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

1. Executive Summary Maine is among the most rural states in the nation; 61.4% of residents lived in rural areas in 2020, heightening access, workforce, and infrastructure challenges across northern and Down East counties. The CMS Rural Health Transformation (RHT) Program offers cooperative-agreement funding beginning in FY 2026 with a one-time application due November 5, 2025. The funding formula splits awards between an equal Baseline share and a performance-based Workload share scored on rural facility/population factors and technical factors that Maine can influence through initiatives and policy actions. (ncsl.org)

The Rural Health Transformation Collaborative (the Collaborative) brings a configurable set of provider, technology, data, and advisory capabilities that can support Maine's RHT objectives while aligning with the program's scoring framework. For immediate impact, priority offerings include: (a) statewide tele-specialty support for rural hospitals and EDs (Avel eCare), (b) remote physiologic monitoring for chronic disease and maternal care (BioIntelliSense), (c) cloud security and analytics (Microsoft), (d) community access points through retail pharmacy/clinic partners (CVS, Walgreens, Walmart), (e) AI-enabled population analytics (Pangaea Data), and (f) rural provider High Value Network formation to coordinate investments (Cibolo Health). These functions are documented in the Collaborative portfolio and map directly to allowables A, D, F, G, H, I, J and to multiple technical factors (e.g., C.1, C.2, F.1–F.3).

Maine's existing infrastructure—HealthInfoNet as the statewide HIE; a maturing broadband buildout via the Maine Connectivity Authority; and an active Section 1115 SUD demonstration transitioning to a broader "Whole Person Care Waiver"—positions the State to activate distributed, data-connected care models quickly, subject to contracting, regulatory alignment, and local integration. (hinfonet.org)

The guide below synthesizes RHT NOFO requirements, Maine's context, and Collaborative capabilities into coherent, Maine-specific design options and an implementation path that is compliant with 2 CFR and program-specific caps (e.g., ≤15% provider payments; ≤20% capital/infrastructure; ≤10% admin), with risk-aware governance and measurement against CMS's initiative and data-driven scoring constructs. (files.simpler.grants.gov)

One-page summary (printable)

- Maine fit: Most-rural population share (61.4%, 2020); 17 Critical Access Hospitals (CAHs); 18 HRSA-funded health center awardees serving 207,134 patients (2024); OB service reductions in at least 16 hospitals; unserved broadband locations down to roughly 11% of addresses by 2024. (ncsl.org)
- High-leverage RHT use-of-funds for Maine (non-exhaustive): A Prevention/chronic; D Training/TA for tech-enabled care; F IT/cybersecurity; G Right-sizing service lines; H Behavioral health/SUD; I Innovative/value-based care; J Minor renovations/equipment. Caps: B provider payments ≤15%; J capital ≤20%; EMR replacement ≤5% (if HITECH-certified system existed 9/1/2025); admin ≤10%. (files.simpler.grants.gov)
- Fast-start Collaborative capabilities (illustrative): 24/7 tele-ER/ICU/hospitalist; RPM for CHF/COPD/diabetes/maternity; pharmacy-anchored chronic care support; ambient documentation and AI-gap closure; cyber hardening; HVN governance and PMO tooling.
- Maine-tuned program options: (1) Rural Primary Care + RPM Network; (2) EMS-enabled Community Paramedicine + Tele-specialty; (3) Maternal & Newborn Continuum in OB-limited counties; (4) Behavioral Health & SUD Integration with 1115 alignment. Each option includes payment, policy levers, and data integration with HealthInfoNet. (maine.gov)
- Scoring strategy: Align initiatives to C.1 Partnerships, C.2 EMS, F.1–F.3 Remote/Data/Consumer Tech; pursue policy points under D.2 Licensure compacts and C.3 Certificate of Need where consistent with Maine law; meet conditional-points deadlines (12/31/2027, 12/31/2028 for B.2/B.4). (files.simpler.grants.gov)

