title: Rural Health Transformation Grant Guide — Illinois version: 1.0 date: 2025-10-14 audience: State health agencies, Medicaid, rural providers, collaboratives

1. Executive Summary

Illinois can compete strongly for CMS's Rural Health Transformation (RHT) cooperative agreement by pairing the State's Medicaid transformation assets with the Rural Health Transformation Collaborative's capabilities in tele-enabled care, data interoperability, retail-and pharmacy-based access, and cybersecurity. CMS's program provides $50B across FY26–FY30 to eligible States, with awards expected by December 31, 2025; one application per State; and funds usable for technology, workforce, innovative care, and provider payments, among other uses. Submission is due November 5, 2025, with CMS hosting September applicant webinars. (cms.gov)

For early impact in rural Illinois, three offerings are particularly leverageable: (a) 24/7 tele-specialty coverage and remote monitoring to keep care local (Avel eCare; BioIntelliSense), (b) statewide interoperability and analytics via TEFCA-designated QHIN connectivity (eClinicalWorks/PRISMANet) atop secure cloud and a rural-hospital cybersecurity program with hundreds of participants (Microsoft + AHA), and (c) community access expansions through retail pharmacy partners (Walgreens, CVS, Walmart) and AHA/Topcon screening. These Collaborative vendors and roles are detailed in the coalition roster. (rce.sequoiaproject.org)

Alignment to Illinois's context is strong. Illinois reports 55 Critical Access Hospitals (CAHs) and 277 Rural Health Clinics (RHCs) (2025), with 45 HRSA Health Center Program awardees serving 1.47M patients (2024). As of September 2025, 2.49M of 3.17M Medicaid beneficiaries were enrolled in managed care (≈79%). The State joined the federal CCBHC Medicaid Demonstration in 2024. These baselines support a transformation model centered on rural primary care, behavioral health, and digitally-enabled specialty backstops. (ruralhealthinfo.org)

The plan outlined below is intentionally conditional and modular. It maps Illinois priorities to RHT requirements and identifies dependencies (e.g., procurement, policy levers, data-use agreements). It also specifies reporting, evaluation, and sustainability paths consistent with CMS guidance, Illinois Medicaid 1115 demonstrations, and federal data-exchange frameworks. (medicaid.gov)

One-page printable summary (for distribution)

- Program fit
  - Applicant: State of Illinois (only States eligible). Five-year cooperative agreement; awards by Dec 31, 2025; submission due Nov 5, 2025. (cms.gov)
  - Uses of funds include chronic disease prevention, provider payments, technology (telehealth/RPM/AI), workforce, cybersecurity, behavioral health, and innovative care models. (cms.gov)
- Illinois context (latest available)
  - Rural health assets: 55 CAHs; 277 RHCs (2025); 45 Health Center awardees, 1.47M patients (2024). (ruralhealthinfo.org)
  - Managed care: 2.49M of 3.17M Medicaid members in MCOs (Sep 2025). (hfs.illinois.gov)
  - Behavioral health: Illinois added to CCBHC Demonstration (2024). (cms.gov)
  - Maternal health: 2018–2020 review found 91% of pregnancy-related deaths potentially preventable; SUD was leading cause (32%). (dph.illinois.gov)
  - Overdose: 3,502 drug overdose deaths in 2023 (−8.3% YoY; opioids 2,855, −9.7%). (dph.illinois.gov)
- Highest-leverage Collaborative supports (subject to contracting/integration)
  - 24/7 tele-hospital services; remote specialty backup; RPM for chronic and post-acute care.
  - TEFCA QHIN connectivity (eClinicalWorks) and Azure-based analytics/cyber hardening; >550 rural hospitals enrolled in Microsoft's program as of Mar 2025 (AHA corroboration); some reports indicate >700 by July 2025. (rce.sequoiaproject.org)
  - Retail/community access and screening via Walgreens/CVS/Walmart; AHA/Topcon community screening.
- Primary options
  - Rural primary care and pharmacy integration; tele-ICU/ED; maternal-behavioral integration; EMS/community paramedicine. See Section 5.

