OMB Number: 4040-0019
Expiration Date: 06/30/2028

Project Abstract Summary

This Project Abstract Summary form must be submitted or the application will be considered incomplete. Ensure the Project Abstract field succinctly describes the project in plain language that the public can understand and use without the full proposal. Use 4,000 characters or less. Do not include personally identifiable, sensitive or proprietary information. Refer to Agency instructions for any additional Project Abstract field requirements. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

Funding Opportunity Number

CMS-RHT-26-001

Assistance Listing Number(s):

93.798

Applicant Name

Department of Health and Human Services, Maine State of

Descriptive Title of Applicant's Project

Maine’s Rural Health Transformation Plan proposes a new approach to delivering rural health care so that rural Mainers will have a resilient and integrated rural healthcare system accessible to all.

Project Abstract

Maine stands out as America’s oldest and one of its most rural states, where rural residents face far higher risks of chronic disease than the national average. Adults in Maine’s rural communities are more likely to have heart disease, the leading cause of death in our state. Nearly one in eight lives with diabetes, and one in five has lost six or more teeth to decay or disease. These complex health needs, combined with our aging population, drive rising demand for services, while rural geography adds costs, logistical barriers, and workforce shortages. Together, these challenges call for a new approach to delivering rural health care, and Maine’s Rural Health Transformation Plan (RHTP) proposes a path to achieve that transformation.

Maine’s RHTP strategy envisions a future rural health system in which where one lives no longer dictates health outcomes or access to care; a stronger workforce, mobility innovations, and technologies ensure quality care is available to rural Mainers when they need it, where they need it; and a rural health system that is strong and sustainable for generations of Mainers. Maine will track our progress towards achieving this vision through four overarching goals:

(1) Increase the relative percentage of residents in rural areas with high BP that is well-controlled by 10%.
(2) Reduce the relative 30-day all-cause readmission rate among rural patients by 10%.
(3) Reduce the relative percentage of adults in rural areas who report delaying medical care for reasons other than costs by 10%.
(4) Reach at least 75% of Maine's rural hospitals achieving annual operating margins sufficient to make ongoing investments to improve operations and care (at or above 1% operating margin).

Our plan is organized around five initiatives to achieve these goals. To empower rural Mainers to achieve their own healthy living goals, we will adopt and expand proven population health solutions. To expand the supply of care, we will grow our rural healthcare workforce and implement technologies that connect every community to advanced care. And to ensure care will be available and affordable long into Maine’s future, we will pair affordability measures with strategies that advance quality, efficiency, and fiscal durability. By the conclusion of this work, rural Mainers will have a resilient and integrated rural healthcare system that is accessible to all, delivers consistent, high-value care, and achieves better health outcomes statewide. Our proposal’s total budget is $1 billion, per CMS instructions, using an illustrative award amount of $200 million for each budget period.

The plan’s implementation will be led by Maine’s Department of Health and Human Services in collaboration with other State agencies and many partnering organizations secured through Subawards and contracts.

Janet T. Mills
GOVERNOR

STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

October 31, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services | U.S. Department of Health and Human Services
7500 Security Boulevard, Baltimore, MD 21244

RE: Governor's Letter of Endorsement for RHTP – Opportunity number CMS-RHT-26-001

Dear Dr. Oz:

Support for RHT Plan: I am pleased to submit this letter of support for, and committing to, our State's proposed Rural Health Transformation Plan. From the woods of Aroostook County to the islands off the Downeast coast, to the hills of Oxford County and everywhere in between, I care deeply about the people of Maine's rural communities and about innovative ways to strengthen their health care. Maine is one of the most rural states in the nation. I am proud of the transformative path set forth by this plan towards better health for all rural Mainers.

Lead agency: I have designated the Maine Department of Health and Human Services (ME DHHS) as the lead agency responsible for this program. Commissioner Sara Gagné-Holmes is our application's primary point of contact. She can be reached at sara.gagne-holmes@maine.gov or 207-287-4223.

Certification of engagement with required entities and engagement with other key stakeholders: I certify that Maine's application was developed in collaboration with input from the following:

- ME DHHS, our State health agency, which includes Maine's State Medicaid agency
- Maine's Rural Health and Primary Care Program at Maine Center for Disease Control and Prevention (ME CDC), which functions as the State office of rural health
- Chiefs or their representatives from the Houlton Band of Maliseet Indians, Mi'kmaq Nation, Passamaquoddy Tribe at Indian Township, Passamaquoddy Tribe at Pleasant Point, and Penobscot Nation as well as Wabanaki Public Health and Wellness
- Private sector stakeholders, including the Maine State Chamber of Commerce, the Maine Hospital Association, the Maine Primary Care Association, the Maine Alliance for Addiction and Mental Health, and Consumers for Affordable Healthcare
- Higher education institutions, including the University of Maine System and the Maine Community College System
- Other Maine State Agencies, including the Department of Economic and Community Development, the Department of Public Safety, the Bureau of Maine Emergency Medical Services, the Department of Education, the Department of Labor, the Department of Professional & Financial Regulation, the Office of Affordable Health Care, and the Governor's Office of Policy Innovation and the Future

- Public comments from 300+ respondents submitted online, 65 participants at four regional community listening sessions, and 65 participants at Maine's health workforce summit.

From these stakeholders, we sought input about the biggest challenges facing rural health in Maine and what kinds of solutions Maine's RHT Plan should prioritize. The challenges we heard were consistent and shaped the five initiatives through which Maine's plan is organized: unaddressed root causes of disease, workforce shortages, gaps in technology and infrastructure, barriers to accessing care, and financial instability of providers. The activities proposed within each of Maine's initiatives address these priorities and reflect much of the creativity and innovative ideas suggested by Maine's rural residents.

To enable continued stakeholder engagement through implementation and support the long-term sustainability of Maine's rural health advancements, Maine will convene the *Maine RHTP Advisory Group* and, in Maine's most rural communities, several *Rural Regional Planning Groups*. Both are described in more detail in our proposal. Maine will also continue to collaborate with a wide range of state and regional partners to advance the efforts of the RHTP.

State-level commitments: I commit my administration to the effective, efficient, and transparent implementation and leadership of Maine's plan, and to the careful stewardship of U.S. taxpayer dollars in this work. The plan's implementation will be led through ME DHHS in collaboration with my office, other State agencies, and our many partnering organizations. Maine's current legislative and regulatory framework supports RHTP objectives by promoting expanded access, high-quality care, and cost-effective services in rural communities. Maine's State policies largely align with the intent of the scoring factors and provide a strong foundation for advancing rural health transformation.

Certification of compliance with prohibited uses of funds: I hereby certify that the State will not spend any award funds on activities prohibited under 42 U.S.C. 1397ee(h)(2)(A)(ii).

Benefiting rural residents across Maine: To ensure that the funding will benefit rural residents across the entire State, my administration will conduct annual formal evaluations that include data on the reach of RHTP initiatives throughout Maine's rural communities, and on integrating these findings in our governance, performance improvement, and oversight operations.

Maine's RHT Plan, using investments in technology and other tools, positions our State for a future in which where one lives no longer dictates health outcomes or access; in which quality care is available to rural Mainers when they need it, where they need it; and in which our rural health system is strong and sustainable for future generations of Mainers. It is my hope that CMS will act favorably on this application.

Sincerely,

Janet T. Mills
Governor

State of Maine

Rural Health Transformation Program
Project Narrative

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EXECUTIVE SUMMARY

Maine stands out as America's oldest and one of its most rural states, where rural residents face far higher risks of chronic disease than the national average. Adults in Maine's rural communities are more likely to have heart disease, the leading cause of death in our state. Nearly one in eight lives with diabetes, and one in five has lost six or more teeth to decay or disease. These complex health needs, combined with our aging population, drive rising demand for services, while rural geography adds costs, logistical barriers, and workforce shortages. Together, these challenges call for a new approach to delivering rural health care, and Maine's Rural Health Transformation Plan (RHTP) proposes a path to achieve that transformation.

Maine's RHTP strategy envisions a future rural health system in which where one lives no longer dictates health outcomes or access to care; a stronger workforce, mobility innovations, and technologies ensure quality care is available to rural Mainers when they need it, where they need it; and a rural health system that is strong and sustainable for generations of Mainers.

This plan is organized around five initiatives. To **empower rural Mainers to achieve their own healthy living goals**, we will adopt and expand proven population health solutions. To **expand the supply of care**, we will grow our rural healthcare workforce and spread technologies that connect every community to advanced care. And, to **ensure care will be available and affordable long into Maine's future**, we will pair affordability measures with strategies that advance quality, efficiency, and fiscal durability. By the conclusion of this work, rural Mainers will have a resilient and integrated rural health system that is accessible to all and delivers consistent, high-value care and better health outcomes statewide.

1. RURAL HEALTH NEEDS AND TARGET POPULATION

Maine's Rural Population: For generations, Maine has carved its resilient character and economic might out of the forests, farms, rivers, and oceans that makeup our rural regions. With a population of approximately 1.36 million people spread across a land area nearly equivalent to all other New England states combined, Maine is one of America's most rural states. Portland, Maine's largest city, is home to fewer than 70,000, ranking 558th largest in the country and Maine's only city in the nation's largest 1,000. Bangor, the largest community in Maine's northern region, is home to fewer than 33,000, ranking it 1,262 largest.

For the purposes of the RHTP, rural areas and populations of Maine are defined in accordance with the Federal Office of Rural Health Policy (FORHP). Under this classification, over 690,000 Maine residents, equating to 51% of the state's total population, live in rural areas, as compared to 19% of the U.S. population. Twelve of Maine's 16 counties are considered "fully rural," with 100% of their populations in rural areas. The remaining four counties are designated as "partially rural," with a mix of rural and non-rural populations. Significant portions of the populations of several counties, including Aroostook (99%), Washington (99%), and Knox (78%),

reside in areas deemed “frontier and remote” (FAR) by the United States Department of Agriculture. Additionally, Maine’s rural population includes year-round residents of 15 offshore islands, with populations ranging from a few dozen to over a thousand residents. Many have no healthcare facilities while others are served by a single small clinic.

In this proposal, data are aggregated at the county level since many measures are not available at the census-tract level. This analysis provides the foundation for identifying and describing the target populations that will benefit from our RHTP. Detailed Data Tables are provided in the **Other Supporting Documentation**.

Target Population: Our proposal focuses on the 690,000 Mainers living in rural areas and the health care providers who serve them. This includes residents of Maine’s 12 fully rural counties and rural areas within its four partially rural counties. Because providers in both rural and non-rural areas care for these communities, the program is expected to benefit all Mainers. In 2024, for example, nearly 50% of patients receiving inpatient services at Northern Light Eastern Maine Medical Center, the only tertiary care facility for northern Maine located in Bangor, came from fully rural counties. To address the needs of these rural populations, Maine’s RHTP focuses on high-priority health areas, including primary, specialty, perinatal, behavioral, and oral healthcare, with special attention to older adults and youth with behavioral health needs.

Rural Demographics: Maine is home to hundreds of thousands of rural residents seeking a great place to live, work, and raise a family. We are also America’s oldest state with a median age of 45; fully rural counties are home to an even older population, with an average median age exceeding 50. As our population ages, our healthcare system has experienced a growing demand for services, increase in complex conditions, and shortages of critical healthcare workers. With

Maine's population aged 65 and older projected to increase by 16% from 2025 through 2030, strains on Maine's rural healthcare system are only expected to intensify.

Economic challenges compound barriers to rural health. In the past 25 years, global forces have battered Maine's heritage industries of forestry, fishing, and farming, which are the lifeblood of our state's economy. These changes have taken millions of dollars out of our rural areas. As jobs are lost, communities have been disrupted, contributing to substance use disorders and behavioral health needs. Employment, wages, and education among rural Mainers lag their peers in other parts of the state and country. Median household income in rural Maine is 13% below the national average and one in six children live below the poverty line.

Employment is also lower, with only 37% of working-age adults in fully rural counties employed full-time and year-round, compared to 44% in partially rural counties. Median household income in fully rural counties is $68,000, 13% below the national average, and nearly one in seven individuals and one in six children in these counties live below the poverty line. Health insurance coverage varies as well: over 10% of non-elderly adults in fully rural counties are uninsured (versus less than 8% in partially rural), and the rate of Medicaid coverage is higher: nearly one in three individuals in fully rural counties versus 1 in 4 in partially rural counties.

Population Health: Residents of fully rural counties experience higher rates of chronic disease, oral and behavioral health challenges, and adverse maternal and infant outcomes. These communities also have higher shares of residents with complex healthcare needs: over 10% are veterans (compared to 6% nationally), one in seven of whom has a service disability of 70% or more, reflecting complex healthcare needs related to their service. In addition, disability prevalence is higher across Maine than nationally (16% vs. 13%), with more than one in five residents affected in three fully rural counties.

Adults in Maine's fully rural counties have higher rates of chronic conditions than the national average. Heart disease is the leading cause of death, with coronary heart disease affecting 9% of fully rural residents compared to 7% nationally. Diabetes rates are highest in Aroostook (14%), Piscataquis (13%), Somerset (12%), and Washington (13%) counties. High blood pressure impacts 36% of adults in fully rural counties, compared with 32% nationally, with Aroostook and Washington counties the highest at 40%. The effect of these elevated chronic condition rates is reflected in mortality outcomes. In 2023, fully rural counties had an age-adjusted mortality rate of 856 per 100,000, compared with 769 in partially rural counties and 751 nationally. Age-adjusted mortality rates for cancer, cardiovascular disease, and chronic lower respiratory disease are substantially higher in fully rural counties than in partially rural counties or nationally, underscoring disparities in access to primary and specialty care and gaps in preventive services among Maine's rural population.

Behavioral Health: Rural Maine communities also face worse behavioral health outcomes. While 21% of adults in the U.S. reported ever having received a depression diagnosis in 2022, this rate is higher across Maine's fully rural counties at 25%. Acute behavioral health needs have become especially pronounced among Maine children in recent years Between 2019 and 2021, suicide-related emergency department (ED) visits among children under 19 years of age increased by 59% and have remained elevated since. In 2023, rural Mainers experienced higher rates of alcohol-induced deaths (17 vs. 13 per 100,000 nationally), drug-induced deaths (48 vs. 32), and suicide (21 vs. 14), reflecting both unmet behavioral health needs and limited access to crisis response care in these communities.

Infant and Maternal Health: Infant and maternal health outcomes highlight additional disparities. Statewide, 8% of infants were born with low birth weight from 2022 to 2023, but this

exceeded 10% in two fully rural counties (Oxford and Washington). Every single child death is a tragedy, and in five fully rural counties, infant mortality rates exceeded the statewide rate of 6 deaths per 1,000 live births, including Franklin (9), Kennebec (7), and Somerset (7). Moreover, between 2014 and 2025, 11 of the state's 28 birthing units closed, leaving only 17 remaining. The impact has been greatest in rural areas. During this period, the average driving distance to a birthing unit in fully rural counties increased by 27%. In 2023, women in fully rural counties traveled 27 miles on average to reach a birthing unit. This is 80% farther than the 15 miles traveled by women in partially rural counties. In two northern Maine counties, some women must drive two hours for perinatal and birthing services, and for significant pregnancy complications, the drive can extend to four hours one way, as the state has only one Level 4 Maternal and Newborn Care Center, located in southern Maine.

Access to Care: Rural residents also face significant challenges in accessing care due to provider shortages and limited hospital capacity. Maine has 32 general acute care hospitals (GACHs) and critical access hospitals (CAHs) in operation (14 and 18, respectively), but eight of 12 fully rural counties have no GACHs, leaving communities heavily reliant on CAHs.

In addition to limited hospital and facility access, rural Maine residents face disparities in access to primary care, dental, and behavioral health providers. Fully rural counties in Maine have 983 residents per primary care physician, 39% higher than partially rural counties. Four fully rural counties exceed 1,400 residents per physician: Oxford (1,526), Piscataquis (1,451), Somerset (1,419), and Washington (2,096). The gap in dental access is also stark, with 2,331 residents per dentist in fully rural counties compared to 1,518 residents per dentist in partially rural counties, a 54% differential. Two fully rural counties exceed 5,000 residents per dentist.

Similar disparities exist in access to behavioral health providers. Fully rural counties have 217 residents per mental health provider, 35% higher than the ratio in partially rural counties (160). In Lincoln and Somerset Counties, the ratio exceeds 1:400 (437 and 424, respectively). These provider shortages are reflected in ED utilization: among commercially insured individuals under 65 with a mental health condition, mental-health related ED visits are highest in fully rural counties, reaching 40 per 1,000 insured in Somerset and 33 per 1,000 in Franklin Counties, compared with 22 statewide.

In addition to provider shortages, rural Maine residents face challenges in accessing care both in person and virtually. Nearly 40,000 Maine households lack a vehicle, including nearly one in 10 older households, and our most rural counties have some of the highest share of residents without transportation. Public transportation is very limited as a practical option for Mainers, with only 0.2% of working-age adults using it in Maine's fully rural counties. Internet access is also more limited across rural Maine, with one in eight households in Maine's fully rural counties going without an internet subscription, compared to one in 10 nationally. The share of households without an internet connection is highest in Maine's most remote counties, including Aroostook (20%), Piscataquis (16%), and Washington (17%). These counties also have notably lower rates of telehealth usage among commercially insured residents with a mental health condition, likely reflecting limited internet access.

Rural Facility Financial Health: Maine's rural healthcare system includes hospitals, federally qualified health centers (FQHCs), Rural Health Clinics, community mental health centers, Certified Community Behavioral Health Clinics (CCBHCs), and Opioid Treatment Programs (OTPs). Maine's rural hospitals, which include 18 CAHs and five larger hospitals with Sole Community Hospital, Medicare-Dependent Hospital, and Rural Community Hospital

Demonstration designations, face financial pressures. In 2023, 19 of 23 (83%) rural hospitals fell below the S&P Global threshold for adequate days cash on hand, 43% had financially vulnerable operating margins, 57% had financially vulnerable total margins, and 74% did not meet the target for adequate average age of plant. Eight of the 23 rural hospitals failed in all four benchmarks, underscoring widespread financial vulnerability. Operational responses include two hospitals converting from GACH to CAH status to access higher Medicare and MaineCare reimbursements in recent years. In June 2025, Northern Light Inland Hospital, a Medicare-dependent hospital in fully rural Kennebec County, closed due to operating losses.

Financial pressures are compounded by shifts in payor composition. From 2017 to 2023, inpatient days for commercially insured patients declined by 51% across Maine's rural hospitals, while Medicaid inpatient days increased by 20%. Commercially insured outpatient visits fell 22% across Maine's rural hospitals during this time, while Medicaid visits rose 46%. Medicaid payments accounted for 16% of net patient revenues across Maine CAHs in recent years, compared with 13% for CAHs nationwide.

Maine's FQHCs play a critical role in mitigating access gaps, serving over 200,000 patients in 2024, 72% with incomes below 200% of the federal poverty level. Medicaid and Medicare patients comprised 29% and 27% of FQHC patients in 2024, respectively, and over 8% of patients were uninsured. In the most rural areas, FQHCs serve even higher proportions of Medicaid and uninsured patients, providing preventive care, dental care, cancer screenings, behavioral health, and chronic condition management. Maine's FQHCs offer dental care in 13 of 16 counties and are the only dental providers accepting MaineCare in two of these counties.

2. RHTP: GOALS AND STRATEGIES

Maine's RHTP strategy envisions a future rural health system that:

- **Bridges the Rural Divide:** This means that where one lives no longer dictates health outcomes or access to care. All Mainers have the tools to make healthy choices and live healthier lives, and rural communities have the information, choices, and flexibility to create their own local, data-driven solutions.
- **Provides Seamless Delivery:** This means that a stronger rural healthcare workforce, innovations, and technologies ensure convenient, accessible and effective care - available to rural Mainers when they need it, where they need it.
- **Offers Efficient, Incentive-Aligned Systems:** This means communities come together to reduce fragmented service delivery, and value-based payments move us beyond fee-for-service, ensuring dollars go further and rural health systems are strong and sustainable for future generations of Mainers.