2. Eligibility and RFP Fit 2.1 Key NOFO facts (CMS-RHT-26-001)

- Eligibility: Only 50 States; DC/territories ineligible. One application per State; Governor designates AOR. (files.simpler.grants.gov)
- Dates: Optional LOI due 9/30/2025 to MAHARural@cms.hhs.gov; application due 11/5/2025 11:59 p.m. ET; award and earliest start 12/31/2025; info webinars 9/19 and 9/25/2025. (files.simpler.grants.gov)
- Funding structure: ~$50B over five budget periods (FY26–FY30); funds each year spendable until end of following fiscal year; 50% Baseline equal split; 50% Workload via points; rural facility/population factors fixed once using Q4 2025 data; technical factors recalculated annually. (files.simpler.grants.gov)
- Scoring weights (Table 3): A.1–A.7 (50% total) and B–F technical factors (50% total); initiative-based max 100 points per factor; conditional points for policy actions with deadlines (12/31/2027; 12/31/2028 for B.2/B.4). (files.simpler.grants.gov)
- Use of funds: must cover ≥3 categories; 2 CFR/HHS GPS apply. Selected caps/limits: provider payments

≤15%; category J capital ≤20%; EMR replacement cap ≤5% if HITECH-certified EMR already in place as of 9/1/2025; “Rural Tech Catalyst”-style funds ≤ the lesser of 10% or $20M/budget period; telecom/video surveillance restrictions per 2 CFR 200.216; admin (incl. indirect) ≤10% per period; SF-424 Box 19c “No” (E.O. 12372 not applicable). (files.simpler.grants.gov)

2.2 Compliance checkpoints (extract of NOFO)

- Required narratives: Project summary (1 p), Project narrative (≤60 p; format rules), Budget narrative (≤20 p). Required attachments/forms listed in Section 3. (files.simpler.grants.gov)
- Risk review: 2 CFR 200.206; award via Notice of Award; substantial CMS involvement (cooperative agreement). (files.simpler.grants.gov)

2.3 Requirement-to-capability mapping

- Table: RFP requirement → Collaborative capability → Evidence

RFP requirement (NOFO cite)	Collaborative capability	Evidence
≥3 use-of-funds categories; focus on prevention, tech, behavioral health, right-sizing (Program description; Use of funds; Appendix)	Integrated tele-specialty (Avel eCare), RPM (BioIntelliSense), behavioral health tele-supports, pharmacy-enabled chronic care, data/cyber platforms (Microsoft)	Collaborative portfolio description; aligns to categories A, D, F, G, H, I, J.
Scoring factor C.1 Strategic partnerships and C.2 EMS (Table 3; factor write-ups)	Formal rural provider High Value Networks; EMS tele-support and training	Documented HVN model (Cibolo Health) and EMS tele-support (Avel eCare).
F.1–F.3 remote/data/consumer tech; TEFCA/HIE references (Appendix examples)	Integration with HealthInfoNet; consumer screening tools; analytics and interoperability services	HealthInfoNet statewide HIE; Collaborative’s consumer-facing and analytics tools. (hinfonet.org)
Administrative cap ≤10% and 2 CFR/HHS GPS compliance (Funding policies)	Advisory partners provide compliant budgeting/PMO and subrecipient monitoring frameworks	Portfolio notes on program management, dashboards, and compliance support.
Policy conditional points w/ deadlines (12/31/2027; 12/31/2028 for B.2/B.4)	Technical assistance to draft implementable policies (e.g., licensure compacts adoption/implementation planning; EMS policies; nutrition CME coordination)	NOFO policy calendar; Collaborative advisory capabilities. (files.simpler.grants.gov)

3. Maine Context Snapshot 3.1 Population and geography

- Rural share: 61.4% of Maine’s population was rural in 2020 (2nd highest nationally), with large, low-density areas in Aroostook, Piscataquis, Somerset, and Washington counties. (ncsl.org)
- Frontier/remoteness: Maine includes Frontier and Remote (FAR) areas by USDA ERS criteria; remoteness complicates access to services. (primary.ers.usda.gov)

3.2 Health care facilities and networks

- CAHs: Maine DHHS notes 17 CAHs. (maine.gov)
- Health centers: HRSA UDS 2024 shows 18 Health Center Program awardees serving 207,134 patients (2024). (data.hrsa.gov)
- Rural Health Clinics (context): HRSA program materials indicate Maine hosts several dozen RHCs; exact counts vary by program year; planning should use current HRSA designations at time of award. (hrsa.gov)
- HIE: HealthInfoNet operates Maine’s statewide health information exchange supporting clinical/community providers. (hinfonet.org)