2. Eligibility and RFP Fit

2.1 Program summary (condensed)

- Eligible applicant: Any U.S. State (not DC/territories). One submission per State; cooperative agreement over five fiscal years; awards Dec 31, 2025. (cms.gov)
- Funding: $50B total, FY26–FY30; 50% evenly split among approved States; 50% allocated by CMS using state rural metrics and technical factors, with specifics in the NOFO. (cms.gov)
- Uses of funds: prevention/chronic disease; provider payments; consumer-facing tech; training/TA for

tech-enabled care; workforce; health IT/cybersecurity; right-sizing services; behavioral health/SUD; innovative/value-based models; other Administrator-approved uses. (cms.gov)
- Timeline checkpoints: Applicant webinars (Sep 19 and Sep 25, 2025); application due Nov 5, 2025; awards by Dec 31, 2025. (ruralhealth.us)

2.2 Requirement–capability–evidence mapping

RFP requirement (abbrev.)	Collaborative capability (conditional)	Evidence
Five priority goals: health, access, workforce, innovative care, tech	Integrated tele-specialty (Avel eCare), RPM (BioIntelliSense), pharmacy access (Walgreens/CVS/Walmart); analytics and cyber stack (Microsoft + TEFCA QHIN connectivity)	CMS program overview of goals/uses; Collaborative roster and solution briefs. (cms.gov)
State-level data and interoperability plans	eClinicalWorks designated as a TEFCA QHIN (Jan 2025) to enable statewide exchange; Azure-based data lake and analytics.	Sequoia RCE designation; RCE QHIN directory. (rce.sequoiaproject.org)
Cybersecurity for rural providers	Microsoft–AHA rural hospital cybersecurity program; hundreds of rural hospitals enrolled (≥550 by Mar 2025; reports of >700 by Jul 2025).	AHA news; Microsoft blog; trade coverage. (aha.org)
Behavioral health integration	CCBHC integration and TA; State is in the CCBHC Medicaid Demonstration (2024).	CMS press release on CCBHC demonstration expansion. (cms.gov)
Telehealth, remote monitoring, and AI	Tele-hospitalist/ICU/ED (Avel eCare) and FDA-cleared RPM (BioIntelliSense BioButton System 510(k) Sep 2024).	Collaborative brief; FDA 510(k) K241101; BioSticker K191614. (accessdata.fda.gov)
Innovation with payment alignment	SI/advisory partners (Accenture, KPMG, PwC, AVIA) for value analytics, payment integrity, and program management.	Collaborative catalog.
Stroke/critical time-sensitive conditions	AI triage (Viz.ai) with CMS NTAP in 2020.	Viz.ai NTAP announcements; CMS NTAP page. (viz.ai)

Note on NOFO specificity: Some scoring weights, cost caps, and form-level instructions are referenced in Section 12's Assumptions and Open Questions pending direct citation to the final NOFO PDF (CMS RHT page confirms program structure and timeline). (cms.gov)

3. Illinois Context Snapshot

3.1 Selected metrics and context (latest available)

- Rural population share: 13.1% (2020 Census state estimate via NCSL). (ncsl.org)
- Rural facility mix: 55 CAHs; 277 RHCs; 119 FQHC sites outside urban areas ≥50,000 (as of July 2025, RHIhub/HRSA). (ruralhealthinfo.org)
- Health centers: 45 HRSA Health Center Program awardees; 1,467,629 patients served (UDS 2024). (data.hrsa.gov)
- Medicaid managed care: 3.17M total Medicaid; 2.49M in MCOs (Sep 2025). (hfs.illinois.gov)
- 1115 demonstrations: Healthcare Transformation waiver extended through 2029; Continuity of Care & Administrative Simplification active with extension pending. (medicaid.gov)
- Broadband: Illinois BEAD Initial Proposal approved (Jun 13, 2024); provisional BEAD plan indicates ~160,000 eligible locations targeted (Sep 2025). (ntia.gov)
- Maternal health: 2018–2020 maternal review—91% of pregnancy-related deaths potentially preventable; SUD leading cause (32%). (dph.illinois.gov)
- Overdose: 2023 overdose deaths 3,502 (−8.3% YoY), opioid deaths 2,855 (−9.7%). (dph.illinois.gov)

3.2 How the Collaborative slots into Illinois needs

- Keeping patients local: Tele-ICU/ED and virtual hospital services reduce transfers and support rural workforce; RPM stabilizes discharges and chronic disease management.
- Interoperability and reporting: TEFCA QHIN connectivity and cloud analytics support CMS reporting, ACO/APM readiness, and HIE augmentation. (rce.sequoiaproject.org)
- Community access: Retail-based hypertension/diabetes screening and pharmacy care models expand access points in rural counties.
- Cyber resilience: Enrollment of hundreds of rural hospitals nationally in Microsoft's program indicates feasibility for Illinois CAHs and small rurals. (aha.org)

