of funds

NJ RHT Initiative	NJ RHT Plan Goal	Prevention and Chronic Disease	Provider Payments	Consumer tech solutions	Training and technical assistance	Workforce	IT advances	Appropriate care availability	Behavioral Health	Innovative Care	Capital expenditures and infrastructure	Fostering collaboration
RHT1 Workforce	1	X			X	X			X			X
RHT2 Infrastructure	2	X	X	X	X	X	X	X	X	X	X	X
RHT3 Technology	3	X	X	X	X		X		X	X	X	X
RHT4 Prevention	2	X	X				X	X				X
RHT5 Chronic disease	3	X	X		X		X			X		X

NJ RHT Initiatives—Key stakeholders

A major state government partner is the SORH within DOH. SORH staff has been critical in guiding the NJ RHT application and will continue to play an important role if awarded. DOH will be a subawardee to administer many of the NJ RHT Initiatives given that they bring the expertise of the SORH to NJ RHT implementation combined with their operational expertise with competitive RFAs. Additional key stakeholders will only be identified after the competitive RFA process is completed for a given Initiative. In general, our criteria for selecting RFA awardees will rely on:

- Our typical processes to assess subawardees' readiness to efficiently implement programs in a manner consistent with the RHT-specific terms and conditions of this federal award.
- RHT-specific scoring based on the assessment of the applicant's existing relationships with rural New Jerseyans and rural-serving providers, the impact of any prior related work, and their capacity to consistently and meaningfully monitor and report on their ongoing implementation.
- Initiative-specific scoring based on any Initiative-specific requirements, including the elements that lend to scoring priority.

NJ acknowledges that many organizations, providers and facilities contribute to the healthcare ecosystem that cares for our rural residents. Therefore, we plan to design our RFA process to allow a broad range of rural-serving entities to apply. These include but are not limited to: the facilities included in the RHT NOFO, health systems, NJ Medicaid's regional health hubs, healthcare entities funded by programs from sister agencies (e.g., Department of Children and Families-funded agencies providing universal newborn nurse home visiting or pediatric behavioral health through the state's Children System of Care; DMHAS' maternal wrap around agencies supporting pregnant women with SUD), local public health agencies, schools, academic institutions, libraries, and other community organizations.

NJ RHT Implementation—Management Structure

DMAHS was chosen as the applicant for NJ's RHT application based on our regular working relationship with CMS, including our expertise with CMS reporting expectations for activities related to regular Medicaid operations, 1115 Demonstration, and CMMI Medicaid Innovation models. Throughout the application phase, we have been working closely with SORH

staff and the DOH staff at large given their expertise and insights in rural health. If awarded, we plan to continue to work closely with them during the implementation of NJ RHT Initiatives.

DMAHS will maintain a NJ RHT Core administrative team of seven people. The NJ RHT core team is necessary to ensure compliance with anticipated RHT-wide requirements—including but not limited to quarterly and annual reporting, annual Non-competing continuation applications, collaboration across state agencies, and monitoring and oversight of initiative implementation.

NJ RHT Stakeholder Engagement

NJ RHT's Stakeholder Engagement: Pre-award engagement

During the RHT application development phase, DMAHS collaborated closely with SORH to involve rural stakeholders. We utilized existing networks, targeted engagement, and created new forums for involvement and feedback with rural stakeholders.

(1) Existing networks: SORH hosts with New Jersey's Rural Health Council which includes FQHCs, NJ Primary Care Association, hospital systems, local public health, higher education institutions, and community-based organizations. We used an existing quarterly meeting to discuss RHT with the Council.

(2) Targeted engagement: We specifically sought out feedback from the following stakeholders: FQHCs; NJ Primary Care Association; leadership in rural-serving hospitals; the NJ Department of Children and Families, the NJ Maternal and Infant Health Innovation Authority, the NJ Department of State and its Commission on American Indian Affairs; the NJ Department of Education, the NJ Department of Labor, and the NJ's Office of Attorney General.

(3) New forums: We hosted a public listening session (which included verbal testimony from dozens of stakeholders), created a public email to receive feedback or program proposals, and created an online forum that received over 200 responses.

The information collected through these forums was used to inform the assessment of rural needs and prioritization of NJ RHT Initiatives.

After the submission of this application, DMAHS and DOH will host a pre-award innovation and technology informational meeting at the Robert Wood Johnson Foundation on December 4 to bring together prospective subawardees and innovation / technology vendors. This meeting is intended to create an opportunity for prospective subawardees to hear from the best in class innovators and technologists, discuss rural health, and begin to strategize about potential collaborations during NJ RHT implementation if NJ is awarded funding. We expect to host approximately 400 individuals at this event where stakeholders will hear details regarding NJ's RHT proposal and build relationships with participating vendors.