3.3 Workforce and shortage designations

- Maine participates in the Interstate Medical Licensure Compact (2017 law) and the Nurse Licensure Compact (NLC), facilitating cross-border practice to augment rural access; Maine is also joining the Physical Therapy Compact effective 1/1/2026. (legislature.maine.gov)
- HRSA designates primary care, dental, and mental health HPSAs across Maine; October 2025 HRSA map sets show statewide presence of HPSAs by discipline. (data.hrsa.gov)
- Maine CDC’s Rural Health & Primary Care program sponsors J-1 Conrad placements and rural workforce initiatives. (maine.gov)

3.4 Broadband and telehealth readiness

- Maine Connectivity Authority reports strong progress: as of 2024, an estimated 11% of locations remained unserved (<100/20 Mbps); 39% had 100/100 or better; MCA and partners have facilitated 70,000+ connections (by June 2024) and secured BEAD approval to target remaining unserved locations. (mdf.org)

3.5 Maternal and behavioral health

- OB service reductions: Maine EMS reports at least 16 ED destination hospitals without inpatient OB services as of March–April 2025, underscoring gaps in rural maternity access. (maine.gov)
- Overdose trends: Maine recorded 490 fatal overdoses in 2024 (preliminary), a 19% decline from 606 in 2023; Maine Drug Data Hub tracks ongoing reductions in nonfatal overdoses as well. (mainedrugdata.org)

3.6 Medicaid policy backdrop

- Section 1115: Maine's SUD Care Initiative (approved 2020; through 12/31/2025) is being renewed and broadened as the Whole Person Care Waiver effective 1/1/2026, adding SMI/IMD, pre-release services, HRSN supports, and traditional healing services. (medicaid.gov)

3.7 Maine metrics-to-solution table (examples)

Need/metric (year)	Source	Collaborative capability matched
61.4% population rural (2020)	NCSL summary of 2020 Census	Telehealth reach (Avel eCare); pharmacy-based access expansion (CVS/Walgreens/Walmart); RPM for chronic disease. (ncsl.org)
17 CAHs statewide	Maine DHHS	24/7 tele-ER/ICU; cyber hardening; shared hospitalist coverage. (maine.gov)
18 health center awardees; 207k patients (2024)	HRSA UDS	Chronic care RPM and ambient documentation; analytics to close care gaps. (data.hrsa.gov)
16 hospitals without inpatient OB services (2025)	Maine EMS	Tele-MFM, RPM for high-risk pregnancy, community hubs via pharmacies. (maine.gov)
11% of locations unserved; BEAD plan active (2024)	MDF; Governor's Office/MCA	Remote care (F.1) with broadband targeting; cyber/interop investments (F.2). (mdf.org)
490 overdose deaths in 2024 (−19% YoY)	Maine Drug Data Hub (Dec 2024 report)	Tele-behavioral health; SUD care pathways; risk-alerts via consumer apps. (mainedrugdata.org)

Assumptions and Open Questions (for confirmation)

- Latest, official counts of Maine Rural Health Clinics and Medicaid DSH-receiving hospitals for the most recent SPRY are pending retrieval from HRSA/CMS/MaineCare sources; placeholders above avoid quoting a specific 2025 count. (files.simpler.grants.gov)
- CCBHC site list as of 9/1/2025 requires SAMHSA/Maine DHHS confirmation for the application attachment.
- SNAP waiver status and B.4 Nutrition CME policy feasibility require review with relevant Maine agencies and professional boards; conditional points depend on enactment by NOFO deadlines. (files.simpler.grants.gov)

4. Strategy Aligned to RFP 4.1 Model overview for Maine

- Concept: A statewide, distributed "network-of-networks" anchored by rural providers, HealthInfoNet data services, and county-level access nodes (clinics, pharmacies, EMS bases) to deliver prevention, chronic care, urgent/critical consults, maternal/behavioral supports, and right-sized hospital services. Collaborative members can support technology, clinical service augmentation, workforce enablement, and PMO/evaluation within Maine's governance. (hinfonet.org)
- Alignment to NOFO pillars and scoring:
  - Partnerships (C.1): organize High Value Networks (HVNs) to pool investments, share coverage, and negotiate value-aligned arrangements.
  - EMS (C.2): equip EMS with tele-medical backup and training to extend rural access.
  - Remote/data/consumer tech (F.1–F.3): deploy RPM, secure cloud analytics, and patient-facing screening/triage tools; integrate to HIE.
  - Policy factors (D.2 compacts; C.3 CON; B.4 nutrition CME; B.3 SNAP waivers): provide technical assistance for feasible policy paths by 2027/2028 conditional-point deadlines.