3.3 Metric-to-capability table

Domain	Illinois metric (year)	Source	Matched Collaborative capability
Rural footprint	13.1% population rural (2020)	NCSL using 2020 Census	Pharmacy networks + mobile/community screening to reach dispersed populations. (ncsl.org)
CAHs/RHCs	55 CAHs; 277 RHCs (2025)	RHIhub (HRSA)	Tele-hospitalist/ICU/ED coverage; RPM; SI support for small-facility IT. (ruralhealthinfo.org)
Health centers	45 awardees; 1.47M patients (2024)	HRSA UDS	QHIN-enabled data sharing; ambient documentation; pop health analytics. (data.hrsa.gov)
Medicaid MCOs	2.49M in MCOs of 3.17M total (Sep 2025)	HFS enrollment PDF	Value analytics; payment integrity; SPA/contracting TA. (hfs.illinois.gov)
Maternal health	91% preventable pregnancy-related deaths; SUD leading cause (2018–2020)	IDPH	Integrated maternal-behavioral care; CCBHC + RPM postpartum monitoring. (dph.illinois.gov)
Overdose	3,502 deaths (2023), −8.3% YoY	IDPH	Tele-BH; SUD analytics; harm-reduction engagement via community sites. (dph.illinois.gov)
Interoperability	eClinicalWorks designated QHIN (2025)	Sequoia RCE	TEFCA exchange, statewide record retrieval, CMS reporting. (rce.sequoiaproject.org)
Cybersecurity	550–700+ rural hospitals enrolled nationally (2025)	AHA; Microsoft	Security assessments, discounts, training for rural IL hospitals. (aha.org)

4. Strategy Aligned to RFP

4.1 Transformation model (Illinois-tuned; conditional)

- Anchors: (1) Rural primary care and pharmacy integration with tele-specialty backstops, (2) behavioral health and maternal integration leveraging CCBHCs and FQHCs, (3) statewide data/cyber foundation to support reporting and cross-payer value models. (cms.gov)
- Mechanisms: Tele-ICU/ED/consults; RPM for high-risk CHF/COPD/diabetes; pharmacy-based HTN/diabetes management; community screening (AHA/Topcon); AI stroke triage; TEFCA-enabled care coordination; cyber uplift. (viz.ai)

4.2 Coverage of RHT pillars and scoring dimensions

- Access and outcomes: Tele-hospital services across CAHs, EMS consult, and specialty clinics; retail pharmacy engagement to extend hours and reach.
- Technology use: TEFCA QHIN connectivity; Azure-based analytics; RPM devices with FDA 510(k) clearance. (rce.sequoiaproject.org)
- Partnerships: Cibolo-enabled High Value Networks (HVNs) among rural providers; payer engagement for value-based arrangements.
- Workforce: Ambient documentation and tele-mentoring to reduce burden; pharmacy workforce development.
- Sustainability: Payment integrity and claims modernization; actuarial/economic modeling by SI partners.

4.3 Equity (rural and Tribal)

- Screening and navigation in retail/community settings with multilingual intake and patient-facing tools; routing to local FQHC/CCBHC resources; focus on Black maternal morbidity drivers noted by IDPH (2018–2020). (dph.illinois.gov)

4.4 Data use and privacy

- TEFCA-aligned exchange via eClinicalWorks QHIN; HIPAA-compliant cloud; role-based access; alignment with CMS reporting calendars. (rce.sequoiaproject.org)

5. Program Design Options (Illinois-tuned; any can be primary/backup; combinations possible)

Option A: Rural primary care + pharmacy integration for cardiometabolic control

- Target: Adults with hypertension/diabetes in rural counties; initial cohort ~50,000 patients across

CAHs/FQHCs/RHCs.
- Problem data: 13.1% rural population (2020) with access gaps; FQHCs serve 1.47M patients statewide (2024). (ncsl.org)
- Components: Retail pharmacy BP/diabetes management; RPM (BioIntelliSense); tele-primary/specialist consults; community screening (AHA/Topcon).
- Payment logic: Care-management fees and shared-savings pilots with MCOs; targeted provider payments within RHT allowances; pharmacy performance incentives where permissible. (cms.gov)
- Enablers: eClinicalWorks QHIN for care-gap closure; Azure analytics; pharmacy data integration. (rce.sequoiaproject.org)
- Risks: Scope-of-practice alignment; data-sharing agreements; addressed via standard agreements and SI support.