NJ RHT Stakeholder: Post-award engagement

The stakeholders that have contributed feedback to build the NJ RHT proposal will be crucial to the successful implementation of New Jersey's initiatives. DMAHS, SORH, and other state agencies will work jointly to execute the programs proposed within this grant and communicate with our agencies' rural stakeholders. We will leverage existing outreach and stakeholder efforts to the fullest extent possible, instead of creating new entities or structures. This approach respects the limited bandwidth of stakeholders, while advantageously relying on entities with established credibility. The NJ RHT team intends to sustain stakeholder engagement using the following forums:

(1) SORH virtually convenes the NJ Rural Health Council on a quarterly basis. In addition, on an annual basis, SORH hosts an in-person NJ Rural Health Conference. Launched first in 2023, this conference is now an annual convening of statewide stakeholders to focus specifically on how to improve rural health for New Jerseyans.

(2) DMAHS convenes quarterly with its Medical Assistance Advisory Council and Beneficiary Advisory Council. These forums can be used to discuss all aspects of NJ Medicaid work, which would include updates on RHT.

(3) DMAHS will also leverage other convenings in the state, such as those focused on maternal health (e.g., NJ Maternal Care Quality Collaborative's quarterly meetings), SUD care (e.g., NJPN's Annual Addiction Conference), or children's health (e.g., Children's Interagency Coordinating Council, county-based stakeholder group).

NJ RHT's Sustainability Plan

DMAHS has crafted NJ RHT to ensure lasting change rather than a temporary infusion of funds into rural areas. We anticipate building significant resources (workforce, technological and programmatic) in rural communities that will outlast the RHT funding and lays the groundwork for improved health outcomes for rural residents in the years beyond.

We do not intend to replace every dollar of funding that the RHT provides in FFY31. Instead, we are making targeted investments so that by the end of the funding period we will know which projects should continue and which should be scaled back.

There are several types of initiatives in this proposal—those that build infrastructure, those that train, retain and upskill workforce and those that direct proven models of care and support to previously unserved rural areas. In each case, NJ has a strong case for sustainability beyond the RHT funding horizon. Significant partnerships will be built locally to build support and

sustainability for the initiatives proposed in this application. The close partnership in the application between DMAHS and DOH ensures that many workforce enhancements will be sustainable through Medicaid reimbursement. Areas of innovation will be closely monitored and thoughtful metrics used to enable NJ to rapidly, and within the RHT funding period, determine which innovation projects demand further state investment as more permanent parts of our service array, and which do not have the return on investment for the health of rural populations and should be sunset.

NJ RHT Endnotes

[i] Source: https://www.nj.gov/health/fhs/primarycare/rural-health/

[ii] See Table D in *Other Supporting Documents* for excerpted health trends that are specific to NJ's RCTs.

[iii] Source: US Census Bureau (2023). American Community Survey 1-year estimates. Retrieved from Census Reporter Profile page for New Jersey [Online] http://censusreporter.org/profiles/04000US34-new-jersey/ .

[iv] Unemployment data source: New Jersey Department of Labor and Workforce Development. Unemployment Rates and Labor Force Estimates. Labor Market Information. [Online] October 7, 2025. https://www.nj.gov/labor/labormarketinformation/employment-wages/unemployment-rates-labor-force-estimates/.

[v] Sources: (1) *Association of Educational Attainment with Chronic Disease and Mortality: The Kidney Early Evaluation Program (KEEP).* Choi, Andy I, et al. 2, American Journal of Kidney Diseases: The Official Journal of the National Kidney Foundation, Vol. 58, pp. 228-234. (2) HD Pulse: An Ecosystem of Minority Health and Health Disparities Resources. *National Institute on Minority Health and Health Disparities.* [Online] October 10, 2025. https://hdpulse.nimhd.nih.gov.

[vi] Source: U.S. Census Bureau (2023). Presence and Types of Internet Subscriptions in Household American Community Survey 1-year estimates. [Online] October 7, 2025. https://censusreporter.org .

[vii] The AllTransit Performance Score is a weighted sum of transit connectivity, access to land area and jobs, and frequency of service. Source: The Center for Neighborhood Technology (CNT). AllTransit Rankings. AllTransit. [Online] [Cited: October 21, 2025.] https://alltransit.cnt.org/rankings/.

[viii] Source: Centers for Disease Control and Prevention. PLACES. [Online] [Cited: October 1, 2025.] https://www.cdc.gov/places.

[ix] Source: https://data.hrsa.gov/topics/health-workforce/shortage-areas/hpsa-find. For a map, see Figure E in *Other Supporting Documents.*

[x] NJ Hospital data (NJ vs national medians): higher debt (28.8 vs. 27.1), lower days cash on hand (98.29 vs. 199.7), higher accounts payables (71.17 vs. 67.9), older facilities (14.34 vs. 12.3). NJ FQHC data (NJ vs national medians): lower days cash on hand (40.3 vs. 122), higher accounts payable (42.49 vs. 29), lower operating margin (-6.44% vs. 7.00%), higher accounts receivables (39.23 vs. 37). Source: New Jersey Health Care Facilities Financing Authority (NJHCFFA).