Maine will track our progress through four overarching performance objectives:

Objective	Baseline	Goal	Motivation
Living Healthier Lives: Well-controlled blood pressure (BP) among individuals in rural areas with high BP	Baseline rate for all Mainers is not currently available but will be collected beginning in FY 2026 using RHTP funding. For Maine Medicaid populations in 2023, 64% of members with high BP had adequate BP control.	Increase the relative percentage of residents in rural areas with high BP that is well-controlled by 10%.	Heart disease is the leading cause of death across the state's most rural and remote counties. Improving BP control among rural residents will demonstrate effectiveness of healthy lifestyles, preventive interventions, and chronic disease management strategies.
Quality of Healthcare Delivered: 30-day all-cause readmission rate	Baseline rate for all Mainers is not currently available but will be collected beginning in FY 2026 using RHTP funding. Nationally, the 30-day all-cause readmission rate from 2016-2020 was 13.9.	Reduce the relative 30-day all-cause readmission rate among rural patients by 10%.	Rural Maine residents face access barriers due to limited provider availability, a challenge that is expected to grow as the state's population ages substantially in the coming years. Delivering efficient and high-quality care, central to Maine's RHTP strategy, will be paramount to managing patient care and preventing complications during this period.
Getting Care When Mainers Need It: Non-financial barriers to care	In 2022, 26% of Maine adults in rural areas reported delaying medical care for reasons other than costs.	Reduce the relative percentage of adults in rural areas who report delaying medical care for	Between 2018 and 2022, the percentage of adults in rural areas of Maine who reported delaying medical care for non-cost reasons rose from 14% to 26%, an 86% relative increase. Maine's RHTP plan aims to significantly reduce non-

		reasons other than costs by 10%.	financial barriers and improve access to care in rural communities, through initiatives that include workforce recruitment, telehealth expansion, and AI-driven provider efficiencies.
Durability of Care Options: Rural hospitals' financial health	In 2023, 57% of Maine's rural hospitals had operating margins at or above 1%.	Reach at least 75% of Maine's rural hospitals achieving annual operating margins sufficient to make ongoing investments to improve operations and care (at or above 1% operating margin).	Maine's rural hospitals serve as crucial access points for care and economic anchors in their communities, yet a recent hospital closure and two hospital conversions highlight the financial challenges these facilities face. Maine's RHTP initiatives aim to not only prevent closures but to strengthen hospital operations and support investments in quality care improvements.

To fulfill this vision, Maine has organized its RHTP around five major initiatives. While our initiatives particularly highlight the needs and solutions related to rural behavioral health, perinatal care, children and youth, and older adults, all rural residents will benefit from the activities and funding, which are delivered efficiently, effectively, and transparently.

Maine's overall strategy is designed to tackle the challenges identified during our plan's development, including unaddressed root causes of disease, workforce shortages, gaps in technology and infrastructure, concerns about losing access to care, and the financial instability of rural hospitals and providers. Each of our solutions (initiatives) directly responds to these priorities and reflects the creativity, insights, and innovative ideas contributed by Maine's rural residents. These five initiatives translate community-driven insights into concrete actions that will improve health, access, and sustainability for all rural Mainers.

Initiative 1- Population Health: Promoting timely access to high-quality care

The first pillar of our strategy empowers rural Mainers across all stages of life to achieve their own healthy living goals by expanding their access to high-quality preventive, primary, chronic, and specialty care in their own communities. It responds to the growing complexity of rural health needs tied to aging populations, increases in chronic disease and behavioral health conditions,

and fragmented care delivery infrastructure that together make it harder for rural Mainers to stay healthy or recover from illness. This initiative aligns with the RHTP strategic goal to **Make America Healthy Again** by increasing the reach of Evidence-Based Practice (EBP) interventions for chronic disease management and other conditions, and by supporting new access points that promote preventive health and address root causes of disease. This initiative also promotes **Sustainable Access** by helping rural providers become long-term access points for care. It does this by expanding mobile and co-located services and by strengthening navigation supports and care delivery alternatives through community-based models. The initiative's activities include:

Initiative 1 – Activities	Alignment with Required Elements
Expand Alternative Sites of Care	Improving access; Improving outcomes; Partnerships
Deploy Evidence-based Practices	Improving outcomes
Strengthen Rural Maine's Nutrition Education Infrastructure	Improving outcomes
Expand Community Paramedicine programs	Improving access; Improving outcomes; Partnerships
Expand Community Health Worker and Peer Support Programs	Improving outcomes; Partnerships; Workforce
Support access to mental health and SUD support for special populations	Improving outcomes; Improving access; Partnerships

This strategy will expand School-based Health Clinics (SBHCs) and add new Opioid Treatment Programs (OTPs) in rural areas, increasing access for students and those struggling with substance use. It will also expand behavioral health services, helping more rural residents receive timely support. Finally, it will establish a Community Paramedicine (CP) program in every county, bringing critical care into local communities. Together, these activities strengthen Maine's rural healthcare system, improve outcomes, and ensure all services are closer to home.

Initiative 2- Workforce: Strengthening Maine's rural health workforce

The second pillar of our strategy grows the local health workforce in rural communities. Despite recent progress, shortages of clinicians and health support workers persist in rural Maine, limiting patient choice, driving up costs, and increasing strain on remaining providers. This initiative

aligns with the RHTP's **Workforce Development** strategic goal by strengthening cultivation, recruitment, and retention of healthcare workers in rural communities, helping rural providers practice at the top of their license, and developing a broader set of providers to serve the healthcare needs of Maine's rural communities. The initiative's activities include:

Initiative 2 - Activities	Alignment with Required Elements
Recruit and retain healthcare clinicians	Improving access; Workforce
Strengthen local talent pipelines	Improving access; Workforce; Partnerships
Develop and deploy a Healthcare Workforce Data Dashboard	Data-driven solutions; Workforce
Invest in mobile training labs and simulation centers	Workforce; Partnerships
Pilot new models in rural workforce transportation	Workforce: Improving access

These activities will build Maine's rural health workforce by expanding rural school-based career programs, training more nurses and allied health professionals with five-year commitments to serve rural areas, and increasing preceptors mentoring students. This initiative will also attract more physicians, clinicians, and advanced practice providers to rural communities, bringing critical care closer to home for rural Mainers.

Initiative 3- Technology Innovation: Modernizing rural care delivery with digital health technology

Investments in growing Maine's workforce will be complemented by the third pillar of our strategy: accelerating the connection to and adoption of health-enabling technologies. These technologies will give people better access to their health information, expand care delivery options, and provide local access to world-class specialty expertise. The core of this initiative is modernizing and interconnecting EMR systems among rural providers, recognizing that these platforms often serve as the foundation into which telehealth, Augmented Intelligence (AI) solutions, consumer tools, and other health technologies are built. Our strategy recognizes AI as a promising solution for rural health, with opportunities to develop new innovations that could

help to overcome many challenges faced by rural providers. This initiative aligns with the RHTP **Tech Innovation** strategic goal, as it fosters the adoption of innovative technologies that promote efficient care delivery, data security, improved connectivity, and access to digital health tools. By expanding and strengthening access to and use of telehealth services, this initiative also supports the RHTP **Sustainable Access** strategic goal by increasing the availability of primary, specialty, behavioral health, oral, and perinatal care to patients in their own home or community, reducing transportation barriers, allowing for flexible scheduling, and providing cost-effective, competent care. Many technology-based activities will be delivered with the Northeast Telehealth Resource Center (NETRC), operated by Medical Care Development (MCD). Activities include:

Initiative 3 - Activities	Alignment with Required Elements
Expand telehealth services	Improving access; Technology use; Partnerships
Support data integration and the reliable exchange of healthcare data	Technology use; Data-driven solutions
Expand the use of consumer-facing health technology tools	Technology use; Improving outcomes
Enhance Electronic Medical Records (EMR) systems	Technology use; Improving outcomes; Data-driven solutions
Create a Maine Rural AI Hub to support rural providers in adopting today's AI technologies and establish a Rural Health AI Innovation Institute to promote development of new AI technologies purpose-built for rural populations	Technology use; Data-driven-solutions

As a result, Maine will increase the percentage of adults who have had a primary care visit delivered via telehealth, the percentage of youth who are accessing behavioral health services via tele-behavioral health (tele-BH), the percentage of practices that gain access to specialty consultations via telehealth, and the percentage in rural practices implementing AI tools.

Initiative 4- Access: Bridging the healthcare affordability gap for rural Mainers

Our strategy's fourth pillar protects the long-term accessibility and affordability of rural healthcare in Maine by ensuring hospitals and other providers remain available as reliable access points, supporting the RHTP goal of **Sustainable Access**. This initiative will improve access to services via enhanced provider enrollment systems, better use of transportation resources for

health and wellness services, the provision of strategic payments to at-risk rural providers, and improved consumer technology tools that empower residents to make their own health coverage choices. Expanded access will strengthen disease prevention, chronic disease management, and behavioral health outcomes. It will also better enable residents to pursue employment and educational opportunities that increase self-sufficiency, open long-term health coverage options, and **Make Rural America Healthy Again**. The Office of MaineCare Services (OMS) will administer this strategy. Key activities include:

Initiative 4 - Activities	Alignment with Required Elements
Issue Provider Payments for Uncompensated Care delivered by FQHCs, hospitals, and CCBHCs	Improving access; Improving outcomes; Financial solvency strategies; Cause identification
Issue Provider Payments for provision of Essential Health Benefits to uninsured population	Improving access; Improving outcomes; Financial solvency strategies; Cause identification
Implement more efficient and user-friendly MaineCare Provider Enrollment technology	Improving access; Technology use
Improve coordination and leveraging of existing transportation infrastructure to assist rural Mainers to meet their health and wellness needs through technology and mobility planning.	Improving access; Improving outcomes; Technology use
Improve consumer-friendly transparency tool on state-based marketplace to improve access to and create competition for more affordable care plan options.	Improving access; Financial solvency strategies; Cause Identification

As a result, Maine will increase the number of MaineCare-enrolled providers. The initiative will also serve to expand access to chronic disease management, substance use disorder treatment, primary care, and preventive services in rural communities.

Initiative 5- Sustainable rural health ecosystems: Addressing financial instability of rural providers

The final pillar of our strategy promotes the long-term resilience of Maine's rural health ecosystem through systems-level incentives and operational strategies that complement the prior initiative's focus on patient-facing barriers to care. Nearly 40% of Maine's rural hospitals are stand-alone facilities facing significant financial headwinds due to an aging and shrinking

population, changes in payer composition, and workforce shortage. This puts them at high risk of service reduction or closure. This initiative aligns with the **Sustainable Access** strategic goal and is designed to stabilize and develop the infrastructure, partnerships, operational structures, and financing models needed to sustain advancements after RHTP funding ends.

Initiative Five begins with the short-term provision of tools and tailored technical assistance to improve the efficiency and financial management of at-risk hospitals serving rural Maine residents. Strategic investments in capital improvements and technology, aligned with these plans, will help these hospitals strengthen their financial stability. Once financial stability is achieved, the strategy moves into a second phase: coordinated regional strategic planning to assess community needs, right-size services, build non-hospital care capacity, and enhance collaboration among rural providers. The strategy also includes two targeted activities to address critical structural needs and improve access to appropriate levels of care for rural residents. The first will coordinate with hospitals to establish a sustainable system for inter-hospital patient transfers. The second will increase inpatient step-down treatment capacity for children with complex behavioral health needs in a psychiatric residential treatment facility (PRTF).

To implement this strategy, Maine DHHS will collaborate with the Office of Affordable Health Care (OAHC), Maine's all-payer claims database (Maine Health Data Organization, MHDO), the Maine Hospital Association (MHA), and the behavioral health provider Sweetser. Key activities within this initiative include:

Initiative 5 - Activities	Alignment with Required Elements
Improve hospital financial stability through tailored hospital financial management, planning and targeted investment.	Financial Solvency Strategies; Cause identification
Conduct rural regional health ecosystems planning and implementation	Financial Solvency Strategies; Cause identification; Partnerships
Develop multi-payer alternative payment models	Financial Solvency Strategies; Cause identification
Strengthen Maine's interfacility non-emergency transport system	Improving access

Expand access to high-acuity, non-inpatient hospital care for children with complex behavioral health needs	Improving access

As a result of this initiative, Maine will increase regional rural healthcare provider collaboration, the percentage of MaineCare payments that are made through alternative payment models (APMs), the number of hospitals that develop and implement financial management plans, the percentage of Maine children and youth who receive high-acuity behavioral health services in-state, and access to transportation in rural areas.

RHTP Partnerships

Maine's network of regional and statewide partnerships will be a critical asset in implementing our initiatives. The state is committed to fostering collaboration to maximize RHTP investments by leveraging existing partnerships both within Maine and across New England. Maine will also develop new partnerships to promote the regional and statewide collaboration needed to advance and sustain improvements in rural healthcare.

Efforts to transform rural health in Maine began in 2019, when Maine DHHS convened its Rural Health Transformation Team to bring together an external group with cross-sector rural health expertise to advise and shape the state's improvement efforts. This group will be reconvened as the **RHTP Advisory Committee**, uniting stakeholders from rural hospitals, FQHCs, CCBHCs, behavioral health organizations, emergency medical services (EMS), community-based organizations (CBOs), Tribal health organizations, employers, and academic institutions to guide Maine's RHTP initiatives.

To strengthen RHTP efforts across northern New England, Maine will continue its participation in the **New England Rural Health Association** (**NERHA**) and will contribute toward the development of NERHA's proposed New England Rural Health Transformation Center. This cross-state collaborative will provide technical assistance (TA) for rural health

challenges addressed regionally through RHTP activity. This includes policy and regulatory issues, data sharing, and opportunities for shared services.

To support the long-term sustainability of Maine's rural health advancements, the state will organize and convene **Rural Regional Planning Groups** in Maine's most rural communities. These groups, co-led by state and community leaders, will include local healthcare providers, government representatives, public health leaders, social service entities, and community members. RHTP leadership, together with Maine's OAHC, will provide a structured, data-driven process to help these groups identify essential health services for their communities.

Maine will continue to collaborate with a range of state and regional partners to advance RHTP efforts and ensure the activities outlined in this proposal benefit providers and patients in rural areas. Letters of support from partners are included in **Other Supporting Documentation**.

Legislative Action

Maine's current legislative and regulatory framework supports RHTP objectives by promoting expanded access, high-quality care, and cost-effective services in rural communities. State policies largely align with the scoring factors and provide a strong foundation for advancing rural health transformation. Maine does not currently plan to make additional changes to the State Policy Actions, which are scored based on the analysis referenced in the NOFO and Maine's internal review, as no external report or analysis was provided.

RHTP Category	State Policy Action Requirement	Maine's Current Score	Maine's Current Policy and Future Policy Commitments
B.2. Health and Lifestyle	Re-establishment of the Presidential Fitness Test	0/100	Once the Federal administration releases implementation guidance regarding the Presidential Fitness Test, Maine will review and consider whether to implement the Test in Maine. Until that occurs, Maine cannot commit to requiring that schools implement the Presidential Fitness Test.
B.3. SNAP Waivers	USDA-approved waiver prohibiting the purchase of non-	0/100	Maine does not have a USDA-approved SNAP waiver in place and does not plan to pursue one.

	nutritious SNAP items in SNAP		
B.4. Nutrition Continuing Medical Education	Requirement for nutrition to be included in CME for physician licensing is currently in place and enforced	0/100	Maine does not currently require nutrition to be included in continuing medical education and does not consider it feasible to make a requirement. Maine physician licensing CME requirements are established by the two medical Boards (allopathic and osteopathic), which have both been consulted and expressed that their licensees receive adequate nutritional education and would not be well served by adding an additional regulatory requirement that they perceive as burdensome.
C.3. Certificates of Need	Eliminate or loosen CON laws	50/100	Pursuant to the Cicero Institute report, Maine scores a 65/100 in the Certificate of Need categories, which translates to 50 Points for RHTP scoring. Maine does not plan to change its current requirements pertaining to its Certificate of Need review process.
D.2. Licensure Compacts	Become a full member of physician, nursing, EMS, Psychology, and PA interstate compacts	80/100	Maine is a member of all Licensure Compacts referenced except for the EMS REPLICA Compact. Maine believes that the current landscape of laws and regulations regarding EMS professionals is best aligned to promote the recruitment and retention of EMS staff in rural areas of the state. Additional potentially burdensome regulation is not needed.
D.3. Scope of Practice	Ensure the most expansive scope of practice for PAs, NPs, Pharmacists, and Dental Hygienists	68.75/100	Maine gets full points for Nurse Practitioner and Dental Hygienist categories and 75% of allocated points for the Physician Assistant category. Pursuant to the Cicero Institute Report, Maine receives 0 points for the Pharmacist category. Maine believes that its current practice permissions for pharmacists merit a higher score than the Cicero Institute's review. Maine's rules and regulations governing pharmacists' scope of practice are frequently reviewed and have been expanded several times over the past 15 years. These policies currently allow pharmacists to have prescriptive authority for contraceptives, naloxone dispensing, vaccine administration, HIV prevention, and emergency insulin refills. In addition, Collaborative Drug Therapy Management remains the most impactful mechanism for broader prescribing authority. Maine will continue to review and determine whether additional prescriptive authority for pharmacists is necessary.
E.3. Short-Term, Limited-Duration Insurance	STLDI plans are not restricted in the State beyond the latest federal guidance.	0/100	STLDI plans are available for purchase in the state and are not prohibited or banned. Maine does have some additional requirements for STLDI plans.
F.1. Remote Care Services	Medicaid reimbursement for different forms of telehealth and licensing/registration processes for telehealth.	80/100	Maine allows for Medicaid payments for at least one form of live video, store and forward, and remote patient monitoring. As determined by the Center for Connected Health Policy (CCHP), Maine meets requirements for a telehealth license/registration process. Although CCHP did not determine that Maine has an in-State licensing requirement exception, Maine's current law, regulations, and procedures expedite the process for out-of-state telehealth-based providers. Lack of a specific licensure exception has not shown to be a barrier to the practice of telehealth into Maine, as numerous out-of-state providers are now licensed to provide telehealth services to patients in Maine.

Other Required Information

For Factor A.2: Maine is home to six CCBHC entities as of September 1, 2025. A list of every active site of care associated with each CCBHC entity and the address of every active site of care is provided in the **Other Supporting Documentation**.

For Factor A.7: Two hospitals, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center, received a Medicaid Disproportionate Share Hospital (DSH) payment, consistent with 42 U.S.C. 1396a(a)(13)(A)(iv), from Maine for the most recent Maine plan rate year (SPRY) as defined at 42 CFR 455.301.

3. PROPOSED INITATIVES AND USE OF FUNDS

Maine's suite of initiatives will be implemented statewide, with clear focus on the needs of the state's most rural communities. The sections that follow describe each initiative in detail, including all proposed activities and how RHTP funds will be used to enact them. (FIPS codes: 23001, -3, -5, -7, -9, -11, -13, -15, -17, -19, -21, -23, -25, -27, -29, -31.)

Initiative 1- Population Health: Promoting timely access to high-quality care

This initiative targets the complex health challenges facing rural Mainers. It focuses on an aging population, rising chronic and behavioral health conditions, and fragmented care. Activities include improving access by expanding mobile and co-located care, including SBHCs, broadening the reach of evidence-based interventions, increasing access to substance use disorder (SUD) services, and developing alternative community-based care delivery models.