Option B: Tele-ICU/ED + community paramedicine

- Target: CAHs and rural EMS agencies serving high-transfer counties.
- Problem data: 55 CAHs (2025); workforce strain. (ruralhealthinfo.org)
- Components: 24/7 tele-ICU/ED, tele-pharmacy, EMS tele-consult; AI stroke triage (Viz.ai) with CMS NTAP precedent to offset costs; RPM for post-ED follow-up. (viz.ai)
- Payment logic: RHT funds for technology/services; Medicaid SPA for paramedicine pilots; MCO care-coordination payments (subject to CMS and State approvals). (cms.gov)
- Enablers: TEFCA connectivity and hospital/EMS interfaces; cyber uplift. (rce.sequoiaproject.org)

Option C: Maternal-behavioral integration with CCBHCs

- Target: Rural birthing populations and postpartum parents with SUD/MH risks.
- Problem data: 91% of pregnancy-related deaths potentially preventable; SUD 32% of causes (2018–2020). (dph.illinois.gov)
- Components: CCBHC-anchored BH access; RPM postpartum monitoring; pharmacy naloxone distribution and maternal HTN monitoring kits; tele-psychiatry. (cms.gov)
- Payment logic: RHT behavioral health supports; Medicaid 1115 HRSN/BH authorities for sustainment. (medicaid.gov)

Option D: Data and cybersecurity backbone for rural value-based care

- Target: CAHs, RHCs, FQHCs, small PPS rurals.
- Components: TEFCA QHIN participation; Azure analytics; cyber program enrollment; training and workforce development; payment integrity analytics. (rce.sequoiaproject.org)
- Outcome: CMS-ready reporting; incident reduction; accelerated SPA/APM design feasibility. (cms.gov)

6. Governance and Collaborative Roles

6.1 Structure (illustrative; subject to State decisions)

- State lead agency (designated by Governor): program authority, compliance, federal reporting.
- PMO (with SI support): integrated workplan, subrecipient monitoring, dashboards.
- Provider networks (e.g., Cibolo-enabled HVNs): joint investment planning; performance tracking.
- Payers (MCOs): alignment on incentives and value metrics; data-use frameworks.
- HIE/TEFCA QHIN (eClinicalWorks): exchange enablement, data agreements. (rce.sequoiaproject.org)

6.2 RACI (selected)

Task	State lead	Medicaid (HFS)	Provider networks	Payers	Collaborative (SI/tech)
Program governance & reporting	R	C	C	C	A (PMO tools, dashboards)
TEFCA onboarding	C	C	A	C	R (QHIN, cloud) (rce.sequoiaproject.org)
Tele-ICU/ED deployment	C	C	A	C	R (Avel, pharmacy, RPM)
Cyber program enrollment	C	C	A	C	R (Microsoft + AHA) (aha.org)
Evaluation & learning	R	A	C	C	C (analytics)

7. Payment and Funding

- Federal RHT funds can support provider payments (with program limits), technology, workforce, and innovative care models; half of funds are baseline, half workload-based per CMS. (cms.gov)
- Illinois Medicaid alignment: use existing 1115 Healthcare Transformation authorities (through 2029) for

sustainment of BH/HRSN-linked elements and to test aligned incentives; managed-care contracts for care-coordination and value-based pilots. (medicaid.gov)

Illustrative cost/deliverables table (planning placeholder)

Cost category	Illustrative ROM (annual)	Funding source	Timing	Collaborative deliverables
Tele-ICU/ED coverage for 15 CAHs	$20–30M	RHT + hospital match (if any)	Y1–Y5	24/7 clinician coverage, QA, metrics.
RPM (10,000 pts)	$8–12M	RHT + payer supports	Y1–Y5	Devices, dashboards, training, reports.
Data platform + TEFCA onboarding	$6–10M	RHT	Y1–Y3	QHIN onboarding, data lake, analytics. (rce.sequoiaproject.org)
Cyber uplift (50 hospitals)	$5–8M	RHT + Microsoft discounts	Y1–Y3	Assessments, training, security tooling. (aha.org)
Pharmacy-based HTN/DM mgmt.	$5–7M	RHT + payer	Y1–Y3	Protocols, training, data feeds.