(files.simpler.grants.gov)

4.2 Equity strategy (rural and Tribal)

- Use HealthInfoNet to stratify outcomes by geography and demographics; extend access through retail and community venues in northern and Washington/Aroostook counties; integrate traditional healing services anticipated under Maine's 1115 renewal for Tribal partners, subject to Tribal leadership direction and contracting. (hinfonet.org)

4.3 Data use & privacy

- HealthInfoNet as data backbone augmented by cloud analytics; adherence to HIPAA, 42 CFR Part 2, and ONC information-blocking rules; alignment with TEFCA-oriented exchanges referenced in the NOFO examples; cyber controls per Microsoft/Azure security patterns, configured to Maine policies. (files.simpler.grants.gov)

5. Program Design Options (Maine-tuned) Option A: Rural Primary Care + RPM Network (primary)

- Target population: Adults with CHF, COPD, diabetes in CAH/FQHC panels in Aroostook, Somerset, Washington, Piscataquis. Need: high chronic burden; travel barriers; rural workforce scarcity. (ncsl.org)
- Services: BioIntelliSense BioButton RPM; tele-cardio/pulmonology consults; pharmacy-anchored BP/diabetes management; ambient documentation to reduce clinician burden; HIE integration for alerts.
- Payment: blend of category B capped provider payments (≤15%), A/D/F investments; evaluate shared-savings or global budget pilots within I (innovative care) for HVNs. (files.simpler.grants.gov)
- Policy enablers: compacts (retain/implement where applicable), scope-of-practice optimization. (legislature.maine.gov)
- Partners/IT/staffing: FQHCs, CAHs, retail partners; state PMO; Collaborative SI/advisory.
- Pros/risks: Pros—directly addresses F.1–F.3; scalable via pharmacies. Risks—RPM adherence, broadband gaps; mitigations—digital navigators, MCA targeting. (mdf.org)

Option B: EMS-Enabled Community Paramedicine + Tele-specialty

- Target: High-acuity rural EDs and EMS regions with long transports. Need: EMS response times/skills maintenance, limited specialty on call. (files.simpler.grants.gov)
- Services: Tele-ER/ICU, community paramedicine protocols, EMS tele-training; hospitalist backup.
- Payment: D (training), F (tech), G (right-sizing), with minimal B (≤15%). (files.simpler.grants.gov)
- Pros/risks: Pros—supports C.2; reduces transfers. Risks—protocol adoption; mitigations—HVN governance and Maine EMS engagement. (maine.gov)

Option C: Maternal & Newborn Continuum in OB-limited counties

- Target: Counties with OB service closures/reductions. Need: access to prenatal/postpartum care; high-risk monitoring. (maine.gov)
- Services: Tele-MFM; RPM (BP/weight, glucose); pharmacy/community hubs for screenings; HIE-driven care coordination.
- Payment: A, D, F, J (minor renovations/equipment) within ≤20% capital cap. (files.simpler.grants.gov)

Option D: Behavioral Health & SUD Integration aligned to 1115

- Target: MaineCare members with SUD/SMI; justice-involved pre-release pilots. Need: access, continuity, overdose prevention. (maine.gov)
- Services: 24/7 tele-behavioral consults; mobile crisis support; consumer risk-alerts; transitions-of-care; data-sharing via HIE. (hinfonet.org)
- Payment: HRSN pilots via 1115; A/H/I categories; minimal B. (maine.gov)

6. Governance and Collaborative Roles 6.1 Structure (text diagram)

- State (Lead Agency designated by Governor): program oversight, policy coordination, compliance, funds flow.
- MaineCare (Medicaid): payment alignment, SPA/1115 interfaces, data-sharing agreements.
- HealthInfoNet: statewide data exchange services, analytics interfaces, privacy governance. (hinfonet.org)
- HVN(s) of rural providers (with Cibolo Health support): investment coordination, shared services, value arrangements.
- Collaborative partners: clinical services (Avel eCare), RPM (BioIntelliSense), retail access nodes, cloud/cyber/AI (Microsoft), analytics (Pangaea), SI/PMO (Accenture/KPMG/PwC/AVIA).