INITATIVE 1 – POPULATION HEALTH: Summary of Activities	
Main Strategic Goal	*Main*: Make Rural America Healthy Again *Secondary:* Sustainable Access, Innovative Care, Workforce Development
Use of Funds	A, G, H, K, I
Technical Score Factors	B.1, B.2, C.1, C.2, F.1
Key Stakeholders	Schools, MDOE, FQHCs, healthcare providers, families, CHWs, Peer Supports, Veteran's Administration (current mobile vans), local Planning Boards, EMS agencies, home health providers, Wabanaki Public Health &

	Wellness, the Houlton Band of Maliseet Indians, the Mi'kmaq Nation, the Passamaquoddy Tribes at Indian Township and Pleasant Point, and the Penobscot Nation.
Estimated Funding	$182,033,832 over five years
Outcomes	To assess initiative impact, Maine will track and report the number of SBHCs, EBP trainings, OTP rural access points, primary and behavioral health connections, as well as the reach of Community Paramedicine, as detailed in Section 6. Metrics and Evaluation Plan.

Activity 1.1: Alternative Sites of Care: Making Care Available Where People Are

Mobile Units: Maine has at least 10 mobile units in operation, serving diverse populations and healthcare needs (e.g., a mobile OTP, perinatal services, mammography, oral health). These units currently all work independently with no central coordination of need assessments or service delivery. While mobile units have gained positive support and Maine's regulatory and reimbursement frameworks support the work, there is currently limited ability to evaluate their reach, impact, need, or leverage peer experiences across these services.

To reduce inefficiency and coordinate access points that bring care closer to rural communities, Maine proposes contracting with an organization that will provide statewide coordination and mobile unit deployment. This contractor will develop toolkits to support unit implementation and assist organizations in building trusting community relationships critical to success. In coordination with rural planning efforts, the contractor will develop a framework for local communities and potential providers to evaluate whether a mobile unit is a good fit. The contractor will manage RHTP funding to purchase and outfit new mobile units as those needs are justified. Finally, this effort will ensure mobile units contribute to a coordinated and efficient care delivery, including having public health nurses and community health workers (CHWs) on mobile units to support longer-term community connections.

Certified Community Behavioral Health Clinics (CCBHC): CCBHCs are behavioral health organizations that provide broad services and meet state and federal requirements for access and standards of care. Maine's CCBHC Model launched in March 2025. While CCBHCs serve all

people with behavioral health needs, the model places special focus on service members and veterans as well as individuals with co-occurring intellectual and developmental disabilities. Maine CCBHCs serve over 8,500 MaineCare members a month at 21 sites, with additional certified sites expected in 2026. The state will use RHTP funds to initiate weekly primary care co-location hours within CCBHC sites, following the successes of other national CCBHC models. Co-location of primary care within CCBHCs will improve a person's ability to get coordinated care in one location and get more coordinated, comprehensive treatment. RHTP funding will be used to cover interprofessional care team meetings and administrative support, develop workflows, and make minor clinic space modifications to accommodate privacy needs for clients. Funding will also support MaineCare rate setting work to sustain these efforts.

School-Based Health Centers (SBHCs): Located within school buildings, SBHCs provide comprehensive healthcare services and are operated through partnerships between schools, communities, and healthcare providers. While SBHCs increase access to essential healthcare services and reduce caregiver work absence and barriers to care such as transportation, fewer than 10% of Maine public schools have SBHCs. Utilizing RHTP funds, Maine CDC will establish new SBHCs in rural schools and expand existing services, including extending services to additional grade levels, adding mental health and dental care, and enhancing preventive health services.

Activity 1.2: Spreading Effectiveness and Implementation of Evidence-Based Practices

As Maine deploys new care models and onboards healthcare staff, it is important that the state leverages Evidence-Based Practices (EBPs) to ensure consistent and efficient approaches. Spreading EBPs has been a focus of the State in recent years, but funding has been siloed, and there has been a lack of coordination to make programming more accessible and ensure lasting implementation. Through this activity, Maine DHHS will launch new EBP training and

implementation efforts by contracting with a vendor to deliver trainings, provide implementation funding, and generate a more accessible list of resources for busy providers and community partners to access. The RHTP Advisory Committee will prioritize training areas to align with Maine's RHTP goals and span age ranges and health areas.

Activity 1.3: Nutrition Education Infrastructure

Integrating nutrition education into the clinical health infrastructure is an evidence-based approach to address population health needs and focus on upstream interventions to mitigate or prevent disease. Maine proposes to fund nutrition education to support community-level transformation and create the foundation for future innovative clinical health interventions such as “Food-Is-Medicine.” Community education regarding the impact of lifestyle choices on health is essential to complement clinical interventions. Maine’s nutrition education model for RHTP will focus on supporting information technology, staffing infrastructure, referral pathways, and tracking to create a sustainable system for nutrition education.

Activity 1.4: Transforming Care Capacity through Community Paramedicine

Community Paramedicine (CP) programs can fill critical gaps in the traditional healthcare system by reaching patients where they are - increasing access to preventive care, extending medical services, and reducing EMS usage. Maine is uniquely positioned to become a national leader in the CP model due to its formal EMS licensure rules, which establish education standards, licensing levels, and a clear CP scope of practice. While at least 40 states have some type of CP program, only 23 have enacted CP-based laws, established pilots, or authorized EMS personnel to provide nonemergency care. CP programs have consistently shown reduced emergency department visits, improved chronic disease management, and high patient satisfaction. Despite

these successes, expansion, especially in Maine's most rural areas, has been limited by education system constraints, short-term siloed funding, and the lack of national standardization.

Led by Maine EMS, RHTP funds will support the expansion of CP programs across the state, providing the time and resources needed to implement CP reimbursement models, establish sustainable career pathways for rural EMS providers, and strengthen partnerships. These efforts aim to deliver measurable improvements within five years. Under a joint workforce structure, CPs will enhance continuity of care and create a scalable framework that complements Maine's other EMS-related RHTP initiatives.

Activity 1.5: Expand Community Health Worker and Peer Support Programs

Community Health Worker (CHW) Program: Maine has a long-standing and well-organized CHW workforce, with an estimated 200 individuals, a forthcoming certification process, and integration into several team-based APMs. Despite this foundation, there remains significant opportunity to further support CHWs in statewide health improvement efforts.

This activity will provide a focused investment in CHWs to serve rural communities by delivering targeted interventions and bridging the gap between individuals and healthcare providers. Maine CDC will deploy CHWs across a variety of settings. In schools, they can encourage children and families to engage with school health offerings, while in other settings they can help vulnerable populations access telehealth and other consumer-facing technology innovations. Maine will continue to support contractual relationships between CBOs employing CHWs and healthcare entities under APMs. Funds will also support professional association infrastructure, as well as training and certification needs for the workforce.

Peer Support Programs: Recovery coaches and Certified Intentional Peer Support Specialists (CIPSS) represent a growing sector of Maine's behavioral health workforce. Each year, roughly

300 individuals complete CIPSS training, and another 400 train to become recovery coaches. However, gaps remain in ensuring peer supports are readily available in ED settings, where their services not only support individuals directly but can also expedite care connections and, where appropriate, discharges that might otherwise result in prolonged ED stays or repeat visits. Led by the Office of Behavioral Health (OBH), funding will support provider trainings (e.g., peers, supervisors, clinical staff) to help integrate peers into multidisciplinary teams and assist programs implementing peers in the remaining EDs throughout Maine.

Activity 1.6: Supporting Access to the Continuum of Care for Mental Health and SUD Services for Special Populations

Maine's RHTP will directly support expanded access to targeted SUD treatment and mental health services in rural Maine, including via tribal health providers. Wabanaki Public Health & Wellness (WPHW) serves four federally recognized tribes located in five communities across Maine: the Houlton Band of Maliseet Indians, the Mi'kmaq Nation, the Passamaquoddy Tribe at Indian Township, the Passamaquoddy Tribe at Pleasant Point, and the Penobscot Nation. WPHW will use funds to expand the number of medically supervised withdrawal and 30- to 60-day SUD treatment beds and conduct related prevention, support, and outreach activities to promote healthier communities. These funds will expand the Tribal crisis response system and the development of traditional healing services.

Initiative 2- Workforce: Strengthening Maine's rural health workforce

Maine's current rural health workforce shortage limits access to care, forces patients to travel farther, and strains existing providers. Using RHTP funds, Maine will grow the pipeline of rural health workers, mitigate barriers, strengthen incentives for health professionals to serve rural communities, and expand education, training, and clinical rotations in rural health settings.

INITATIVE 2 – WORKFORCE: Summary of Activities	
Main Strategic Goal	*Main:* Workforce Development
Use of Funds	E, F, J
Technical Score Factors	D.1., F.2.
Key Stakeholders	Health Employers, Maine DHHS, MDOL, University of Maine System, Maine Community College System, MaineDOT, education and training partners, healthcare workers
Estimated Funding	$202,691,606 over five years
Outcomes	To assess the impact of the Workforce initiative, Maine will track and report progress along the rural health career pipeline; education enrollments; rural clinical training preceptorships and mentorships; and increased rural provider recruitment as detailed in Section 6. Metrics and Evaluation Plan.

Activity 2.1: Recruitment and Retention

Initial recruitment efforts will focus on encouraging already licensed healthcare professionals to live and work in rural Maine. Expanding on the Maine Careers with Purpose campaign, Maine will support strategies designed to attract younger professionals and experienced providers, showcase the unique benefits of working in rural communities, and emphasize the incentives available to support living and working in rural Maine. Financial incentives will be offered to eligible groups including physicians, dentists, advanced practice providers, nurses, social workers, and behavioral health clinicians who commit to working in rural communities for five years. Awards may be used to offset education and other costs associated with training, living and working in rural Maine (i.e., transportation or relocation). A vendor with expertise in managing incentives and award programs will implement this strategy in collaboration with Maine DHHS.

Customized training, mentoring, and support: Beyond attracting clinicians, rural Maine must also retain them. Providing rural healthcare in areas away from large health systems can be a daunting task for new and even experienced clinicians who often report feeling isolated without a large care team or the ready availability of additional training and supports. To address these needs, Maine will customize training, provide access to mentoring, and offer customized support to equip rural clinicians with the unique skills and tools needed to serve rural populations. This

strategy includes recalibrating training for early career professionals and existing clinicians to help rural providers practice at the top of their license, adapt to new technology, and grow professionally.

Activity 2.2: Local Workforce Development and Training Pipelines

K-12 Talent Pipeline: Maine must better support rural K-12 students on their journey to becoming the next wave of clinicians. Maine successfully piloted "career pathways" that blend academic support, guidance, real world experience, and credit-bearing courses to launch young people into in-demand fields. Maine will expand rural access to successful Career Pathway models like Bridge Academy and the AHEC pipeline. RHTP funds will support rural cohorts of K-12 students who already live in rural areas with health workforce shortages. These students can earn workforce credentials such as CNA or EMT while also earning college credit and gaining healthcare experience, expediting the timeline to launch into the field and/or complete health degrees.

Healthcare Training for ME (HTFM): Through Healthcare Training for ME, a statewide partnership to rapidly train and upskill healthcare workers, individuals looking to enter or advance in the health sector can access career guidance and can easily connect to training programs and information on available funding or scholarships relevant to their health career goals. The model also provides a centralized portal for health employers to share their training needs and access workforce resources. In early 2026, HTFM will launch a consolidated training aggregator to include: earn while you learn programs, apprenticeships, certifications, and degree programs for health careers, searchable by region, credential, and job category.

Maine will leverage the HTFM partnership to expand access, with a focus on growing programs delivered *locally* in rural areas. Because rural students face unique educational barriers,

this partnership provides an approach that meets their needs, ensuring success in attaining the in-demand credentials and skills required by employers. The HTFM pipeline includes unemployed workers, career changers, adult learners, and parenting students already embedded in rural communities. HTFM will add a diverse array of new rural training cohorts, including **Nurses, Certified Nurse Aides, Certified Residential Medication Aides, Emergency Medical Technicians (EMT), Advanced EMTs, Medical Assistants, Mental Health Rehabilitation Technicians, Dental Assistants, Pharmacy Technicians, and Phlebotomists**, aiming to serve more than 3,000 rural certificate learners and 150 rural associate degree registered nurses.

The Consortium for Healthcare Education and Training (CHET): We know that where health professionals complete their clinical training is often where they ultimately practice. Unfortunately, that training usually occurs in larger, urban hospitals or health systems with more resources to support students. Costs and logistics associated with hosting students and physicians in residency can be a barrier to expanding health career training in rural settings. To fill current and future vacancies, rural health employers must receive support to better train new workers and provide on-ramps to high-quality jobs in the healthcare field.

CHET expands rural clinical training sites and Graduate Medical Education residency rotations, supports preceptors, and creates streamlined pathways into healthcare careers. RHTP funds will be used to expand access across a range of careers, from phlebotomists to physicians. Maine will leverage CHET's statewide, first of its kind digital preceptor/student matching platform to match students with rural preceptors. By amplifying the capacity of rural health providers to offer clinical training sites, rotations, and preceptorships in rural care settings, more health professionals will be trained locally - growing capacity to meet workforce demand, and more people living in rural areas will have access to well-paying healthcare jobs where they

already reside and have community ties. This strategy will engage healthcare learners from entry-level, allied health positions through the provider levels, such as medical students, graduate medical education resident physicians, and advanced practice providers. We anticipate approximately 500 healthcare learners per year to complete clinical rotations in rural settings, with 15-20 new rural clinical training sites, and 50 new preceptors annually.

Rural Training Labs and Mobile Simulation Units: To improve access to high-quality training in rural areas, Maine will invest in mobile Training Labs and Simulation Centers, which can travel to rural training sites. These labs will be used to both train new workers and upskill existing health professionals to meet the unique needs of rural populations.

Activity 2.3: Innovation: New Models and Technology

Healthcare Workforce Data Dashboard: Maine's ability to respond and grow its healthcare workforce is hampered by a lack of centralized healthcare workforce data. The MHDO will build a centralized platform for the collection and reporting of health workforce data. This will align Maine's efforts with other states to develop a Cross Profession Minimum Data Set, to improve planning and resource allocation for greater access to essential care services.

Rural Medical Workforce Transportation Pilot: Barriers to transportation impact both patients and rural healthcare workers. This pilot will support the recruitment and retention of clinical workers in rural communities by replicating a successful Maine Department of Transportation (MDOT) program. MDOT will administer funds to support innovative transportation solutions to help rural healthcare providers find the workforce needed to meet their patient care needs.

Initiative 3- Technology: Modernizing rural care delivery with digital health technology

This initiative will enable rural health providers and patients to benefit from technology and information advances. Activities include enabling electronic medical record (EMR) upgrades,

building interconnectivity of EMRs, expanding telehealth access, and supporting the adoption of emerging digital and Augmented Intelligence (AI) applications.

INITATIVE 3 – TECHNOLOGY: Summary of Activities	
Main Strategic Goal	*Main*: Tech Innovation *Secondary:* Sustainable Access, Innovative Care, and Make Rural America Healthy Again
Use of Funds	A, C, D, F, G, H, I, J
Technical Score Factors	C.2., F.1., F.2, F.3
Key Stakeholders	Patients, primary care providers, hospitals, schools, oral health providers, EMS, specialty care providers, community-based organizations.
Estimated Funding	$200,942,115 over five years
Outcomes	To assess the impact of this initiative, Maine will track and report adult telehealth utilization; youth BH-telehealth utilization; rural access to specialty care; and use of AI tools as detailed in Section 6. Metrics and Evaluation Plan.

Activity 3.1: Expanded Use of Telehealth Services to Improve Access to Care

Virtual Quick (Urgent) Care Program: RHTP funds will support the development of a statewide, on-demand Virtual Quick Care telehealth program available to improve access for urgent care needs, with guaranteed availability of same-day care, including after-hours and weekend hours. The service will be coordinated with local primary care clinicians by securely sharing health records through the statewide health information exchange (HIE) and will be actively promoted with rural hospitals, clinics, community organizations, and workplaces.

Tele-Behavioral Health (Tele-BH) Programs Targeted to Youth and Perinatal Care: Building off the successful state-funded School Tele-BH Pilot program, RHTP funds will be used to contract with an organization with experience in providing tele-BH services for youth, including mental health counseling and psychotherapy, psychiatric consultation, and medication management. Working in partnership with schools across the state, with a focus on rural communities, the program will provide tele-BH services during or after school hours, including evenings and weekends, as well as wrap-around support services for families and school staff.

RHTP funds will also be used to contract with an organization with expertise in providing tele-BH services for perinatal women and will offer a full range of behavioral health services, including counseling, psychiatric consultation, and medication management. Building off Maine's successful HRSA-funded Rural Maternity and Obstetric Management Strategies (RMOMS) initiative, the program will work with perinatal and obstetric providers to identify women who may need BH services and refer them directly for treatment services.

On-Demand Specialty Telehealth Services for Special Populations: Building on a previous successful state-funded pilot, funds will be used to contract with an organization with expertise in providing tele-BH services to Individuals with Developmental Disabilities who reside in group homes (Private Non-Medical Institutions). The previous pilot demonstrated improved health outcomes, reduced ED visits and hospitalizations, and lower costs. Maine will also contract with an organization to provide telehealth geriatric care services to individuals in nursing facilities. By contracting with a telehealth organization with experience in geriatric care and geriatric psychiatry, this program will improve access for acute care needs of older adults living in nursing facilities, decrease avoidable ED use, and improve health outcomes.

Telehealth Facilitators: If patients are unfamiliar or uncomfortable with using telehealth services, none of the above strategies will be effective. To address this, RHTP funds will support training for teams of Telehealth Facilitators and CHWs to assist patients in accessing and navigating telehealth services, providing direct assistance to help individuals connect with telehealth providers and resolve problems as they arise. Telehealth Facilitators can provide in-person services in healthcare or other public settings, or act as Virtual Assistants, connecting with patients via telephone or video connections to manage a range of tasks remotely, including scheduling, data entry, and managing communications for healthcare providers.

Telehealth Hubs: Funds will be used to support the development of rural Telehealth Hubs, which are dedicated physical spaces where individuals can go to access telehealth services. Built on and modeled after the Maine Connectivity Authority's Connectivity Hubs concept, funds will be provided to community organizations to make facility renovations to create dedicated spaces for people to access telehealth services via high-speed internet. Funds will also support public communications to promote the availability of these services within rural communities.

Provider-to-Provider Specialty On-Demand (Synchronous) Consultations: Funding will be used to contract with a specialist consultation network to provide primary care providers with access to synchronous "curbside consultations" with specialists. By accessing synchronous specialist e-consults, primary care providers can optimize patient care without the need for formal, and often unnecessary, specialty referrals that can often be delayed for months, enhancing timely access as well as saving time and travel. This model reduces avoidable ED use, lowers healthcare costs, and strengthens primary-specialty collaboration, while building primary care expertise and capacity.

Recognizing that access to perinatal and maternity care has become increasingly challenging in rural communities in Maine, RHTP funds will be further used to contract with a specialty service offering provider-to-provider telehealth consultations from obstetric specialists for perinatal care, as well as from neonatal and pediatric intensive care specialists for post-partum care. This on-demand specialty consultation will support and expand the ability of rural healthcare providers to provide specialty-informed perinatal care in their local communities.

Finally, to address the significant needs for dental services in rural areas, RHTP funds will be used to contract with a tele-dentistry network that can offer oral health consultation to providers

in schools, childcare settings, and other community-based settings. This will provide expert support and link children in need of additional services to ongoing dental care.