Note: Amounts are planning placeholders for structuring narratives and will require procurement and pricing. All spend must adhere to final NOFO limits and 2 CFR/HHS GPS (see Section 12). (cms.gov)

8. Data, Measurement, and Evaluation

- Core measures: access (tele-encounters, time-to-consult), quality (BP control, A1c, readmission), behavioral health engagement, maternal outcomes (postpartum follow-up), EMS metrics, cybersecurity maturity indicators, and program implementation KPIs.
- Data sources and integrations: Medicaid claims (MCO + FFS), TEFCA QHIN exchange, EHRs (eClinicalWorks and others), EMS run data, pharmacy systems, and retail screening feeds; Azure analytics layer; secure dashboards for CMS reporting. (rce.sequoiaproject.org)
- Evaluation: independent third-party design with quasi-experimental methods where feasible; leverage SI partners for value tracking and learning health system loops.

9. Implementation Plan (12–24 months; subject to procurement)

Gantt-style view

Workstream	Start	End	Owner	Outputs
PMO stand-up; governance charter	Jan 2026	Mar 2026	State + SI	Charter, risk log, reporting plan.
TEFCA onboarding (pilot sites)	Feb 2026	Aug 2026	QHIN + providers	Data-sharing live for pilot cohort. (rce.sequoiaproject.org)
Cyber assessments (wave 1: 20 hospitals)	Feb 2026	Oct 2026	Microsoft partner	Findings, remediation roadmap, training. (aha.org)
Tele-ICU/ED launch (5 CAHs)	Apr 2026	Nov 2026	Avel eCare + CAHs	24/7 service live, quarterly QA reports.
RPM program (2,500 pts)	May 2026	Nov 2026	BioIntelliSense + FQHCs	Enrollments, alert protocol, outcomes. (accessdata.fda.gov)
Pharmacy HTN/DM pilots (10 counties)	May 2026	Dec 2026	Retail partners + providers	Protocols, shared care plans, metrics.
AI stroke workflow (5 hospitals)	Jun 2026	Dec 2026	Hospitals + Viz.ai	Door-to-needle time metrics, NTAP billing support. (viz.ai)
Evaluation baseline + dashboards	Mar 2026	Jul 2026	SI + State	Baseline report, dashboard v1.

Critical gating items: data-use agreements; BAA/security; procurement; Medicaid SPA (if used); facility privileging and credentialing for tele-specialists; pharmacy scope and payer engagement (as applicable).

10. Risk Register (selected)

Risk	Likelihood/Impact	Mitigation (owner)
Delays in subrecipient onboarding	Med/High	Pre-procured vendor pools; phased cohorts; PMO surge capacity (State/SI).

Risk	Likelihood/Impact	Mitigation (owner)
Data-sharing barriers across networks	Med/High	TEFCA QHIN participation and template DUAs (QHIN/State). (rce.sequoiaproject.org)
Cyber incident at a participating hospital	Low/High	Enrollment in rural cyber program; MFA, endpoint management, tabletop exercises (Hospital/Microsoft/AHA). (aha.org)
Workforce burnout/turnover	Med/Med	Tele-mentoring, ambient documentation tools, staffing models (Providers/Collaborative).
RPM patient adherence	Med/Med	Digital navigators; simple kits; patient education (BioIntelliSense/Providers).
Pharmacy scope or payer policy misalignment	Med/Med	Targeted pilots; payer MOUs; data on outcomes to inform coverage (State/Payers). (cms.gov)
APM/SPA timelines slip	Med/Med	Use existing 1115 authorities and contract levers; phased financial incentives (HFS). (medicaid.gov)
Vendor interoperability gaps	Med/Med	TEFCA exchange testing; interface financing (QHIN/Providers). (rce.sequoiaproject.org)
Maternal-behavioral coordination gaps	Med/Med	CCBHC partnership requirements; cross-referral pathways (HFS/CCBHCs). (cms.gov)
Rural hospital financial stress	Med/High	Tele-enabled service lines; value programs; targeted RHT provider payments (State/Providers). (cms.gov)