6.2 RACI (selected)

- CMS reporting and continuation applications: Responsible—State PMO; Accountable—Lead Agency; Consulted—Collaborative SI; Informed—providers/HIE. (files.simpler.grants.gov)
- HVN formation and provider onboarding: Responsible—HVN/Collaborative; Accountable—State; Consulted—hospital assoc./FQHCs/payers; Informed—HIE.
- Cybersecurity plan (if accessing HHS systems/PII/PHI): Responsible—State/HIE; Accountable—Lead Agency; Consulted—Microsoft/partners. (files.simpler.grants.gov)

7. Payment and Funding 7.1 Paths consistent with NOFO

- Short-term provider payments (≤15%) to catalyze chronic disease management or coverage enhancements; transition to sustainable arrangements (e.g., shared savings/global budgets) under category I. (files.simpler.grants.gov)
- Capital/equipment (≤20%) for telehealth rooms, monitoring kits, EMS equipment, and minor renovations tied to right-sizing service lines. (files.simpler.grants.gov)
- Administrative ceiling (≤10%) including indirects; transparent subrecipient monitoring per 2 CFR. (files.simpler.grants.gov)

7.2 Illustrative budget ROM (per year; final to SF-424A/Budget Narrative)

- Table: Cost category → ROM → RHT category → Funding timing → Deliverables

Category	ROM	Category tag	Timing	Collaborative deliverables
Tele-specialty services	$25–35M	A/I	BP1–BP5	24/7 coverage, protocols, dashboards.
RPM & devices	$20–30M	A/D/F/I	BP1–BP5	Kits, triage, navigation, analytics.
Cyber/data platform	$10–20M	F	BP1–BP3	Secure cloud, identity, SOC services.
Community hubs (retail/EMS)	$10–15M	A/G/J	BP1–BP3	Kiosks, rooms, minor renovations.
Workforce training	$5–10M	D	BP1–BP5	CME/CE, tele-mentoring.
Admin/PMO/eval (≤10%)	≤$20M	Admin	BP1–BP5	PMO, subrecipient monitoring, evaluation. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Measures: access (virtual visits per 1,000 rural residents), quality (HEDIS-like chronic metrics), utilization (avoidable ED, transfers), maternal outcomes (prenatal/postpartum visit adherence), SUD outcomes (initiation/engagement), financial sustainability (operating margin trends), tech adoption (RPM adherence), and implementation KPIs. Ties to CMS initiative scoring and data-driven factors. (files.simpler.grants.gov)
- Sources: HealthInfoNet clinical data; Medicaid claims/T-MSIS; EMS run data; HRSA UDS; pharmacy/hub data; RPM streams; surveys. (hinfonet.org)
- Evaluation: mixed-methods; quarterly dashboards; annual continuation applications ~60 days before period end as required. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; subject to procurement) 9.1 Gantt-style summary

Workstream	Start	End	Owner	Outputs
Program mobilization & governance	Jan 2026	Mar 2026	State PMO/HVN	Charter, RACI, subrecipient protocols.
Data & cyber foundation (HIE integration, cloud)	Jan 2026	Oct 2026	HIE + Microsoft	Data pipelines, SOC runbook.
Tele-specialty activation (tiered sites)	Mar 2026	Dec 2026	Avel eCare + CAHs	24/7 tele-ER/ICU at initial 8–10 sites.
RPM cohort onboarding (chronic/maternal)	Apr 2026	Dec 2027	BioIntelliSense + FQHCs	5k–10k patients onboarded; adherence program.
Community hubs (retail/EMS)	Apr 2026	Sep 2027	Retail + EMS + providers	Screening stations; tele-rooms; training.
Workforce training & tele-mentoring	Feb 2026	Dec 2027	NACHC/Avel/Advisors	CME/CE, EMS protocols, digital navigator cadre.

Workstream	Start	End	Owner	Outputs
Evaluation & CMS reporting	Ongoing	Ongoing	State PMO	Quarterly dashboards; annual NCCs. (files.simpler.grants.gov)

9.2 Gating decisions

- Data-use agreements and BAAs executed; procurement compliance; policy change timelines aligned to conditional points (12/31/2027; 12/31/2028). (files.simpler.grants.gov)