Specialty e-Consult (Asynchronous) Consultations: Assessments of rural health needs in Maine routinely cite a profound lack of specialty services in rural communities. To address this need, Maine will build on the previous state-funded Maine eConsult Network to contract with a specialty eConsult network that provides consultation services to primary care clinicians. Specialty eConsults, or interprofessional consultations, offer an innovative solution to address barriers to specialty care access, providing timely specialty consults to patients who might otherwise experience long delays in receiving critically important care or not receive services at all. eConsults have also been proven to reduce the overall cost of healthcare.

Activity 3.2: Expand the utility, functionality, and security of Electronic Medical Record (EMR) systems

Replace, upgrade, and enhance EMR systems: To better support care coordination and population health management, RHTP funds will be made available to replace outdated EMR systems or purchase new systems. Funds will also be used to purchase additional modules, interfaces, and functionality for existing EMR systems needed to implement key upgrades and enhance interoperability. Finally, funds will be used to equip Maine CDC Public Health Nurses with an upgraded EMR platform and iPads to improve care and communications.

Strengthen cybersecurity systems for healthcare providers: RHTP funding will be used to support rural healthcare providers in selecting, implementing, and maximizing the use of cybersecurity to safeguard healthcare systems and protect patients from digital threats and security breaches. The state will contract with an information technology (IT) provider with deep experience in cybersecurity systems to (1) assist providers with assessing their current

cybersecurity systems; (2) select and implement system upgrades and enhancements sufficient to meet cybersecurity needs; and (3) provide training to staff on safety, security, and cybersecurity issues needed to ensure appropriate protection of systems and patient data.

Emergency Medical Services connectivity and telehealth: To ensure that all EMS units can connect and exchange information with other providers, RHTP funds will be used to build on a previous federally funded initiative, the Maine EMS Connectivity project, which provided over 300 EMS units with high-speed models that connected to a central dispatch system and allowed connected EMS units to transmit digital data with telehealth providers. Funding will allow Maine EMS to purchase high-speed modems for the remaining 200 EMS units in the state that are not currently connected, ensuring statewide telehealth connectivity for EMS.

Activity 3.3: Support data integration and reliable exchange of healthcare data

Expand and strengthen State Health Information Technology Systems: RHTP funding will be used to expand and strengthen state data systems to improve health and healthcare, including linking several sources of child health data by adopting the Child Health Advanced Records Management (CHARM) data system, and making improvements to the Medicaid data system to better identify and track conditions across the spectrum of care.

Expand use of HealthInfoNet (HIN): HIN is Maine's designated HIE. While all of Maine's 32 acute care hospitals are connected to HIN, gaps remain in connecting outpatient providers to HIN and its range of health management tools. RHTP funds will be used to increase the number of outpatient provider organizations connected to HIN and to support education and outreach efforts to providers to better utilize and leverage the information available in HIN.

Support the development of Maine's Community Information Exchange (CIE): RHTP funds will be used to build on emerging efforts to develop a Maine statewide CIE to facilitate the

exchange of patient-level information related to social health needs and referrals to community-based social service organizations. Maine will contract with an organization to support local and regional efforts to develop CIE components such as "closed loop referrals" for social services; data sharing between healthcare providers and community-based organizations; and longitudinal patient health records that combine medical and social needs and service history.

Activity 3.4: Provide individuals with technology to improve their own health outcomes

Remote Patient Monitoring (RPM): RPM programs can provide significant value in managing chronic illnesses by enabling continuous, proactive care and extending that care into patients' homes using connected devices and real-time data sharing. RPM programs can also improve clinical outcomes, improve patient engagement in self-management, and reduce avoidable ED visits and hospitalizations. Funding will be used to contract with an organization to work with providers statewide to implement centralized programs that offer RPM for patients with high-prevalence chronic conditions such as high blood pressure and heart failure. This effort will coordinate with Maine's Transforming Maternal Health (TMaH) initiative, currently offering RPM for blood pressure monitoring in perinatal care. Using a centralized program will maximize efficiencies to conduct provider and patient education and outreach, distribute equipment, and respond to patient-collected data using evidence-based protocols.

Patient-Facing Digital Health Tools: RHTP funds will be used to support the implementation of one or more patient-facing digital health tools to extend care into rural communities and enable patients to be more engaged in their own health. Selection of specific tools will be made with the input of statewide partners and will build on efforts already in place in Maine, such as the use of automated text messaging to patients to support their management of chronic conditions and building on a state-funded pilot to promote use of the Mammha app to support perinatal care.

Activity 3.5: Create Maine Rural AI Hub and Rural Health AI Innovation Institute

Funds will be used to support the creation of a Maine Rural AI Hub in partnership with Duke University, building on its experience with the Health AI Partnership (HAIP) to create a "hub and spoke" model with rural providers. The AI Hub will provide expertise, oversight, and guidance to assist rural healthcare organizations to establish effective local governance models needed to accelerate and manage AI adoption in their clinical and business functions. Funding will also be used to support efforts by rural providers to implement AI tools that have been shown to improve provider and patient satisfaction with processes of care, such as ambient documentation systems. Additionally, Maine will establish a Rural Health AI Innovation Institute to spur development and dissemination of new AI health innovations to address the needs of rural health populations.

Initiative 4- Access: Bridging the healthcare affordability gap for rural Mainers

This initiative addresses the financial and transportation barriers to healthcare experienced by rural Mainers that limit access to preventive care and effective disease management and often result in people experiencing emergent needs requiring costly care. Activities include provider payments to reimburse for otherwise uncompensated care, technology to help rural Mainers select best value coverage for their needs, and innovating transportation solutions.

INITATIVE 4 – ACCESS: Summary of Activities	
Main Strategic Goal	*Main:* Sustainable Access *Secondary:* Innovative Care and Make Rural America Healthy Again
Use of Funds	B, C, I
Technical Score Factors	C.1.; F.2.
Key Stakeholders	Hospitals, FQHCs, CCBHCs, other providers (primary care, chronic disease management, SUD treatment, pharmacy, and dental.)
Estimated Funding	$185,546,540 over five years
Outcomes	To assess the impact of this Initiative, Maine will track and report MaineCare provider network capacity; primary care access, chronic disease management (asthma), SUD treatment, and preventive care (breast cancer screening) for Mainers accessing the limited uninsured benefit as detailed in Section 6. Metrics and Evaluation Plan.

Activity 4.1: Uncompensated Care Payments (Year 1)

In Year 1 of the RHTP, hospitals, FQHCs, and CCBHCs will receive singular supplemental payments proportional to their relative documented dollar amounts of uncompensated care. Providers may not receive a payment that exceeds the dollar amount of uncompensated care they provided. These payments will enable time-sensitive stabilization and financial relief and improve access to care while the State works to set up the infrastructure for broader and more sophisticated provider payments as described below in Activity #2.

Activity 4.2: Provider Payments for Essential Health Benefits to Uninsured (Years 2-5)

In years 2 through 5 of the RHTP, providers may bill and receive payments for a limited essential health benefit provided to low-income individuals who are uninsured and not otherwise eligible for Medicaid. Total annual provider payments will be capped annually as needed so as not to exceed 15% of the annual RHTP grant award. Requirements and payments for services will align with those for MaineCare. Benefits covered will include primary care, chronic disease management, community-based behavioral health services, SUD treatment, pharmacy, dental, and hospital services. Services such as long-term services and supports, home and community-based services, and residential treatment (other than withdrawal management) will be excluded.

These payments will improve access to care, helping to sustain existing hospitals, clinics, and other healthcare providers. In tandem with Maine's proposed Population Health Initiative, these payments will also improve prevention, chronic disease management, behavioral health, and maternal/infant health for Mainers who may otherwise forego care. Administering these provider payments through claims that will populate Maine's HIE and all payer claims database enables Maine to evaluate impact and options to sustain access.

OMS will administer these provider payments. The MHDO and HIN, Maine's Statewide HIE, will partner with OMS to analyze uncompensated care levels by provider, and to gauge healthcare utilization and outcomes.

Activity 4.3: Enable Dynamic Medicaid Provider Enrollment Experience (Years 4-5)

MaineCare's outdated provider enrollment system has resulted in long wait times and frustration but has limited opportunity for improved efficiencies under the current architecture. OMS has received feedback that the provider enrollment process is a barrier to providers accepting MaineCare and expanding services. Improved provider enrollment will enhance member access to care, minimizing negative impacts related to prior authorizations and prescriptions. Maine proposes upgrading its current Provider Enrollment system to a dynamic version that will allow processing of multiple provider cases at once for one organization.

Activity 4.4: Coordinated Transportation (Years 1-5)

Another critical aspect to improving rural residents' access to healthcare is transportation. Maine's Medicaid Non-Emergency Medical Transportation (NEMT) system is by far the state's largest and most highly funded source of publicly funded transportation. However, residents not enrolled in MaineCare are currently unable to access the vast majority of this system, given the current inability of NEMT transporters and brokers to accurately track, report on, and distinguish the relative cost of Medicaid and potential non-Medicaid ridership. An activity under this strategy will enable the State to move forward on the September 2024 recommendation from a joint evaluation sponsored by MaineDOT and DHHS to create a Maine Regional Coordinated Services Pilot. This pilot would align with efforts by the Federal Coordinating Council on Access and Mobility to implement a technology application to enable trip sharing and coordination through accurate cost allocation between Medicaid transportation and other federally funded

transportation programs to reduce gaps in access to transportation for health and wellness. In addition to these government programs, a range of volunteer driving programs currently help fill transportation gaps in rural areas. RHTP funds will be used to strengthen and expand these community transportation programs by funding the University of Maine's Center on Aging to coordinate and expand volunteer driving programs being offered by many of Maine's "Age Friendly Community" organizations.

To improve coordination of efforts, funds will provide support for the Maine Coordinating Working Group on Access and Mobility, established by legislative resolve in 2025, to develop and implement a "mobility management" plan to identify the regional structure to increase access to rural healthcare with a focus on older adults, people with disabilities, and people of low income.

Activity 4.5: Consumer Transparency Tool for State-Based Marketplace

This activity seeks to improve rural Mainers' access to affordable care by improving consumer technology associated with Maine's state-based marketplace, CoverME.gov, to promote understanding of plan options and impacts. The improved version of the plan comparison tool will include Transparency in Coverage data, to reflect plans' cost-sharing structures and negotiated network rates, provider network locations, and other data elements and improvements based on Maine market research.

These improvements will provide consumers with a comprehensive understanding of both direct healthcare and travel costs to improve plan comparison, selection, and planning for healthcare needs. Improved plan selection will result in fewer unanticipated medical-related expenses and lower levels of underinsurance. In addition, greater transparency will drive consumer choice and competition among health plans that can better meet consumer needs.

Initiative 5- Sustainable rural health ecosystems: Addressing financial instability of rural providers

This initiative supports the long-term financial strength and resilience of Maine's rural health ecosystem, which is challenged by shrinking patient volumes, rising supply and labor costs, gaps in the service continuum, and a shifting payer mix. Activities include stabilizing rural hospital finances, expanding the service continuum, and developing regional structures to support improved APMs through capital investments and technical assistance.

INITATIVE 5 – SUSTAINABLE RURAL HEALTH ECOSYSTEMS: Summary of Activities	
Main Strategic Goal	*Main:* Sustainable Access *Secondary:* Innovative Care
Use of Funds	D, I, J, K
Technical Score Factors	B.1., C.2., E.1., E.2.
Key Stakeholders	Maine DHHS, Maine Office of Affordable Health Care, Maine Hospital Association, hospitals, Sweetser,
Estimated Funding	$197,383,494 over five years
Outcomes	To assess the impact of this initiative, Maine will track and report MaineCare value-based payment adoption; rural hospital financial health; in-state access to PRTF care; regional health system collaboration; and rural transportation access as detailed in Section 6. Metrics and Evaluation Plan.

Activity 5.1: Support Hospital Efficiency and Financial Management

The availability of appropriate hospital services is key to ensuring long-term improvements in the health and well-being of rural residents. However, many Maine hospitals are facing acute financial challenges that put them at risk of closure or significant service changes driven by short-term financial pressures rather than population health needs. Considering these circumstances, the state is proposing to provide tailored support to assist these hospitals in managing their costs more efficiently and serve as key collaborators in creating a sustainable healthcare ecosystem.

Under this initiative, the State will identify a cohort of financially vulnerable hospitals that serve rural Mainers and provide them with tailored assistance to improve their financial solvency through increased efficiency, including:

- Funds to support senior hospital staff time and resources to conduct financial and operational sustainability planning and transformation activities. Hospitals will need to participate in specified financial planning and technical assistance activities to be eligible for targeted sustainability investments that align with their sustainability plans.
- Funds for one-time capital and technology expenditures necessary for improving financial management and stability. Examples include transitioning to cost-based accounting systems that will assist hospitals in more accurately understanding cost and revenue drivers or making minor renovations that will reduce ongoing overhead costs. Hospitals must participate in the specified financial planning and technical assistance activities to be eligible for these funds.

The MHDO, which houses Maine's all-payer claims database, will assist with analysis and reporting on provider financial health to promote transparency and measure success.

Activity 5.2: Regional Health Ecosystems Planning and Implementation

For advancements to be sustainable, it will be necessary for a wide range of stakeholders to come together to reassess how care is delivered and paid for in rural communities. This activity, led by Maine DHHS with support from OAHC, will support both planning and implementation stages to create financially sustainable rural health ecosystems across the state that support rural residents by providing the services they need to sustain good health and thrive.

The state will work with its consultant to facilitate a regionalized rural planning process involving a range of healthcare providers, local government, public health leaders, social services entities, and community members. The process will begin by defining and identifying essential services and the distance to those services. The MHDO will develop a comprehensive provider database to assist with this effort, expanding the kinds of provider organizations included in the current database, and incorporating service line data, multi-payer utilization analysis, and

geographical visualization. The process will identify options for the provision of essential services, including preventive care and disease management, including physical sites, telehealth, and technology-enabled, in-home and mobile care. Finally, the planning process will contemplate existing and potential financing and operational structures to support necessary changes in care delivery, including collaborative models and multi-payer APMs.

The implementation period will focus on equipping regions to execute critical elements of their plans. Funding will support infrastructure changes, staff recruitment, and the establishment of new legal and business relationships to develop more efficient and effective systems of care. Providers will need to participate in specified regional and financial planning and technical assistance activities to be eligible for regional planning funds.

Activity 5.3: Multi-Payer Alternative Payment Model (APM) Development

Maine's Office of MaineCare (Medicaid) Services (OMS) has been a leader in the state in designing and implementing successful APMs. OMS administers several value-based APMs. Currently more than 57% of MaineCare reimbursement is tied to APM models (HCP-LAN, category 2C or higher). This activity will enable the State to transform payment for team-based patient-centered medical homes under its Primary Care Plus (PCPlus) initiative, which was recognized as an aligned payer under Medicare's Primary Care First initiative. Maine will determine, in collaboration with primary care providers and other stakeholders, an APM that moves beyond fee-for-service to rewarding value. Implemented statewide in July 2022, PCPlus now has over 230 participating practices. The structure of the program will be modified to financially incent and reimburse practices for RHTP population health activities.

In addition, Maine will use the opportunity provided under this grant to collaboratively design a multi-payer reimbursement model to benefit the sustainability, right-sizing, and

population health focus of rural hospitals. Finally, this grant will support MaineCare's continued progress on the review and determination of service reimbursement that is efficient, sustainable, and rewards high-value care under its unanimously passed and award-winning rate reform law, MRSA 22, 3173-J.

Activity 5.4: Interfacility Transport System

As a relatively large, rural state with a small, dispersed population, Maine experiences challenges in the transportation of individuals between different levels of healthcare settings, such as CAHs and skilled nursing facilities. Typical non-emergency transportation is insufficient based on the level of care that the patients need. However, there are limited resources (personnel, IT systems) to arrange transportation and long distances to cover, resulting in delayed discharges that contribute to back-ups in EDs and available beds.

This activity will build off Maine's experience leveraging COVID FEMA to coordinate and execute inter-facility patient transport. RHTP funding will be used to support the expansion of the inter-facility transportation communications system across all hospitals, with coordination and oversight and personnel, providing the jumpstart needed to ensure long-term coordination and financial sustainability. The State will leverage related work by the Maine EMS Transport and Transfer Committee, the MHA, and its members to address this need.

Activity 5.5: Access to Full Care Continuum for Children with Complex Behavioral Health Needs

Maine currently lacks a children's psychiatric residential treatment facility (PRTF) that provides a stepdown level of care between inpatient hospitals and children's residential care facilities for children with complex behavioral health needs. This missing link has led to extended hospital stays for children, creating quality, operational, and financial challenges. Funding for this activity

will support the retrofitting of an existing building on the campus of a behavioral health treatment provider, Sweetser, to create a PRTF with capacity to deliver this service.

4. IMPLMENTATION PLAN AND TIMELINE

Timeline of Proposed Activities

Maine has developed timelines for all activities and milestones in each of our five initiatives.

Initiative 1 - Population Health						
Activity	**Milestone** **SS**: State Staff • **V**: Vendor • **SR**: Subrecipient	Milestone stage in yr.				
		Y1	**Y2**	**Y3**	**Y4**	**Y5**
Alternative Sites of Care: Making Care Available Where People Are	Hire support for SBHC, CCBHC rate setting, and Mobile Unit programs; create Mobile Unit inventory and toolkit; develop needs assessment and co-location framework ***SS + V***	0-2				
	Fund 1-2 additional Mobile Units and multiple SBHC sites; incorporate co-location costs into MaineCare rate setting ***SS + V***		2-3			
	Finalize materials; provide TA for SBHC billing and rural site sustainability ***V***			3		
	Continue Mobile Unit expansion and SBHC operations; maintain rural support. ***V***				4-5	
Spreading Effectiveness, Reach & Implementation of Evidence-Based Practices (EBPs)	Hire staff; establish decision-making framework; begin EBP training statewide ***SS + V***	0-1				
	Continue EBP trainings ***V***		2			
	Provide implementation TA/support statewide to trainees ***V***			3-5		
Nutrition Education Infrastructure	RFP/contracting; launch nutrition education programming statewide. ***V***	0-1				
	Finalize Food-is-Medicine implementation plan ***SS + V***		1-2			
	Launch Food-is-Medicine statewide (if 1115 waiver approved) ***SS + V***			2-3		
	Continue programming ***V***		2-5			
Transforming Care Capacity: Community Paramedicine	RFP/contracting for CP Training Center; hire staff; deliver CP education ***SS + V***	0-2				
	Implement CP Models; continue education	2-4				
	Continue CP models; Design MaineCare reimbursement of CP Services ***SS + V***			2-4		
	Continue CP models; MaineCare rulemaking and State Plan Amendments ***SS + V***				2-4	
	Continue CP models; MaineCare coverage begins to sustain CP models ***SS + V***					5
Community Health Worker / Peer Program to Improve Rural Mainers' Access	Hire Peer and CHW staff; RFP/contracting process for CHW work (CHW orgs, Training, Infrastructure Support); Amend Peer work contract ***SS + V***	0-1				
	Offer Peer trainings; implement Peer & CHW models; support CHW infrastructure ***V***		1-2			
	Continue: CHW funding & TA, Peer training, and Peer program models ***V***			3-5		

Supporting Access to the Continuum of Care for Mental Health and SUD Services for Special Populations	RFP/contracting with sole source vendor ***V***	0				
	Develop implementation plan ***V***		1			
	Fund implementation of new SUD sites ***V***			2		
	Expand crisis supports; finalize sustainability plans ***V***				3-4	
	Execute sustainability plans ***V***					5

Initiative 2 - Workforce						
Activity	**Milestone** **SS**: State Staff • **V**: Vendor • **SR**: Subrecipient	Milestone stage in yr.				
		Y1	**Y2**	**Y3**	**Y4**	**Y5**
Recruitment & Retention	Launch expanded Maine Careers with Purpose campaign ***SS + V***	0-1				
	Engage in recruitment and monitoring of licensed healthcare professionals for rural service ***SS + V***	0-5				
	Administer financial incentives to eligible clinicians committing to 5-year rural service ***SS + V***		2-5			
	Provide tailored mentoring, onboarding, and training to retain clinicians and mitigate isolation ***SS + V***		2-5			
Local Workforce Development and Training Pipelines: K–12 pipeline	Plan launch of rural Career Pathway cohorts, providing workforce credentials and college credit ***SS***	0-1				
	Offer K–12 cohort program, monitor outcomes, expand access ***SS***		2-5			
Local Workforce Development and Training Pipelines: HTFM	Plan HTFM program launch; start recruitment, prepare training aggregator ***SS + V***	0-1				
	Offer expanded HTFM program; continue recruitment w/ annual goals: rural cohorts in certificate programs and local associate degree RNs; monitor participation and retention; refine program as needed ***SS + V***		2-5			
Local Workforce Development and Training Pipelines: CHET	Plan expansion of rural clinical training sites, rotations, preceptors, and student matching platform ***SS + V***	0-1				
	Expand rural clinical training sites and rotations; establish preceptors; deploy student matching platform ***SS + V***		2			
	Scale clinical training; add 15–20 new sites and 50 preceptors annually; serve 500 learners/year ***SS + V***			3-5		
Local Workforce Development and Training Pipelines: Rural Training Labs & Mobile Simulation	Plan for mobile labs and simulation deployment; purchase mobile labs ***SS + V***	0-1				
	Deploy labs and simulation centers to train/upskill rural health professionals ***SS + V***		2			
	Continue deployment; monitor usage; adjust based on rural site needs ***SS + V***			3-5		
Innovation: Healthcare Workforce Data Dashboard	Build centralized workforce data platform; align with cross-profession min. dataset ***SS***	0-2				
	Maintain platform; collect and report annual workforce data; enable planning and resource allocation ***SS***			3-5		
Innovation: Rural Medical Workforce Transportation Pilot	Administer $2M grant to support innovative rural workforce transportation solutions ***SS***	0-2				

Initiative 3 – Technology		
Activity	**Milestone**	Milestone stage in yr.