11. Draft RFP Response Language (paste-ready; edit to final State voice)

11.1 Project summary (≤1 page) Illinois proposes to advance a Rural Health Transformation model that expands rural primary care capacity, integrates behavioral health, and deploys tele-enabled specialty coverage and remote monitoring to keep care local. The State will build a unified data and cybersecurity backbone leveraging TEFCA QHIN exchange and cloud analytics to support outcomes tracking and CMS reporting. Programs will operate statewide with initial cohorts in rural counties prioritized by burden and readiness. Our approach is collaborative and conditional on contracting; subrecipients will be supported through a State-led PMO with experienced systems integrators. (cms.gov)

11.2 Rural health needs and target population (excerpt) Illinois's rural footprint (13.1% of residents; 2020 Census) relies on 55 CAHs and 277 RHCs (2025). HRSA Health Center awardees (45 organizations) served 1.47 million patients in 2024. Maternal mortality reviews (2018–2020) found 91% of pregnancy-related deaths potentially preventable, with SUD the leading cause (32%). In 2023, overdose deaths declined to 3,502 (−8.3% YoY). Our target population includes rural residents with cardiometabolic risk, pregnant/postpartum people with BH needs, and high-risk ED and EMS encounters in CAH catchments. (ncsl.org)

11.3 Strategies and initiatives (excerpt)

- Tele-ICU/ED and specialty consults for CAHs; remote pharmacy support; AI stroke triage (Viz.ai). (viz.ai)
- RPM for CHF/COPD/diabetes; maternal RPM; digital navigation. FDA-cleared devices are used. (accessdata.fda.gov)
- Community access via pharmacies and AHA-supported screening; referral to FQHCs/CCBHCs.
- Data/cyber: TEFCA QHIN integration; Azure analytics; enrollment in rural hospital cybersecurity program. (rce.sequoiaproject.org)

11.4 Implementation & monitoring (excerpt) A State-led PMO, supported by experienced SI partners, will manage phased roll-outs, subrecipient monitoring, and dashboards aligned to CMS cadence. Evaluation will include clinical, access, financial, and implementation metrics, with quarterly reviews and annual external evaluation.

11.5 Sustainability (excerpt) Sustainment will be driven by Medicaid managed-care arrangements, existing 1115 authorities (Healthcare Transformation through 2029), and payer value programs, with targeted business cases for CAHs and rural networks. (medicaid.gov)

12. Assumptions and Open Questions

- RHT NOFO details: Some specifics (e.g., technical scoring weights, point mechanics, cost caps, SF-424 box instructions) are taken from CMS public-facing summaries and stakeholder communications. The final NOFO PDF should be used for definitive instructions once accessible; CMS confirms eligibility, timeline, uses of funds, and overall structure on its RHT page and press release (Sep–Oct 2025). (cms.gov)
- Budget placeholders: Tables use order-of-magnitude estimates for planning; actual pricing will depend on procurement, negotiated rates, and the final award amount.
- DSH count: The NOFO requests the "count of hospitals receiving Medicaid DSH" for the most recent

reporting year; we reference HFS DSH determination resources but recommend confirming current counts from HFS's DSH unit. (hfs.illinois.gov)
- Pharmacy scope and payer policies: Specific service packages and reimbursement for pharmacy-based chronic disease management may require additional Illinois policy or payer alignment; proposals herein are conditional.

13. References

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19. Illinois HFS — DSH/MPA/MHVA Determination resources (hospital supplemental payment pages), accessed 2025-10-14. (hfs.illinois.gov)
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Appendices

A. Compliance checklists (excerpts; tie to NOFO once accessible)

- Applicant eligibility and submission
  - State applicant; AOR signature; Grants.gov submission; one application. (cms.gov)
  - Application due Nov 5, 2025; awards by Dec 31, 2025; confirm any LOI instructions once NOFO PDF is accessible. (cms.gov)
- Uses of funds (select at least three)
  - Prevention/chronic disease; provider payments; consumer tech; training/TA; workforce; IT/cyber; right-sizing; BH/SUD; innovative models. (cms.gov)
- Data/evaluation
  - Commit to CMS evaluations; define metrics, cadence, and data sources. (cms.gov)

B. Illustrative governance diagram and roles (narrative)

- State lead (HFS/SORH), PMO (SI), QHIN/eClinicalWorks, Microsoft cyber partners, Avel eCare, BioIntelliSense, retail pharmacies, FQHCs/CCBHCs, CAHs/RHCs, MCOs, universities. (rce.sequoiaproject.org)

AI Generation Notice

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