10. Risk Register (selected)

- Broadband unserved pockets delay RPM/telehealth. Mitigation: target MCA-prioritized locations; offer offline workflows and device caching; leverage WIA stopgaps. Owner: State PMO/HIE. (mdf.org)
- Cyber incidents at small facilities. Mitigation: managed security services; tabletop exercises; MFA/zero trust. Owner: HIE/Microsoft.
- Clinician adoption fatigue. Mitigation: ambient documentation; tele-mentoring; phased rollouts; change management. Owner: Providers/Advisors.
- RPM adherence drop-off. Mitigation: digital navigators; pharmacy follow-ups; incentives. Owner: FQHCs/Retail.
- OB coverage gaps persist despite tele-MFM. Mitigation: community doula/CHW supports; transport protocols; targeted capital within caps. Owner: Providers/EMS. (maine.gov)
- Data-sharing friction. Mitigation: standardized interfaces via HIE; privacy governance; patient consent workflows (42 CFR Part 2). Owner: HIE/PMO. (hinfonet.org)
- Policy conditional points at risk. Mitigation: early legal drafting, stakeholder engagement, staged enactment by deadlines. Owner: State/Advisors. (files.simpler.grants.gov)
- Admin cost creep >10%. Mitigation: strict cost accounting; indirect rate oversight; portfolio PMO. Owner: State PMO. (files.simpler.grants.gov)
- Procurement delays. Mitigation: pre-competed vehicles; clear SOWs; phased deliverables. Owner: State Procurement. (files.simpler.grants.gov)
- Overlap with reimbursable services. Mitigation: duplication SOPs; payer coordination; use B-category sparingly within cap with transformation rationale. Owner: State/Providers. (files.simpler.grants.gov)

11. Draft RFP Response Language (paste-ready excerpts; adapt to Maine) 11.1 Rural health needs & target population (Project Narrative section) “Maine is predominantly rural (61.4% rural population in 2020), with significant frontier/remote geography. Access challenges are concentrated in Aroostook, Washington, Somerset, and Piscataquis counties. The State maintains 17 Critical Access Hospitals and 18 HRSA-funded health center awardees serving 207,134 patients (2024). In 2024, Maine recorded 490 fatal overdoses (−19% vs. 2023). OB service reductions affect at least 16 hospitals. This plan prioritizes rural residents in the counties named above, with a focus on adults with chronic disease, pregnant/postpartum individuals in OB-limited markets, and individuals with behavioral health/SUD needs.” (ncsl.org)

11.2 Goals, strategies, policy timeline “Our RHT goals are to (1) improve chronic disease control; (2) expand timely access to urgent/specialty care; (3) strengthen maternal/behavioral health; (4) modernize data/cyber infrastructure. We will pursue conditional points where feasible, with policy actions slated for enactment by December 31, 2027 (and by December 31, 2028 for B.2 and B.4).” (files.simpler.grants.gov)

11.3 Proposed initiatives & use of funds (examples) “Tele-specialty and community paramedicine (C.1, C.2; A, D, F, G): Deploy tele-ER/ICU/hospitalist support to CAHs/REHs and EMS with training and protocols, reducing avoidable transfers and supporting local stabilization.”

“Chronic disease and maternal RPM (F.1–F.3; A, D, F, J): Provide RPM kits and digital navigation for CHF/COPD/diabetes and high-risk pregnancy, integrated with HealthInfoNet and clinic EHRs.”

“Behavioral health & SUD integration with 1115 (H, I): Expand tele-behavioral consults and transitions-of-care, coordinated with the State’s Whole Person Care 1115 renewal.” (maine.gov)

11.4 Implementation plan & timeline (excerpt) “Phase 1 (Jan–Mar 2026): governance, data/cyber baseline. Phase 2 (Mar–Dec 2026): tele-specialty activation at pilot CAHs; RPM cohort onboarding; community hubs established. Phase 3 (2027): scale to additional sites; evaluate outcomes; adjust payment incentives.” (files.simpler.grants.gov)

11.5 Stakeholder engagement “Governance includes Maine DHHS/Medicaid, HealthInfoNet, provider/HVN leadership, EMS, FQHCs, hospitals, retail partners, Tribal/IHS partners where applicable, and payers. Engagement uses joint workgroups, HVN councils, and public reporting dashboards.” (hinfonet.org)

11.6 Metrics & evaluation “We will report initiative scores per NOFO and track data-driven metrics relative to other States. Evaluation uses HealthInfoNet data, Medicaid claims, EMS runs, and RPM feeds to track access,

quality, utilization, and sustainability outcomes." (files.simpler.grants.gov)

12. References

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