	SS: State Staff • **V**: Vendor • **SR**: Subrecipient	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Implement/update State IT systems	Complete assessment & create phased roll-out / enhancement plan. *SS + V*	0				
	Initiate implementation / improvements for key state IT systems. *SS + V*		1-2			
	Complete implementation and improvements for key state systems. *SS + V*			2-5		
	Develop systems to ensure maintenance and operations post-RHTP grant. *SS + V*			2-5		
Support development of statewide Virtual Urgent Care telehealth program	Issue RFP and procure contract / support statewide program development. *SR*	0-1				
	Launch program with rural marketing; assess & refine to boost reach. *V*		2-3			
	Evaluate effectiveness & expand rural engagement. *V*		2-5			
	Improve billing practices for sustainability. *V*				4-5	
Implement tele-behavioral health program for special populations (youth, perinatal, older adults)	Issue RFP, procure contract, program development	0				
	Launch program with rural marketing; assess & refine to boost reach *V*		1-3			
	Evaluate effectiveness & expand rural engagement *V*			2-5		
	Improve billing practices for sustainability *V*				4-5	
Develop staff /spaces for patient tele-health	Identify facilitators; conduct training; distribute dedicated spaces funds *SS + SR*	0-2				
	Assess effectiveness & expand use; continue capital fund usage *SR*			2-5		
Develop platform/network to support specialty e-consultations	Issue RFP / secure contract; launch program & marketing *SS*	0-1				
	Assess effectiveness & expand rural engagement *V*		2-5			
	Improve billing practices for sustainability *V*				4-5	
Upgrade or Replace Electronic Medical Record Systems (EMR)	Establish criteria and priorities and issue RFA *SS*	0				
	Distribute funds for EMR upgrades & replacements *SR*		1-5			
	Assess progress *SR*		2-5			
Grow Maine's Health Info Exchange (HIE) & Develop Maine's Community Info Exchange (CIE)	HIE: Establish subaward, develop criteria, and issue RFA *SS*	0				
	HIE & CIE: Distribute funds to providers/CBOs *SR*		1-5			
	HIE & CIE: Assess program progress *SR*		2-5			
Develop Remote Patient Monitoring (RPM) programs & digital health apps	Issue RFP / secure contract; launch program & marketing *SR*	0-1				
	Assess effectiveness & expand rural engagement *V*		2-5			
	Improve billing practices for sustainability *V*				4-5	
Develop Maine Rural AI Hub & AI Innovation Institute	Develop Maine Rural AI Hub & AI Innovation Institute; distribute funds *SS + SR*	0-1				
	Assess effectiveness & expand reach *SR*		2-5			

Initiative 4 – Access						
Activity	**Milestone** **SS**: State Staff • **V**: Vendor • **SR**: Subrecipient	Milestone stage in yr.				
		Y1	**Y2**	**Y3**	**Y4**	**Y5**
Provider Uncompensated Care Supplemental Payment	Allocate $30M in payments to hospitals, FQHCs, and CCBHCs based on proportional, documented uncompensated care costs. *SS*	0-5				

Provider Payments for Essential Benefits for Uninsured, Low-Income Individuals	Establish program infrastructure for coverage; begin provider billing and payments; track claims to ensure coverage ≤15% of total RHTP award. *SS*	0-3				
	Continue provider payments; monitor utilization and outcomes to meet national median performance for Medicaid on prevention, chronic disease, and SUD treatment. *SS*		4-5			
	Evaluate program effectiveness for uninsured population. *SS*				5	
Enable Dynamic Medicaid Provider Enrollment Experience	Procure vendor to implement upgraded provider enrollment application. *SS*		1			
	Initiate app development and user testing. V, *SS*			3		
	Complete app development and implement. V, *SS*				5	
Coordinated Transportation to meet Health & Wellness Needs	Develop Mobility Management Plan. *V*	1				
	Develop app to enable cost allocation between Medicaid and other funded transportation; monitor implementation. *V*		2			
	Launch regional coordinated transportation pilot (≥10 provider vehicles). *SS*			3		
	Monitor implementation; assess effectiveness; refine coordination; expand participation (+10 provider vehicles). *SS*				4	
	Expand/adjust pilot; sustain expanded coordination. *SS*					5
Consumer Transparency Tool for State-Based Marketplace	Start project plan; conduct focus groups and market research; begin development of improved plan comparison tool. V, *SS*	0-1				
	Continue market research and focus groups; incorporate findings; implement new plan comparison tool. V, *SS*		2-3			
	Continue platform use; monitor usage and effectiveness; refine tools for consumers and businesses. *SS*			4		
	Assess outcomes; sustain consumer-directed decisioning. *SS*					5

Initiative 5 - Sustainable Rural Health Ecosystems						
Activity	**Milestone** **SS**: State Staff • **V**: Vendor • **SR**: Subrecipient	Milestone stage in yr.				
		Y1	**Y2**	**Y3**	**Y4**	**Y5**
Hospital Financial Stabilization Program	Identify financially vulnerable hospitals; provide targeted financial planning support; allocate $30M for capital, infrastructure, and non-EMR technology. *V*	0-2				
	Cont. financial TA; ensure 90% hosp. participation; monitor efficiency & stabilization plans. *V*		3			
	Assess progress; evaluate hospitals' readiness for sustainable long-term operations *V*			4-5		
Regional Rural Health Planning and Implementation Fund for Rural Regional Hospitals	Conduct regional assessments of service needs & collaborative models; engage stakeholders *V*		0-2			
	Continue regional planning, dev. implementation strategies. *V*			3		
	Launch implementation; fund staffing for 5 hosp., renovate 3 facilities, equip 4 TH rooms. *V*				4	
	Cont. implementation; refine service models; double cross-org regional partnerships. *V*					5
Multi-Payer Alternative Payment Model Development	Develop APMs for PCs and SBHCs conduct research, data collection, stakeholder engagement; procure vendors for dental and sole-source contracts. *SS+ V*	1				
	Finalize APM recommendations for primary care, SBHCs, and dental reimbursement; determine budget and implementation plan. *SS+ V*		2			

	Subject to legislative appropriation, implement SBHC APMs at 11 new sites; secure vendor for multi-payer rural hospital APM. *SS+ V*			3		
	Subject to legislative appropriation, implement APM targeting 230 PC practices. *SS+ V*				4	
	Present rural hospital APM recommendations with multi-payer sustainability plan; achieve 60% of MaineCare reimbursement tied to value-based APMs. *SS+ V*					5
	Continue design, implementation, and scaling of rural hospital APMs in collaboration with hospitals, payers, and stakeholders; manage vendor support. *SS+ V*			3-5		
	Prioritize MaineCare-funded services, set value-based reimbursement rates, and align rate-setting with APM dev., aiming for one new rate determination annually. *SS+ V*			4-5		
Interfacility Transport System	Procure vendor; plan centralized coordination function including tech needs. *V*	0-1				
	Implement funding for personnel and tech; ensure ≥12 long-distance transport routes. *V*		2			
	Monitor transport operations and system efficiency. *SS+ V*			2-4		
	Refine transport system; assess long-term financing; ensure sustainable operations. *SS+ V*					5
Access to Care for Children with Complex Behavioral Health	Issue facility funds; begin retrofitting; develop model and recruit staff; dev. referral paths *SS*	0-4				
	Complete renovations; implement clinical staffing; begin serving patients; increase % of children receiving PRTF services in-state. *SS*					5

Governance and Project Management Structure

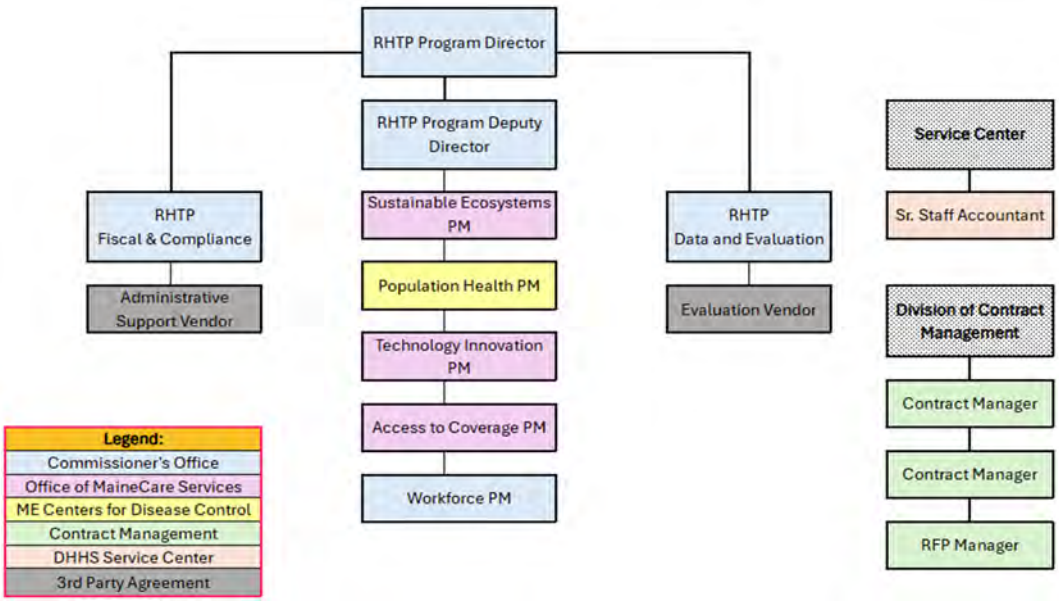
Governance: Maine's RHTP will be governed by the RHTP Governance Committee, consisting of high-level leadership across Maine state government, representing the key Departments and Offices that are affected by the initiatives and activities of the RHTP. The RHTP Governance Committee will be responsible for making major directional decisions pertaining to the program, including any changes that may need approval from CMS. The Committee will meet at least monthly to review progress, make decisions, and provide guidance to the RHTP Program Director and team members. The RHTP Governance Committee will consist of the DHHS Commissioner, a representative of the Governor's Office, the State Medicaid Director, the State Director for Maine's Office of Public Health (Maine CDC), the State Director for Maine Office of Behavioral Health, the Commissioner of the Maine Department of Labor, and the RHTP Program Director (or their designees).

Advisory Committee: Maine will establish an external RHTP Advisory Committee to advise the RHTP Governance Committee throughout the administration of the RHTP. The RHTP Advisory Committee will play a vital role in ensuring that Maine's RHTP is well-supported and advised by individuals representing the rural health community across the state. This Committee will build on Maine DHHS' previous convening of the statewide Maine Rural Health Transformation Team and will consist of individuals with experience of the key sectors comprising Maine's rural health ecosystem, including, but not limited to: rural hospitals (independent and system-affiliated), FQHCs, rural clinics, Tribal Health Centers, behavioral health providers, including at least one CCBHC representative, Maine's perinatal system of care, public health, CBOs operating in rural counties, EMS, long-term care facilities, local businesses, telehealth technical assistance organizations, rural health research organizations, and relevant DHHS Offices and other state Departments.

Administration and Project Management Structure: Maine's RHTP will be administered by the Maine DHHS. Lisa Letourneau, MD, MPH, will serve as Program Director, providing overall leadership, direction, and management. A physician and public health leader, Dr. Letourneau has driven major transformation in Maine's health-care system, leading statewide initiatives such as the multi-payer medical home pilot and rural health transformation efforts, and advancing care models and digital health solutions including AI tools. Her experience spans primary care, behavioral health, value-based payment, and community partnerships. As Program Director within the Commissioner's Office, she will oversee and ensure accountability for all RHTP initiatives and goals.

The Program Director will be supported by a team of 13 Full-Time Employees (FTEs) responsible for program oversight, administration, and evaluation, including positions dedicated

to direct initiative management. DHHS anticipates onboarding all FTEs by the end of Q1 2026. In addition, DHHS will contract for RHTP administrative support to streamline contracting, reporting, and grant management, and will procure an Evaluation Vendor to conduct continuous evaluation of RHTP's effectiveness, including compilation and reporting of all grant metrics.



Internal and External Coordination: This governance and organizational structure will allow Maine to optimize its internal and external coordination of this program. Internally, resources are allocated within the DHHS Commissioner's Office to ensure effective cross-Office implementation of initiatives and embeds key resources within the organization to leverage existing work, processes, and partnerships where possible. This also allows Maine to maintain an efficient, lean and effective administrative structure, keeping administrative costs low. Additionally, retaining an Administrative Support vendor will allow Maine to scale up contracting and procurement activity quickly and throughout the life of the program as needed, ensuring that funding is utilized as efficiently and effectively as possible. Externally, the RHTP team and RHTP Advisory Committee will work collaboratively to ensure that efforts under the program are communicated with and understood by the community and have the desired impacts.

5. STAKEHOLDER ENGAGEMENT

To ensure broad engagement with, and input from, rural stakeholders in the development of Maine's RHTP, the State implemented a robust and multi-faceted community engagement process, including establishing a webpage on the Maine DHHS website that outlined the RHTP structure, funding, strategic goals, and required components. The webpage also provided links and information about opportunities for public input and engagement to help identify critical rural health challenges and make recommendations to strengthen Maine's rural health ecosystem. As a result, rural stakeholders contributed to the RHTP planning process through multiple avenues including:

- A public comment period that received 304 responses Maine stakeholders representing all counties and a wide range of affiliations, including individuals, community organizations, hospitals, and non-hospital providers, as well as from out-of-state vendors, technology firms, and health consultancies.
- Community listening sessions held in-person in Aroostook (7 participants) and Washington (12 participants) Counties, as well as virtually for Midcoast, York, and Cumberland Health Districts (36 participants), and the Penquis, Central, and Western Districts (10 participants).
- Key partner meetings with Tribal Representatives, the MHA, the Maine Primary Care Association, the Alliance for Addictions and Mental Health, and Consumers for Affordable Health Care (CAHC).
- A series of touchpoints (30) with Maine DHHS-led groups, state partners, and community organizations, in which Maine DHHS encouraged written comments.
- A plenary session at the Maine DHHS Health Workforce Summit with 67 submitted comments.

- Letters with additional comments submitted (9) by key health services organizations.

Maine's overall strategy is designed to address the interconnected and urgent challenges identified through this process including unaddressed root causes of disease, workforce shortages, gaps in technology and infrastructure, concerns about losing access to care, and the financial instability of rural hospitals and providers. Maine's RHTP directly responds to these priorities and reflects the recommendations made by Maine's rural residents. A complete list of consulted stakeholders is provided in the **Other Supporting Documentation**

As noted in the Project Management and Governance discussion above, to engage stakeholders on a regular basis, Maine will establish an RHTP Advisory Committee comprised of representatives from key sectors across Maine's rural health ecosystem. Maine will coordinate regularly with State leaders on deploying RHTP funds, tracking milestones, and assessing impact metrics through the RHTP Governance Committee which will consist of the DHHS Commissioner, a representative of the Governor's Office, the State Medicaid Director, the State Director for the Maine CDC, the State Director for Maine OBH, the Commission of the MDOL, and the RHTP Program Director.

6. METRICS AND EVALUATION PLAN

Maine has identified a comprehensive set of metrics that align with each of the five initiatives. All metrics will be collected on an annual basis using a combination of data sources, including claims databases, provider surveys, key stakeholder input, and data from other relevant state agencies. Our metrics were designed based on measurability and data availability; robustness in ability to show outputs and outcomes progress; programmatic alignment with the nature of proposed initiative activities; and geographic granularity.

The following tables outline the specific performance metrics, data collection sources, and frequency of reporting, geographic granularity, baseline measures (where available), and associated goals for each of Maine's RHTP initiatives.