[xi] Source: 49. New Jersey Department of Health. Prevalence of Annual Dental Visits Among Adults. *New Jersey State Health Assessment Data (NJSHAD).* [Online] [Cited: October 21, 2025.] https://www-doh.nj.gov/doh-shad/indicator/summary/Dental.html.

[xii] *Death rate Source*: Office of the Chief State Medical Examiner. Dashboard. [Online] [Cited: October 21, 2025.] https://ocsme.nj.gov/dashboard. *NAS Source*: New Jersey Department of Health. Neonatal Abstinence Syndrome. *Population Health.* [Online] [Cited: October 21, 2025.] https://www.nj.gov/health/populationhealth/opioid/opioid_nas.shtml.

[xiii] *Cause of death Source*: Leading Causes of Death. *New Jersey State Health Assessment Data.* [Online] [Cited: October 21, 2025.] https://www-doh.nj.gov/doh-shad/indicator/summary/LCODall.html. County death rates Source: Deaths due to Cancer by County, New Jersey 2023. *New Jersey State Health Assessment Data.* [Online] [Cited: October 14, 2025.] https://www-doh.nj.gov/doh-shad/indicator/view/CancerDeath.County.html. County Diagnosed rates: National Cancer Institute. Incidence Rate Table. *State Cancer Profiles.* [Online] [Cited: October 14, 2025.] https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=34&areatype=county&cancer=055&race=00&age=001&stage=999&type=incd&sortVariableName=rate&sortOrder=default&output=0#results.

[xiv] *Diagnosed Source*: New Jersey Department of Health. Diabetes (Diagnosed) Prevalence by County, New Jersey, 2021-2023. New Jersey State Health Assessment Data. [Online] [Cited: October 15, 2025.] https://www-doh.nj.gov/doh-shad/indicator/view/DiabetesPrevalence.County.html. *Prediabetes Source:* 33. —. Query Results for New Jersey Behavioral Risk Factor Survey Data - Pre-diabetes, Age-adjusted. *New Jersey State Health Assessment Data.* [Online] [Cited: October 21, 2025.] https://www-doh.nj.gov/doh-shad/query/result/njbrfs/DXDiabPre/DXDiabPreAA11_.html.

[xv] *County-specific source:* New Jersey Department of Health. Prevalence of Asthma among Adults by County, New Jersey, 2021-2023. New Jersey State Health Assessment Data. [Online] [Cited: October 17, 2025.] *https://www-doh.nj.gov/doh-shad/indicator/view/AsthmaPrevalence.County.html*. *State average source*: Centers for Disease Control and Prevention. CDC: Asthma. Most Recent National Asthma Data. [Online] October 3, 2025. https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm . *ER source: Emergency Department Visits due to Asthma. New Jersey State Health Assessment Data. [Online] [Cited: October 17, 2025.] https://www-doh.nj.gov/doh-shad/indicator/summary/NJEPHTAsthmaED.html.*

[xvi] *Source*: New Jersey State Health Assessment Data. *Prevalence of Chronic Obstructive Pulmonary Disease (COPD) among Adults by County, New Jersey, 2021-2023.* [Online] [Cited: October 17, 2025.] *https://www-doh.nj.gov/doh-shad/indicator/view/COPDPrevalence.County.html*. *ER source: Emergency Department Visits due to Chronic Obstructive Pulmonary Disease (COPD) by County, New Jersey, 2024. New Jersey State Health Assessment Data. [Online] [Cited: October 17, 2025.] https://www-doh.nj.gov/doh-shad/indicator/view/COPD_ED.CountyAAR.html.*

[xvii] Source: Prevalence of Obesity Among Adults Aged 20 and Over by County, New Jersey, 2021-2023. *New Jersey State Health Assessment Data.* [Online] [Cited: October 17, 2025.] https://www-doh.nj.gov/doh-shad/indicator/view/Obese.county.html.

[xviii] *Diagnosed Source:* New Jersey Department of Health. Cardiovascular Disease - High Cholesterol by County, New Jersey, 2017, 2021, 2023. *New Jersey State Health Assessment Data.* [Online] [Cited: October 21, 2025.] https://www-doh.nj.gov/doh-shad/indicator/view/CardiovascularDiseaseHC.County.html. *Screening Source:* Query Results for New Jersey Behavioral Risk Factor Survey Data - Cholesterol Test in Past 5 Years - Crude Prevalence. *New Jersey State Health Assessment Data.* [Online] [Cited: October 17, 2025.] https://www-doh.nj.gov/doh-shad/query/result/njbrfs/CholChk5Yr/CholChk5YrCrude11_.html.