Measurable Outcomes			
Metric	*Data Source/ Freq.*	*Granularity*	*Baseline/Goal*
Initiative 1 – Population Health			
Number of Maine CDC recognized SBHCs in Maine	Maine CDC and Maine Public Schools/Annual	School-level (ZIP Code)	Baseline: 19 SBHCs in Maine public schools/Goal: 29 SBHCs by FY 2030
Proportion of attendees at EBP trainings from rural organizations	EBP Training vendor logs/ Annual	ZIP Code of organization	Goal: 50% by FY 2030
Number of new OTP access points located in rural areas	Maine Office of Behavioral Health & Service Providers/ Annual	ZIP Code	Baseline: 6 rural OTP sites/Goal: 1 additional per year
Proportion of MaineCare rural population with BH needs that accessed ambulatory or primary care	MaineCare claims data/ Annual	ZIP Code	Goal: Increase current proportion by 5 percentage points by FY 2030, with progressive growth across Years 1-5
Number of CP agencies per county	Department of Public Safety (EMS)/Annual	County	Baseline: All counties except Aroostook and Washington have a CP agency/Goal: CP agency in every county by FY 2030
Initiative 2 – Workforce			
Number of clinicians that commit to working in rural communities	Award vendor/Annually	ZIP Code	Goal: Recruit 200 clinicians per program year beginning in Year 2 (FY 2027)
Number of new health career pathway programs launched in rural school districts	Maine Department of Education/Annual	School District	Goal: Launch 2 new programs per year in rural communities beginning in Year 2 (FY 2027)
Number of students enrolled in health certificate and degree programs in rural communities	Health Care Training for ME Partners/Annual	ZIP Code	Goal: Enroll 500 new students per year beginning in Year 2 (FY 2027)
Number of new clinical preceptors supervising students in a rural setting	CHET Consortium/Annual	ZIP Code	Goal: Add 50 new preceptors per year throughout program duration (FY 2026 - FY 2030)
Initiative 3 - Technology			
Percentage of adults who have had at least one ambulatory care visit and have one or more of those visits delivered via telehealth	Maine All-Payer Claims Database (APCD) and MaineCare claims data (with 1-2 year lag in APCD reporting, a subset of MaineCare claims will be used for	County	Goal: From FY 2026 to FY 2030, increase the relative percentage of adults who have had at least one ambulatory care visit and have had one or more of those visits delivered via telehealth by 20 percent, with progressive increases across program years

	timely reporting)/ Annual		
Among youth (5 to 18 years of age) the percentage of BH visits that are delivered via tele-BH services	Maine All-Payer Claims Database (APCD) and MaineCare claims data (with 1-2 year lag in APCD reporting, a subset of MaineCare claims will be used for timely reporting)/ Annual	County	Goal: From FY 2026 to FY 2030, increase the relative percentage of youth BH visits delivered via tele-BH by 20 percent, with progressive increases across program years
Percentage of primary care practices in rural communities that gain access to specialty consultations via either synchronous or asynchronous telehealth	Practice surveys/Annual	Provider-level (ZIP code)	Goal: From FY 2026 to FY 2030, increase the relative percentage of practices in rural areas that gain access to telehealth specialty consultations by 20 percent, (excluding practices that had access to services at baseline), with progressive increases across program years
Percentage of primary care practices in rural communities that gain access to an AI-supported ambient documentation service	Practice surveys/Annual	County	Goal: From FY 2026 to FY 2030, increase the relative percentage of practices in rural counties with AI ambient dictation system by 20 percent, (excluding practices that had access to services at baseline), with progressive increases across program years
Initiative 4 – Access			
Rate of primary care utilization among individuals in uninsured pool	MaineCare claims data/Annual	ZIP Code	Goal: Maintain parity with current MaineCare utilization rate throughout program duration
Asthma Medication Ratio: Percentage of individuals in uninsured pool with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater (19-64 years of age)	MaineCare claims data/Annual	ZIP Code	Goal: Match national median for Medicaid (currently 62%) by FY 2030, with progressive increases across Years 2-5 (FY 2027 – FY 2030)
Initiation and Engagement of SUD Treatment: Percentage of new SUD episodes for adults age 18 to 64 in uninsured pool with initiation of SUD Treatment within 14 days.	MaineCare claims data/Annual	ZIP Code	Goal: Match national median for Medicaid (currently 44%) by FY 2030, with progressive increases across Years 2-5 (FY 2027 – FY 2030)
Breast Cancer Screening: Percentage of women ages 50 to 74 in uninsured pool who received a mammogram to screen for breast cancer	MaineCare claims data/Annual	ZIP Code	Goal: Match national median for Medicaid (currently 50%) by FY 2030, with progressive increases across Years 2-5 (FY 2027 – FY 2030)
Number of transportation organization provider vehicles	App vendor/Annual	State	Goal: 10 additional providers per year

participating in Maine Regional Coordinated Services Pilot			
Initiative 5 – Sustainable Rural Health Ecosystems			
Percentage of MaineCare reimbursement in APMs	MaineCare claims data/Annual	State	Baseline: 57%/Goal: 60% by FY 2030
Number of hospitals serving rural communities that implement actions in alignment with developed financial management plans	Maine hospitals/Annual	ZIP Code	Goal: 90% of hospitals selected to participate in trainings
Percentage of Maine children/youth who receive PRTF-level services in-state	Maine Office of Behavioral Health/ Annual	State	Baseline: 0%/ Goal: Increase by 10 percentage points annually beginning in year 2 (FY 2027), reaching 40% by FY 2030
New partnerships as a result of regional health ecosystems planning and implementation	Maine Health Data Organization/Annual	State	Goal: 100% increase in cross-organizational partnerships throughout program period

Program Evaluation

Maine is committed to conducting a thorough and timely evaluation process as a critical component of our RHTP participation. The state will conduct annual formal evaluations to ensure that awarded funding is swiftly and effectively distributed, program milestones are met, and initiatives reach and benefit rural residents across the entire state. The state agrees to cooperate with any CMS-led evaluation or monitoring conducted by CMS and/or third-party evaluators. A formal and annual evaluation process is essential to achieving the following:

- ***Streamlining reporting*** to ensure accuracy and consistency in collecting program initiative metrics. The state views this as an essential step for collecting and collating measured program impacts and presenting gathered data in a transparent and accessible way to CMS, program stakeholders, and members of the public.
- ***Quantifying both initiative-level and overall program impact*** across rural Maine communities. In addition, a formal evaluation process is critical to assessing heterogeneity in program impact across the state and evaluating whether program impacts vary across rural communities.

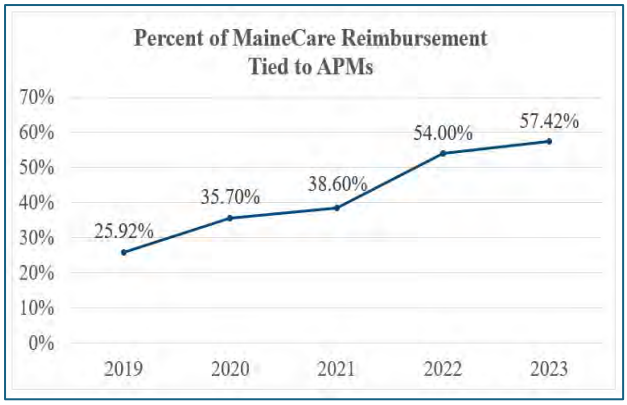
- ***Incorporating stakeholder feedback*** on both program successes and areas for improvement. While the state recognizes that initiative metrics are crucial to quantifying program impact, we recognize that stakeholder insights offer a complementary perspective and will provide valuable insight to highlight achievements, identify challenges, and inform potential recalibrations.
- ***Informing sustainability planning*** to ensure that gains and improvements achieved through the RHTP continue beyond the final funding year. The state views constructive annual evaluations as a critical tool for supporting ongoing progress both during the funding period and after the program concludes. To conduct a formal evaluation, the state will solicit a request for proposals (RFP). Proposal respondents will be strongly encouraged to partner with an academic institution to ensure that methodological rigor is employed in data collection and analyses.

7. SUSTAINABILITY PLAN

Maine's RHTP reflects a thorough vetting of activities that are bold, transformation-oriented, and well positioned for long-term sustainability. To achieve that goal, Maine's RHTP efforts are designed around a framework of five major initiatives that complement and build on each other. Maine's Sustainability Plan identifies five primary pathways, outlined below and detailed in the table (p.60), mapping how each initiative will be sustained.

1) Build a Sustainable Rural Health Ecosystem: Maine must carefully examine the needs of its rural communities and reconfigure its current array of hospitals, healthcare infrastructures, and ambulatory providers to create a more responsive and sustainable local system of care. RHTP funding provides a unique opportunity to convene healthcare communities and healthcare providers - many of whom currently operate independently or within siloed ownership structures

- to right-size healthcare services that better meet the unique needs of their community. While we expect that some critical decisions regarding rural health care service reconfiguration will be made within the RHTP period, our RHTP efforts will build regional relationships, skills, data sources, and financial acumen that will support ongoing planning and change efforts beyond the funding period. Maine's RHTP will strengthen existing and create new rural affiliation models or networks that will become self-sustaining through partner contributions, dues, fundraising, grants, and other new models. Additionally, RHTP investments will improve disease prevention and chronic disease management, enabling individuals to take control of their own health and gain employment and educational opportunities that can improve their overall well-being and long-term economic prosperity.



2) Implement Payment Change: Maine's RHTP effort will support continued development and implementation of **Alternative Payment Models (APMs)** within MaineCare, as well as within commercial health plans, and with support from CMS, within Medicare payment models. Maine's Medicaid program currently administers several statewide, value-based APMs: presently more than 57% of MaineCare reimbursements are tied to APM models (HCP-LAN, category 2C or higher). MaineCare's APM models incent innovative approaches to care delivery and utilize care teams creatively to meet patient needs, and RHTP funding is expected to create a surge of interest, capacity, and partnerships to allow Maine to realize desired impacts of these models. RHTP will support the creation of new entities that can accept value-based arrangements on behalf of new rural health networks as part of transforming

rural ecosystems. The ability to engage in flexible payment models is critical because these models enable providers/health systems to make the investments needed to achieve desired results and sustain RHTP activities (e.g. support non-billable services, IT costs, partnership building). The following examples demonstrate Maine's readiness to expand current and create new APMs:

MaineCare PCPlus	Launched in July 2022, PCPlus provides risk-adjusted, population-based payments to primary care practices that are tied to practice characteristics, cost, and quality outcomes. Moving forward, OMS will link PCPlus payments and financial incentives to RHTP population health activities and goals. Additionally, Maine will continue to pursue efforts to promote multi-payer alignment of advanced primary care payment models and will seek opportunities to work with CMS to include Medicare in new payment models.
MaineCare Accountable Communities	In 2025, Maine successfully transitioned its Medicaid Accountable Care Organization (ACO) program from one- to two-sided risk. MaineCare's ACO program aims to improve the quality of care while reducing the total cost of care. As with PCPlus, Maine will leverage its RHTP efforts and partnerships to financially incent health system changes and encourage multi-payer participation in ACO models to maximize the impact of these programs.
Hospital Value-based Purchasing Supplemental Sub-pool	MaineCare distributes funding each year to eligible hospitals based upon their quality performance assessed at the Hospital Service Area level. In RHTP, Maine will expand this financial incentive program and align it with hospitals' participation in RHTP efforts.
Certified Community Behavioral Health Clinics	Maine's CCBHC model will be further developed and expanded in Maine to align with RHTP goals and is a critical pathway to ensure sustainable payment for advanced care delivery models that can better meet the BH needs of rural communities.
Transforming Mat. Health Value-Based APM for Mat. Services	Maine was one of 15 states selected to participate in the ten-year CMS TMaH model which includes the phased in development and adoption of a maternity services APM. Maine's RHTP activities will build off this work and other TMaH funded activities.

Maine will work with CMS to identify opportunities for future participation in new Medicare payment models, such as the AHEAD model and the 1115 waiver process.

Leveraging existing payment mechanisms: It is well recognized that providers often underuse existing payment mechanisms that could be used to support care coordination, team-based care, and preventive services (e.g. Medicare's Advanced Primary Care Management services), often because of providers' limited understanding of options, limited capacity to make EMR or operational changes to support efficient billing (e.g. SBHCs), and conflicting or confusing requirements across payors (e.g. for dual eligible members). Through its RHTP efforts and partnerships with provider organizations, Maine will invest in structural changes that support and

incent the transition to billing insurance and communicate those opportunities with rural providers across all payers, leveraging DHHS' multi-payer relationships.

3) Implement Policy Change: Over the five years of the RHTP grant period, Maine will engage in a process of continuous improvement to identify and integrate lessons learned, which will inform ongoing policy changes. Maine will prioritize policy changes that can be implemented with executive action and will plan for those that require legislative authority and/or budget appropriations. Highlights of already identified policy changes include:

- Several RHTP services are expected to be permanently built into MaineCare benefits, with necessary appropriations.
- For nutrition services and traditional healing services, Maine submitted a Medicaid 1115 waiver amendment in June 2025, which includes the request to pilot Food is Medicine and traditional healing services as MaineCare benefits.
- Maine recognizes a significant opportunity to improve the integration of Medicare and Medicaid services for Dual Eligibles. OMS manages the State Medicaid Agency Contract with all Dual Special Needs Plans (DSNPs, Medicare Advantage plan service being enrolled in MaineCare and Medicare) and intends to use this mechanism to leverage these health plans for positive state impacts and efficiencies.
- Maine will use its RHTP experience and learnings to inform changes to provider licensing and other regulatory changes that may be needed to support newer models of care, and to inform future versions of Maine's State Health Improvement Plan and Rural Health Plan.

4) Sustain Momentum on Rural Healthcare Workforce: Maine's RHTP includes a strong focus on building a broader, more sustainable rural healthcare workforce by recruiting, retaining, and growing professionals to serve rural communities. Some RHTP workforce investments are one-

time strategies to attract and retain new individuals in rural Maine (e.g., education awards, outreach campaigns), while others will establish new workforce models and strengthen sustainable partnerships with employers, providers, and communities. We anticipate that some employers (e.g., hospitals) will realize significant value from RHTP workforce investments, supporting their continued commitment to these strategies. Several workforce efforts already have momentum, supported by strong public, legislative, health system, and multi-payer interest in regulatory and payment change. For example, LD 1832 from the 131st Maine Legislature created a stakeholder group to review CP programs and explore insurance reimbursement for CP services. MaineCare is developing a CP reimbursement model, and the stakeholder group expects MaineCare's work to serve as a model for other Maine payers, and ideally Medicare, to provide sustainable payment for CP services.

5) Embed Technology & Innovation: RHTP funding will leverage technology and innovation to support sustainable improvements in care and financing. Funding will cover one-time expenses such as updating EMR systems, enhancing cybersecurity, purchasing AI modules, renovating spaces for Telehealth Hubs, and providing high-speed modems for Maine EMS units. Additional investments will develop billable services that can be incorporated into APMs, including telehealth, school-based tele-BH services, and eConsults. Some programs will be sustained through a combination of direct provider payments and partnerships with benefiting organizations. For example, school tele-BH programs will be partially funded by schools/towns once their value is demonstrated. Provider-based ACOs will also benefit from initiatives such as synchronous specialty consultations, which reduce in-person specialist and ED visits, allowing shared savings under value-based payment programs to sustain investments.

Sustainability Action Key									
1	Right-Sizing Rural Planning	2	Economies of Scale & Efficiencies	3	MaineCare Reimbursement	4	Alternative Payment Models	5	Other State/Federal Funding
6	Public/Private Partnerships	7	State Policies Changes	8	1x funds; no sustain. action needed	9	Transitional support only; no sustainability action needed		

Sustainability Action Plan		
Initiative	*Activity or Sub-Activity*	*Action*
Population Health	Alternative Sites of Care	2; 3; 4
	Spreading Evidence-Based Practices	2; 3; 7
	Nutrition Education Infrastructure	3; 4; 5; 7
	Shared Workforce Models for Community Paramedicine	1; 2; 3; 4; 6
	Community Health Worker / Peers Program to Facilitate Access	1; 2; 3; 4; 6
	SUD/MH access	3; 4; 5
Workforce	Careers with Purpose Marketing Campaign	9
	Rural Provider Recruitment Incentive Programs	9
	Provider Training & Upskilling	9
	Consortium for Healthcare Education & Training (CHET)	2; 6
	Healthcare Training for ME Partnership	2; 6
	Health Career Pathway	6
	Healthcare Workforce Data Dashboard	1; 2; 5; 6
	Technology SIM LABS	8
	Rural Medical Workforce Transportation Pilot	1; 2
Technology	Remote Patient Monitoring	2; 3; 4; 5
	Patient-Facing Digital Health Tools	2; 4; 5
	AI-Supported Documentation and Clinical Decision Tools	2; 5; 6; 8
	EHRs, Telehealth Hubs, and Health Technology Infrastructure	2; 5; 8
Access	Provider Uncompensated Care Supplemental Payment	9
	Provider Payments for Essential Services for Uninsured	9
	Enable Dynamic Medicaid Provider Enrollment Experience	2
	Regional Coordinated Transportation to Health-Related Services	1; 2; 5; 6
	Empowering Consumer-Directed Health Care Decision Making	8
Sustainable Rural Health Ecosystems	Hospital Efficiency & Financial Management Program	1; 2; 3; 4; 5; 6; 7
	Regional Rural Health Planning and Implementation Fund	4; 6; 8
	Multi-Payer Alternative Payment Model Development	4; 7
	Interfacility Transport System	2; 5
	Access to Full Care Continuum for Children w/ Complex BH Needs	3

State of Maine

Rural Health Transformation Program

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Congress of the United States

Washington, DC 20510

November 4, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz:

We are writing in support of the State of Maine's application for funding under the Rural Health Transformation Program (RHTP), section 71401 of the "One Big Beautiful Bill Act," H.R. 1 (P.L. 119-21).

We understand that Maine's application is designed to fit the RHTP's statutory and regulatory aims. The state's strategy is organized around five major initiatives that complement and build on each other, including: improving population health; strengthening Maine's rural health workforce; improving health technology; improving access to care; and supporting the State's rural health ecosystem. Across these initiatives, Maine is emphasizing needs and solutions related to behavioral health, perinatal care, children and youth, and older adults.

We appreciate your attention to Maine's application and ask that you give it all appropriate consideration under applicable statutory and regulatory requirements.

Sincerely,

Angus S. King, Jr.
United States Senator

Susan M. Collins
United States Senator

Chellie Pingree
Member of Congress

Jared Golden
Member of Congress

MHA
Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

October 27, 2025

The Honorable Janet Mills Governor of Maine
Office of the Governor 1 State House
Station
Augusta, ME 04333-0001

RE: Maine Rural Health Transformation Fund (RHTF)

Dear Governor Mills,

The Maine Hospital Association (MHA) strongly supports the Maine Department of Health and Human Services' application to the Centers for Medicare and Medicaid Services for funding through the Rural Health Transformation Fund (RHTF). MHA represents 32 hospitals across the state of Maine.

We have reviewed the outline of the state's application and believe it presents a balanced, thoughtful approach to transforming healthcare delivery in one of the most rural states in the nation.

It is a challenging time for Maine's hospitals. The financial condition of our members, compared to hospitals nationally, is troubling. Maine's Prospective Payment System (PPS) hospitals rank fifth poorest in the country in operating margin, fifth oldest in average age of plant, and second most indebted in equity financing. In short, our members simply do not have the financial capacity to make the transformational investments needed on their own.

Despite these financial constraints, quality remains strong. Maine's hospitals have consistently ranked among the top 20 in the nation in each of the last two Leapfrog assessments for healthcare quality.

Maine hospitals were invited to share ideas for reform with the State, and several did so. MHA and its member hospitals actively participated in public meetings held by the State and engaged in two additional private discussions with DHHS staff to explore strategies for transforming rural healthcare. We appreciate that not all stakeholders were afforded such opportunities for input and value the State's efforts to ensure that hospital perspectives were included.

One clear example of how RHTF funding could drive meaningful change involves improving non-emergency patient transport between facilities. Due to Maine's rural geography, transfers are often logistically difficult. A non-emergency transfer may require more than two hours each way, and hospitals currently must contact multiple ambulance providers to find availability.
Local services, often short-staffed, cannot easily commit to a four- or five-hour round trip, leading to delays so significant that receiving facilities may no longer have available beds by the time transport is arranged.

There are proven technical solutions to this problem, such as a centralized dispatch system that coordinates multiple transport providers, similar to an emergency 911 model. However, the initial software and implementation costs are substantial, and it is challenging to secure contributions from multiple independent facilities that would benefit from such a system.

This is just one example of the types of collaborative and innovative projects we look forward to pursuing in partnership with the State through the Rural Health Transformation Fund. We are confident that, together, we can sustain and strengthen rural healthcare for the people of Maine.

Steven R. Michaud
President

Maine Primary Care Association

October 27, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

Dear Governor Mills,

The Maine Primary Care Association (MPCA) is pleased to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted CMS by Maine's Department of Health and Human Services. MPCA is proud to serve as the membership association for Maine's Federally Qualified Health Centers (FQHCs). Our members constitute the beating heart of Maine's rural health ecosystem and together—**as the largest independent primary care network in the state of Maine**—we serve 1 in 5. Each year we grow the number of Maine people who come through our doors, serving them regardless of ability to pay.

60 years into the health center movement, FQHCs have proven that they can be mission-driven while achieving remarkable outcomes. For example, recently we learned Maine's FQHCs are among the top 10 nationally for UDS measures both on an individual health condition basis as well as in aggregate across health condition measures. A decade ago, Maine's FQHCs were among some of the first in the US to build integrated behavioral health into their care model. These days, Maine's health centers host programs and services that respond to community needs – from food pantries to produce baskets; from recuperative care partnerships to community paramedicine, and burgeoning efforts across the network to expand pharmacy access at a time when Mainers are struggling to find a convenient place to get prescription drugs. All of these experiences are central to CMS' intent to make rural America healthy.

RHTP provides a once-in-a-lifetime opportunity to improve healthcare access, quality, and outcomes for people living in rural Maine. Our experience as rural providers makes us particularly able to tackle aspects of each of the proposed initiatives that Maine DHHS includes in their application. As a central partner in advancing the proposed initiatives, MPCA looks forward to working with your administration and Maine DHHS to address rural healthcare challenges. With a joint commitment to the power of FQHCs, we can make major progress to improve health and healthcare in Maine's rural communities.

Sincerely,

Darcy Shargo, CEO
Maine Primary Care Association

Alliance for Addiction and Mental Health Services, Maine
The unified voice for Maine's community behavioral health providers

October 23rd, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04330-0001

RE: CMS-RHT-26-001

Dear Governor Mills,,

The Alliance for Addiction & Mental Health Services, Maine (the Alliance) is proud to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being summitted to CMS by the Maine Department of Health and Human Services.

The Alliance is the statewide association representing Maine's community-based behavioral health providers and is focused on ensuring that Mainers have access to high-quality, recovery-oriented systems of care. We represent 36 agencies across the state who deliver care to over 100,000 Mainers each year. Access to mental health and substance use disorder treatment services is an important issue in Maine, particularly in our rural areas. In recent years, Maine has experienced unprecedented demand for services alongside growing challenges in developing and maintaining a workforce able to meet the full need. In rural Maine, these access barriers become even further exacerbated.

The RHTP represents a tremendous opportunity to support care delivery, strengthen workforce capacity, and expand access to essential services in rural communities. The Alliance and our member agencies have deeply appreciated the opportunities to engage with Maine DHHS on this proposal and look forward to continued collaboration in supporting RHTP implementation efforts.

Maine's community behavioral health providers will greatly benefit from initiatives across all five areas of focus. Supporting key programs such as Certified Community Behavioral Health Clinics (CCBHCs), mobile opioid treatment programs (OTPs), Child ACT teams, and school-based services will have an immediate impact in expanding access to care and enhancing population health. Recruitment, retention, and innovative apprenticeship and educational advancement efforts will be a catalyst in strengthening Maine's behavioral health workforce and incentivizing workers in rural areas to remain in their communities while advancing their carreer.

The Alliance applauds the engagement approach that Maine has taken in developing its RHTP proposal and welcomes the opportunity to continue to work with your administration and Maine DHHS to address rural healthcare challenges and improve behavioral health and mental wellbeing in our rural communities.

Sincerely,

Adam Bloom-Paicopolos, MPP
Executive Director

Consumers for Affordable Health Care
Advocating the right to quality, affordable health care for all Mainers.

mainecahc.org
PO Box 2490
Augusta ME 04338
1-800-965-7476

October 21, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001

RE: CMS-RHT-26-001/ Rural Health Transformation Program Application

Dear Governor Mills,

On behalf of Consumers for Affordable Health Care, I am pleased to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted by the Maine Department of Health and Human Services to the Centers for Medicare & Medicaid Services.

Consumers for Affordable Health is a nonpartisan, nonprofit charitable organization. As designated by Maine's Attorney General, CAHC serves as Maine's Health Insurance Consumer Assistance Program (CAP), which operates a toll-free HelpLine. CAHC's HelpLine fielded nearly 7,300 calls and emails last year from people across Maine who needed help obtaining, keeping, using, or fixing problems with private health insurance or with accessing or affording health care services. CAHC also serves as the Ombudsman program for Maine's Medicaid program, MaineCare, and helps people apply for and navigate the enrollment process. It is with that background that CAHC provides its support of Maine's RHTP application.

We believe RHTP provides an important opportunity to address barriers Mainers face accessing the health care they need and will be a means to improve healthcare access, quality, and outcomes for people living in rural Maine. Nearly half of Maine households report they have accumulated medical debt over the last two years. On average, insurance premiums are increasing 23.9 percent in Maine's individual market and 17.5 percent for its small employer market this coming year. At the same time, hospitals and other health care providers report their struggles to keep doors open, with some in rural areas reporting closures or cessation of certain services. The current path is unsustainable for both Mainers and health care providers.

We believe Mainers and Maine's health care infrastructure will greatly benefit from initiatives proposed in Maine's RHTP application. CAHC stands ready to support the State's work to enable Mainers to access affordable care, to expand and strengthen the state's rural healthcare workforce, and to foster the innovations and efficiencies needed to ensure a sustainable rural health ecosystem in Maine. We will collaborate with other stakeholders, including consumer advocacy groups and health care providers, to promote and shape these initiatives and to provide qualitative and quantitative (when available) information on improvements and/or conclusions achieved by its plan.

We look forward to the opportunity to work with your administration and Maine DHHS to address rural healthcare challenges and to improve health and healthcare in Maine's rural communities.

Sincerely,

Ann Woloson
Executive Director

Wabanaki Public
Health & Wellness

Cultivating the Health of Our Communities

October 27, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

Dear Governor Mills,

Wabanaki Public Health and Wellness (WPHW) is pleased to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted to the Centers for Medicare & Medicaid Services by the Maine Department of Health and Human Services.

Wabanaki Public Health and Wellness is a key stakeholder in Maine's rural health ecosystem. WPHW is a collaborative organization and the vested tribal public health authority (created in state legislation, in partnership between the State of Maine and the Tribal Chiefs) that works with tribal and tribal non-profit organizations to deliver public health services to Wabanaki people, the People of the First Light. These communities include the five tribal communities in Maine: Mi'kmaq Nation, Houlton Band of Maliseet Indians, Passamaquoddy – Pleasant Point, Passamaquoddy – Indian Township, and Penobscot Nation. Each tribal nation works closely with WPHW to deliver critical public health and healing and recovery services, while identifying health inequities and addressing health disparities.

We recognize that the RHTP provides an unprecedented opportunity to improve healthcare access, quality, and outcomes for people living in rural Maine. It is our belief that with the support of these grant dollars, we can ensure that tribal populations and all relatives who reside in the territory now known as Maine have access to critical substance use treatment and mental health support. Wabanaki Public Health and Wellness will support improving population health and enabling Mainers to access affordable care goals by offering a full continuum of services including medication-assisted treatment, detox, sober and transitional housing to support effective treatment and long-term recovery of individuals with substance use disorders.

Wabanaki Public Health and Wellness welcomes the opportunity to work with your administration and Maine DHHS to address rural healthcare challenges and improve health and healthcare in Maine's rural communities.

Sincerely,

Rebecca Petrie, Ph.D., MPH
Co-CEO/Business Official
Wabanaki Public Health and Wellness

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

October 20, 2025

Dear Governor Mills,

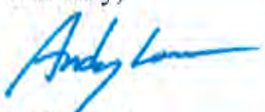
On behalf of the New England Rural Health Association (NERHA), I am pleased to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted to the Centers for Medicare & Medicaid Services by the Maine Department of Health and Human Services (DHHS).

For more than 25 years, NERHA has been the State Rural Health Association for the six New England states, with a mission of improving the health of our rural communities. We have enjoyed a particularly close collaborative relationship with the State of Maine as a long-term partner and stakeholder in advancing the cause of rural health. At NERHA, we are intimately aware of the crises facing our rural hospitals, clinics, long-term care, emergency services, and the entire constellation of provider organizations who care for our underserved rural populations. Workforce shortages, inadequate reimbursement, telehealth policy, burdensome reporting requirements, and many other challenges are forcing rural provider organizations to cut services or, worse, close their doors permanently, resulting in growing healthcare "deserts" in Maine and our other New England states. Further, with the highest median age in the country, Maine's rural residents are facing historic gaps in healthcare services.

The RHTP provides an unprecedented opportunity to improve healthcare access, quality, and outcomes for people living in rural Maine. The infusion of financial support and, equally importantly, fresh thinking about how to deliver rural healthcare, promise to begin addressing the looming crisis in rural health. We at NERHA stand ready to help amplify and optimize the impact of RHTP funds by building on our longstanding contractual and working relationship with the Maine DHHS/State Office of Rural Health by leveraging our extensive reach to rural health providers and stakeholders, with more than 1,400 individuals and organizations in our Maine mailing list. NERHA will support the following RHTP initiatives: 1) strengthen the healthcare workforce through training, education, and technical assistance; 2) expand the rural health workforce through scholarships, internships, and learning opportunities such as the NERHA Rural Health Student Summit; 3) improve access to care by sharing best practices at our annual conference and building rural organizational capacity through technical assistance and training; 4) improve population health with data and analysis using tools such as the NERHA Rural Health Data Analysis Dashboard; and 5) expand technologies and education in partnership with the Northeast Telehealth Resource Center through presentations at our annual conference and webinars.

In closing, let me reiterate our unqualified support for Maine's RHTP application. In preparing its application, the State used an extensive and inclusive process to gain input from sectors across the state including healthcare providers, higher education, the general population, the private sector and more. We welcome the opportunity to work with your administration and Maine DHHS to transform rural healthcare delivery, improve the health of Maine's rural communities, and support our struggling rural healthcare providers. Please do not hesitate to reach out if we can provide more information or assistance.

Sincerely,



Andy Lowe
Executive Directo
New England Rural Health Association

HealthInfoNet

October 27, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

Dear Governor Mills,

HealthInfoNet is pleased to submit this letter in strong support of Maine's Rural Health Transformation Program (RHTP) proposal, led by the Department of Health and Human Services (DHHS) and submitted to the Centers for Medicare & Medicaid Services.

As the operator of Maine's only statewide Health Information Exchange (HIE), HealthInfoNet plays a critical role in strengthening the State's rural health ecosystem. By delivering real-time clinical data, the HIE enables providers across the state to coordinate care, reduce duplication, improve patient safety, and drive better health outcomes for Mainers in every town, city, and county. In one of the most rural states in the country, this infrastructure is critical to ensuring that care remains connected, efficient, and equitable.

Deeply integrated into clinical and IT workflows, the HIE also supports Maine's rural health care workforce by enhancing efficiency and extending capacity. In addition, it serves as a vital public health surveillance tool, thus reducing the time to identify and respond to reportable conditions from hours to minutes.

The HealthInfoNet team views the RHTP as a transformational opportunity to expand access, quality, and innovation in rural care across our great state. We are committed to collaborating with providers and DHHS to achieve the program's goals by leveraging data and technology to support a stronger, smarter, and more connected health system for all rural Mainers.

Sincerely,

Shaun T. Alfreds
Executive Director & CEO
HealthInfoNet
Phone: 207-632-6096
www.hinfonet.org

Maine Community College System

OFFICE OF THE PRESIDENT
323 State Street, Augusta, ME 04330-7131
(207) 629-4000 | Fax (207) 629-4048 | mccs.me.edu

TO: Janet M. Mills, Governor

FROM: David Daigler, President
RE: Maine's Rural Health Transformation Program Proposal (RHTP CMS-RHT-26-001)

DATE:
October 23, 2025

The Maine Community College System (MCCS) is pleased to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted to the Centers for Medicare & Medicaid Services by the Maine Department of Health and Human Services.

Maine's community colleges are a major supplier of skilled workers in Maine's rural health ecosystem. Our seven colleges serve more than 33,000 people each year – more than 25% enrolled in the health sciences – through two-year associate degrees, one-year certificates, short-term workforce training, advanced certificates, and early college programming.

MCCS offers 35 different degree and certificate options in the health sciences as we prepare students for employment in these high-demand occupations. In 2022, in partnership with Maine's leading healthcare providers, MCCS expanded nursing programming. With the expansion, MCCS will double the number of nursing candidates and now offers nursing programs at all seven colleges.

Through the Harold Alfond Center for the Advancement of Maine's Workforce, MCCS offers short-term training that provides Mainers with industry recognized credentials and certifications providing career gateways in healthcare. The Center's healthcare sector partnership will provide short-term, skills-focused programs aligned to industry hiring needs. This model ensures training is industry-led, scalable, and directly connected to good-paying career pathways for Maine people entering the health professions.

We recognize that the RHTP provides an unprecedented opportunity to improve healthcare access, quality, and outcomes for people living in rural Maine.

MCCS's share of the RHTP proposal will provide equipment, training, and the opportunity for rural Mainers to stay in their home communities and still earn high-quality healthcare credentials. It will provide funding for two new mobile EMS units, new cutting-edge simulation equipment, and result in a stronger rural Maine healthcare workforce, providing good jobs and excellent, affordable healthcare to residents.

MCCS welcomes the opportunity to work with your administration and Maine DHHS to address rural healthcare challenges and improve health and healthcare in Maine's rural communities.

Sincerely,

Maine's Public Universities
UNIVERSITY OF MAINE SYSTEM

October 27, 2025

The Honorable Janet T. Mills, Governor of Maine
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

Dear Governor Mills,

On behalf of the University of Maine System (UMS), I am pleased to offer our strongest support for Maine's Rural Health Transformation Program (RHTP) proposal being submitted to the Centers for Medicare & Medicaid Services.

As Maine's largest educational and research enterprise — with public universities, research centers, and Cooperative Extension sites in every county, including our most rural and medically underserved regions — UMS is committed to partnering with the State to expand access to affordable, high-quality health care and improve health outcomes for all Mainers. We see the RHTP as an unprecedented opportunity to strengthen and grow our rural communities and promote prosperity for the people who live there through historic investments in their health and the essential infrastructure they depend on for care.

Our statewide network of public universities leads Maine in preparing practice-ready rural health and human services professionals. Through new rural degree and certificate pathways, investments in rural simulation training and telehealth infrastructure, and collaborations with rural healthcare organizations and State partners, we are already focused on addressing Maine's urgent workforce shortages. Maine's RHTP proposal enhances and expands our existing efforts, with rural Mainers as the beneficiaries. We are especially encouraged by its focus on innovations in care, technology utilization, and workforce development, including through incentives that make it easier for those living in rural areas to access affordable education and training that prepare them for meaningful healthcare careers in their communities. We believe our nationally recognized university research, including through the R1 University of Maine and the University of Southern Maine's Catherine Cutler Institute, which houses the Maine Rural Health Research Center, can be informative to planning and implementation in a manner that improves care and reduces costs, including in the key areas of aging, disease management and prevention, healthcare workforce resilience and retention, injury and violence prevention, substance abuse prevention and treatment, and youth mental health.

As Maine works to build a more integrated, sustainable rural health system that strengthens the continuum of care and supports vibrant rural communities, our public universities are proud to serve as partners in this transformational rural health effort. Thank you for the opportunity to support this important proposal and to build a healthier future for rural Maine together.

Sincerely,

Dannel P. Malloy
Chancellor, University of Maine System

MAINE
STATE
CHAMBER
of
COMMERCE

October 28, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001

Dear Governor Mills,

On behalf of the Maine State Chamber of Commerce, I am pleased to submit this letter in support of the Maine Department of Health and Human Services' proposal to the Centers for Medicare & Medicaid Services for the Rural Health Transformation Program (RHTP).

The RHTP presents a unique and timely opportunity to improve healthcare access, quality, and outcomes for residents of rural Maine. The Chamber is committed to helping make this initiative a success. We look forward to partnering with employers to expand access to wellness programs, invest in cost-effective care delivery models, and promote innovative solutions that reduce barriers to care. We believe that further utilization of technology is essential to achieving these goals. This includes investments in diagnostic equipment, X-ray machines, and healthcare software that can support remote care and improve efficiency across the healthcare system.

We have heard from dozens of Maine businesses expressing concern about rising healthcare costs and the fragile economic condition of rural hospitals. Employers also report that employees often spend significant time traveling from rural areas to urban centers to access specialized care. Ultimately, a healthy population encourages higher workforce participation, which has long been a challenge for the state's economy. Strategic investments in technology and facility upgrades can help reduce these burdens by enabling more efficient remote access and primary care delivery.

As Maine's largest business association, the Chamber represents thousands of employers across all sectors and regions of the state, including rural communities. Our mission is to advance a positive business climate and secure a strong state economy— and would be pleased to partner in the execution of Maine's RHTP plan.

We support Maine's RHTP proposal and welcome the opportunity to work with your administration and DHHS to address rural healthcare challenges and improve health and wellness in Maine's rural communities.

Sincerely,

Patrick Woodcock
President and CEO, Maine State Chamber of Commerce

MCD Global Health

October 26, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

Dear Governor Mills,

On behalf of Medical Care Development, Inc. (MCD Global Health/MCD), I am pleased to offer our support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted to the Centers for Medicare & Medicaid Services by the Maine Department of Health and Human Services.

Since our founding in 1966, MCD has served as a key stakeholder in Maine's rural health ecosystem, working closely with Maine DHHS and state-wide partners to respond to challenges and opportunities with innovative, yet practical technology-based solutions. As home to the HRSA funded Northeast Telehealth Resource Center (NETRC) for well over a decade, one of MCD's primary roles has included provision of high-quality training, technical assistance and resources to thousands of healthcare organizations and providers to support implementation of digital health strategies to meet emerging needs across Maine and beyond. We've also collaborated with Maine DHHS to implement telehealth at 91 private non-medical institutions across the state, complete a successful eConsult pilot resulting in significant increases in access to specialty care for rural populations while decreasing costs and keeping care local, and serve as leaders in state-wide planning for telehealth and broadband expansion.

With critical shortages in the healthcare workforce alongside growing volume and complexity of healthcare needs among our rural populations, the need for integrated and sustainable solutions is evident, and multi-modal telehealth tools which allow for seamless transition between in-person and virtual care must be a key part of the equation. MCD recognizes the unprecedented opportunity the RHTP presents to improve healthcare access, quality, and outcomes for rural Maine and we are fully committed to working with Maine DHHS and partners to help plan, implement and evaluate the impact of technology-based solutions focused on expanding the use of new technologies & innovations, strengthening the state's rural healthcare workforce, and fostering innovations and efficiencies needed to ensure a sustainable rural health system in Maine. This includes replication of effective models, such as school-based telebehavioral health, eConsults, and remote patient monitoring for chronic disease prevention and management, as well as safe and effective use of artificial intelligence (AI).

We welcome the opportunity to expand collaborative efforts with your administration and Maine DHHS to transform rural health systems and improve health access and outcomes in Maine's rural communities through the innovative strategies outlined in Maine's RHTP proposal.

Respectfully,

Danielle Louder
Co-Director U.S. Programs, MCD Global Health
Director Northeast Telehealth Resource Center

Maine Office | 105 Second St., Ste. 2A, Hallowell, ME 04347 U.S.A. (207) 622-7566
Maryland Office | 8403 Colesville Rd., Ste. 320, Silver Spring, MD 20910 U.S.A. (301) 562-1920
www.mcd.org

HEALTHCARE PURCHASER ALLIANCE OF MAINE

October 21, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

Dear Governor Mills,

I am writing to express the Healthcare Purchaser Alliance (HPA) of Maine's strong support for the Rural Health Transformation Program (RHTP) proposal that the Maine Department of Health and Human Services is submitting to the Centers for Medicare & Medicaid Services.

The HPA is a nonprofit that represents the purchasers of health care in Maine. Our mission is to advance and support access to high-quality, affordable care. We have over 70 members, including some of the largest public and private employers and health trusts in Maine. Collectively, our members spend over a billion dollars annually providing health care for nearly one quarter of the commercially insured population in the state.

Maine employers and consumers are struggling to afford the ever-rising cost of health care, and we believe that the RHTP represents a tremendous opportunity to leverage technology and other innovations to help providers deliver care more efficiently. Focusing on efficiency—rather than relying solely on reimbursement rate increases—will help Maine preserve access and health system viability, while also improving affordability for employers and consumers who can no longer afford annual price increases that consistently outstrip inflation.

The HPA looks forward to engaging with your administration on this critical effort, and to advancing strategies that more efficiently deliver care, address hospitals' financial challenges, and ensure quality, affordable care for all Mainers.

Sincerely,

Trevor Putnoky
President and CEO
Healthcare Purchaser Alliance of Maine

www.purchaseralliance.org 366 US Route 1, Suite 3, Falmouth, Maine 04105 phone: 207.844.8106

MPHA
Maine Public Health Association

October 17, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

Dear Governor Mills,

Maine Public Health Association (MPHA) is pleased to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted to the Centers for Medicare & Medicaid Services by the Maine Department of Health and Human Services.

MPHA is the state's oldest, largest, and most diverse association for public health professionals. We represent nearly 900 individual and 80 organizational members across the state, and work to advance the health of all people and places in Maine through advocacy, education, partnerships, and support for the public health workforce.

MPHA has a longstanding commitment to public health planning efforts and is a key stakeholder in Maine's rural health ecosystem. We work on myriad rural health challenges, including access to healthcare, transportation, environmental risks (e.g., PFAS, radon), workforce training, and economic development. We participate in statewide working groups and coalitions focused on addressing these challenges, and offer robust public health and healthcare workforce training, working across sectors to support rural health.

We look forward to supporting the RHTP by helping with workforce development, findings dissemination, and cross-sector partnerships. We are excited by the potential of Maine's RHTP to serve as a scalable and replicable framework for addressing rural health challenges. We recognize RHTP provides an unprecedented opportunity to improve healthcare access, quality, and outcomes for people living in rural Maine. MPHA welcomes the opportunity to work with your administration and Maine DHHS to address rural healthcare challenges and improve health and healthcare in Maine's rural communities.

Sincerely,

Rebecca J Boulos, PhD, MPH
Executive Director
Maine Public Health Association

STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
152 STATE HOUSE STATION
AUGUSTA, MAINE 04333

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISSIONER

WIL O'NEAL
DIRECTOR

October 24, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
RE: CMS-RHT-26-001

Dear Governor Mills,

Maine EMS is pleased to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted to the Centers for Medicare & Medicaid Services by the Maine Department of Health and Human Services.

Maines' EMS agencies are key stakeholders in our rural health ecosystem. In many of the most rural areas across Maine, EMS agencies and local fire departments provide critical access to emergency healthcare, but they require the support of a destination hospital. Hospital closures, and a lack of specialty services, like Labor and Delivery or Behavioral Health, paired with a lack of telemedicine and connectivity options continue to widen the gap in service for our rural patients.

We recognize that the RHTP provides a rare opportunity to improve healthcare access, quality, and outcomes for people living in rural Maine. We believe our focus on expanded Community Paramedicine training will work to strengthen the state's rural healthcare workforce, our plan for increased connectivity and telehealth partnerships has the potential to allow more Mainers to access affordable care and improve rural population health.

Maine EMS welcomes the opportunity to work with your administration and Maine DHHS to address rural healthcare challenges and improve the health and safety of Maine's rural communities.

Sincerely,

Wil O'Neal

Wil O'Neal
Director, Maine EMS
wil.o'neal@maine.gov
Cell (207) 616-8844

October 24, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

Dear Governor Mills,

The Maine Community Health Worker Initiative (MECHWI) and Medical Care Development, Inc. (MCD) are pleased to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted to the Centers for Medicare & Medicaid Services by the Maine Department of Health and Human Services.

MECHWI and MCD are key stakeholders in Maine's rural health ecosystem. MECHWI works to improve health by cultivating a network of well-trained and peer-supported Community Health Workers who are highly valued and fully integrated within diverse sectors and settings. Our members are local residents who have lived experience with health and other challenges that face their neighbors and have learned how to navigate systems and organizations. MECHWI was formed during Maine's participation in the CMS Innovation Center's State Innovation Model grant program. MCD is a public health institute founded in Maine in 1966 which serves as fiscal sponsor and administrative home for MECHWI and which itself provides one of the extensive training programs Maine's CHWs may receive prior to applying for future certification.

Maine's rural residents face myriad health challenges, such as living with multiple chronic diseases, significant distances between where they live and work to where healthcare is available and often are disabled or work in jobs that often do not offer health insurance. CHWs help them navigate these challenges to receive the right care at the right time with appropriate related supportive social services. We recognize that the RHTP provides an unprecedented opportunity to improve healthcare access, quality, and outcomes for people living in rural Maine.

MECHWI and MCD will work with the state and other partners to improve population health; expand and strengthen the state's rural healthcare workforce; assist Mainers to access affordable care; and expand the use of technologies needed to ensure a sustainable rural health ecosystem in Maine.

We welcome the opportunity to continue to work with your administration and Maine DHHS to address rural healthcare challenges and look forward to the transformational opportunities inherent in the ideas and projects described in Maine's RHTP proposal.

Sincerely,

Betty St. Hilaire
MECHWI Co-Chair
Augusta, Maine

Chrissa McIver
MECHWI Co-Chair
Princeton, Maine

Elizabeth Foley
US Programs Co-Director
MCD Global Health x297

MECHW
Maine Community Health Workers

MCD
Global Health

105 Second St. Suite 2A, Hallowell, ME 04347 * 207-622-7566 x2170 (MECHWI) x297 (MCD) * info@mcd.org

Maine Council on Aging
PO Box 988
Brunswick, ME 04011
207-592-9972

October 17, 2025

The Honorable Janet Mills
Governor of Maine
Office of the Governor
1 State House Station
Augusta, ME 04333-0001
RE: CMS-RHT-26-001

Dear Governor Mills,

The Maine Council on Aging (MCOA) is pleased to provide this letter in support of Maine's Rural Health Transformation Program (RHTP) proposal being submitted to the Centers for Medicare & Medicaid Services by the Maine Department of Health and Human Services.

The MCOA is a key stakeholder in Maine's rural health ecosystem. The MCOA envisions a Maine where we can all live healthy, engaged, and secure lives with choices and opportunities as we age. Currently, care for older Mainers is fragmented, uncoordinated, and unaffordable, especially in rural Maine. The workforce needed to meet the health, care, and social health needs of older Mainers is under-resourced and untrained in the care of older people. This is why we are keenly focused on growing Maine's care and support workforce, increasing access to transportation and dementia care, and reorienting services and technologies around the health and social health needs of older Mainers.

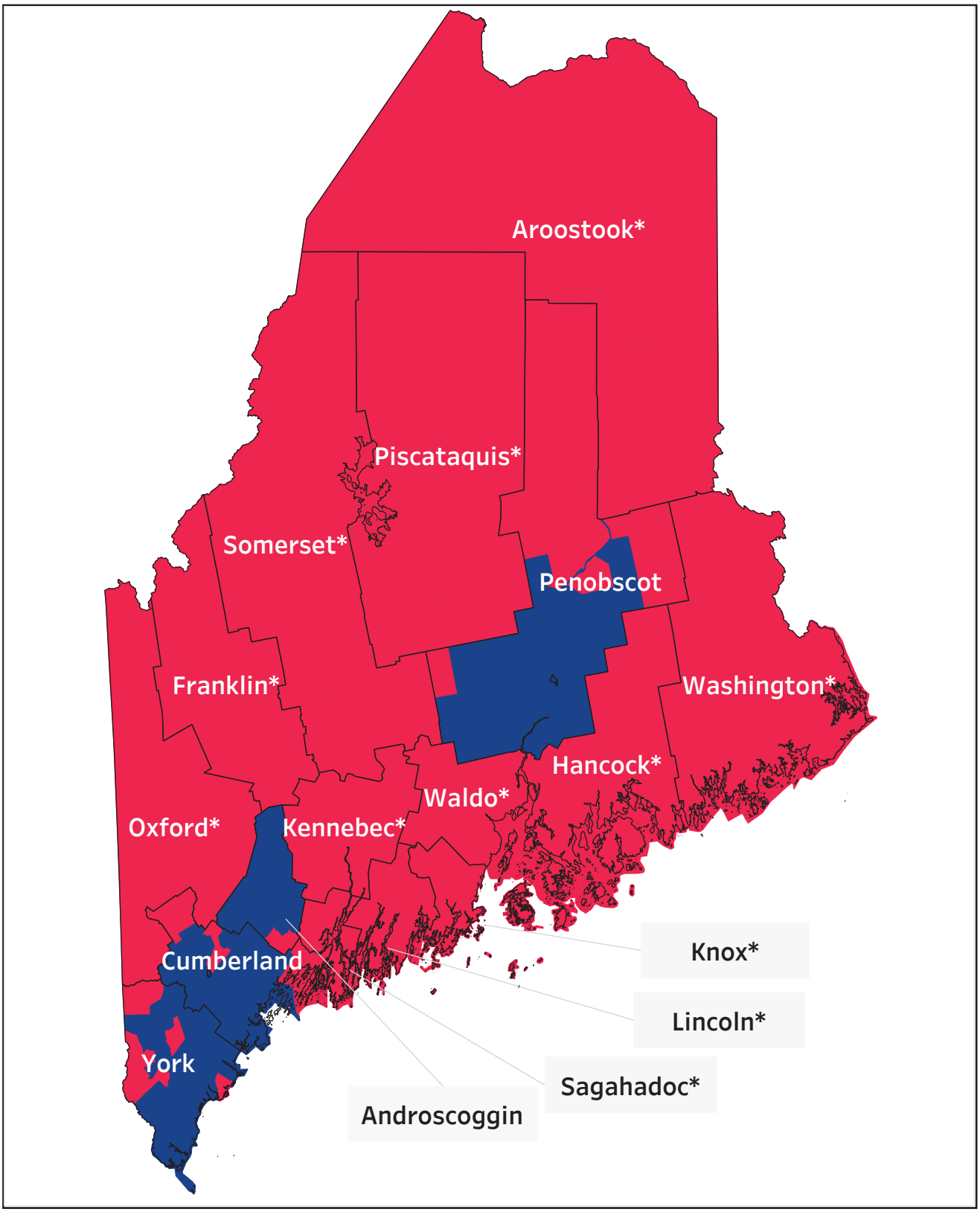
We recognize that the RHTP provides an unprecedented opportunity to improve healthcare access, quality, and outcomes for people living in rural Maine. Our work currently focuses on all five of Maine's RHTP proposed initiatives specifically related to older people. We are focused on decreasing chronic disease and increasing access to behavioral health services, strengthening Maine's care and support workforce, considering new financing mechanisms to increase access to care, building stronger relationships between healthcare and social services organizations, and utilizing technology to better manage health and the healthcare workforce.

The MCOA welcomes the opportunity to work with your administration and Maine DHHS to address rural healthcare challenges and improve health and healthcare in Maine's rural communities.

Sincerely,

Jess Maurer, Executive Director
jmaurer@mainecouncilonaging.org
207-380-3305

Maine Counties by Rurality



* Fully Rural County

Rural Census Tracts

Not Rural Rural

State of Maine

Rural Health Transformation Program

Stakeholders Consulted as Part of Maine's RHTP Development Process

Statewide Healthcare Groups	Maine Hospital Association (Senior Leadership); Maine Primary Care Association (Policy Committee); Maine Alliance for Addiction and Mental Health; Consumers for Affordable Health Care; Maine Tribal Leaders; Bangor and Portland Public Health Department Health Directors
Maine DHHS-led Groups	ME CDC Statewide Coordinating Council; Public Health District Coordinating Councils; MaineCare Advisory Committee; MaineCare Beneficiary Advisory Council; MaineCare Tribal Health Director Meeting; Maine Child Health Leadership Group; Maine Opioid Clinical Advisory Committee; Maine DHHS Rural Health Planning Group; ME CDC OPHE Health Equity Advisory Council; ME CDC Community Care Partners
Other State Departments & Agencies	Maine Department of Labor (Commissioner, Deputy Commissioner); Maine Department of Economic and Community Development (Commissioner); Maine Department of Education (Commissioner); Maine Department of Administrative and Financial Services (Acting Commissioner); Maine Department of Public Safety (Commissioner); Maine Emergency Medical Services (Director); Maine Children's Cabinet (Policy Director); Cabinet on Aging (Policy Director)
Public Health District Liaisons	York District (York County); Cumberland District (Cumberland County); Western District (Franklin, Oxford, Androscoggin Counties); MidCoast District (Sagadahoc, Lincoln, Knox, Waldo Counties); Central District (Somerset, Kennebec Counties); Penquis District (Penobscot, Piscataquis Counties); Downeast District (Hancock, Washington Counties); Aroostook District (Aroostook County); Tribal District (Tribal regions)
External Groups and Community Organizations	New England Rural Health Association; University of Maine System; University of Southern Maine, Muskie School, Rural Health Research Center; HealthInfoNet; Maine Health Care Association; Maine Association of Community Service Providers (MACSP); Maine Public Health Association (MPHA); Maine Council on Aging (MCOA); Medical Care Development Northeast Telehealth Resource Center (NETRC); Medical Care Development / Maine Community Health Worker Initiative (MCHWI); Maine EMS / Community Paramedicine; Maine Community Action Partnership (ACAP); In Her Presence; Maine Mobile Health; Rural Health Action Network (RHAN); Health Purchaser Alliance of ME (HPAM)

Maine's Rural Population and Frontier and Remote (FAR) Level by County

Geography	Maine's Rural Population (2020)				Frontier and Remote Populations (2010)			
	Rural Population	Total Population	% Rural Population	Population Density (per sq. mile)	Level 1	Level 2	Level 3	Level 4
United States	63,758,962	331,449,281	19.2%	93.8	3.9%	2.4%	1.4%	0.7%
Maine	692,887	1,362,359	50.9%	44.2	13.2%	11.7%	11.7%	6.3%
Fully Rural Counties* (12)	583,980	583,980	100.0%	23.2	32.1%	28.6%	28.5%	17.0%
Partially Rural Counties (4)	108,907	778,379	14.0%	136.7	0.7%	0.7%	0.7%	0.6%
(1) Androscoggin County	4,173	111,139	3.8%	237.5	0.0%	0.0%	0.0%	0.0%
(2) Aroostook County*	67,105	67,105	100.0%	10.1	99.7%	99.7%	99.7%	47.1%
(3) Cumberland County	45,663	303,069	15.1%	362.4	0.0%	0.0%	0.0%	0.0%
(4) Franklin County*	29,456	29,456	100.0%	17.4	37.7%	32.7%	32.7%	27.6%
(5) Hancock County*	55,478	55,478	100.0%	35.0	15.8%	15.8%	15.8%	15.0%
(6) Kennebec County*	123,642	123,642	100.0%	142.5	1.1%	0.1%	0.1%	0.1%
(7) Knox County*	40,607	40,607	100.0%	111.2	78.1%	71.8%	71.8%	14.3%
(8) Lincoln County*	35,237	35,237	100.0%	77.3	6.6%	4.1%	4.1%	4.0%
(9) Oxford County*	57,777	57,777	100.0%	27.8	7.1%	7.1%	6.9%	6.7%
(10) Penobscot County	21,890	152,199	14.4%	44.8	3.0%	3.0%	3.0%	2.8%
(11) Piscataquis County*	16,800	16,800	100.0%	4.2	26.1%	26.1%	26.1%	26.1%
(12) Sagadahoc County*	36,699	36,699	100.0%	144.5	0.0%	0.0%	0.0%	0.0%
(13) Somerset County*	50,477	50,477	100.0%	12.9	36.0%	9.4%	9.4%	9.4%
(14) Waldo County*	39,607	39,607	100.0%	54.3	7.1%	5.1%	5.1%	5.0%
(15) Washington County*	31,095	31,095	100.0%	12.1	99.5%	99.5%	99.5%	84.5%
(16) York County	37,181	211,972	17.5%	213.9	0.1%	0.1%	0.1%	0.1%

Notes: Population counts corresponding to the United States are limited to the 50 states and the District of Columbia, and exclude Puerto Rico, U.S. island areas, and other territories, to align with the land area file. County-level Frontier and Remote (FAR) percentages are calculated using a Zip code-to-county crosswalk and 2010 population counts. Stratified fully rural/partially rural county statistics are population-weighted by respective population datasets.

Sources: Health Resources & Services Administration Federal Office of Rural Health Policy; U.S. Census Bureau; U.S. Department of Agriculture Economic Research Service.

Maine's Demographic Characteristics by County (1)

Geography	Age		Education		Employment			Income		
	Median Age (Years)	Population 65 and Older (%)	Without a High School Diploma for Population 25 and Over (%)	Associate's Degree or Higher for Population 25 and Over (%)	Employed Full-Time and Year-Round for Population 16 and Over (%)	Employed in Agriculture, Forestry, Fishing, Hunting, or Mining for Population 16 and Over (%)	Employed in Health Care or Social Assistance for Population 16 and Over (%)	Median Household Income ($)	Poverty Rate (%)	Population Under 18 below Poverty Level (%)
United States	38.7	16.84%	10.61%	43.78%	43.53%	1.68%	13.80%	$ 78,538	12.44%	16.32%
Maine	44.8	21.86%	5.51%	45.73%	41.08%	2.27%	16.97%	$ 71,773	10.78%	13.12%
Fully Rural Counties* (12)	50.5	24.16%	6.41%	40.55%	37.18%	3.77%	16.45%	$ 68,001	13.50%	16.22%
Partially Rural Counties (4)	42.9	20.14%	4.82%	49.72%	44.04%	1.32%	17.31%	$ 80,672	9.37%	11.53%
(1) Androscoggin County	40.8	18.49%	7.53%	36.18%	42.78%	1.12%	16.46%	$ 67,298	12.98%	19.73%
(2) Aroostook County*	48.4	25.36%	8.82%	33.31%	36.80%	5.95%	20.61%	$ 54,254	14.43%	17.09%
(3) Cumberland County	42.1	19.82%	3.50%	60.62%	46.29%	1.09%	16.97%	$ 92,983	7.06%	7.82%
(4) Franklin County*	46.1	23.10%	6.16%	39.26%	34.17%	3.49%	17.35%	$ 58,522	11.77%	11.80%
(5) Hancock County*	49.1	25.97%	5.05%	48.02%	38.37%	5.70%	15.49%	$ 69,630	10.22%	11.88%
(6) Kennebec County*	44.0	20.79%	5.16%	41.38%	41.38%	1.73%	16.75%	$ 65,062	12.32%	16.13%
(7) Knox County*	49.2	27.10%	5.70%	46.75%	35.01%	6.74%	13.86%	$ 71,903	8.76%	10.04%
(8) Lincoln County*	51.1	28.87%	5.14%	48.63%	36.15%	2.24%	13.79%	$ 72,026	8.50%	11.48%
(9) Oxford County*	48.3	23.39%	7.39%	34.17%	34.20%	3.76%	14.79%	$ 57,933	14.18%	19.37%
(10) Penobscot County	42.5	19.76%	5.47%	42.04%	39.31%	1.88%	22.30%	$ 63,248	13.55%	14.82%
(11) Piscataquis County*	51.4	26.91%	8.00%	32.57%	34.81%	4.54%	19.79%	$ 55,234	16.51%	15.65%
(12) Sagadahoc County*	47.3	24.01%	5.23%	51.40%	40.52%	1.06%	15.86%	$ 82,080	11.14%	12.23%
(13) Somerset County*	46.9	22.60%	7.15%	32.25%	35.96%	3.30%	13.92%	$ 56,199	15.56%	16.84%
(14) Waldo County*	46.9	24.49%	6.30%	43.99%	37.20%	3.19%	16.70%	$ 68,441	12.75%	15.87%
(15) Washington County*	48.6	25.82%	8.84%	35.22%	31.12%	8.12%	19.75%	$ 52,237	17.81%	20.14%
(16) York County	45.3	21.74%	4.90%	46.36%	44.85%	1.39%	15.09%	$ 82,904	7.77%	9.59%

Notes: Stratified fully rural/partially rural county statistics are population-weighted by respective population datasets. Data are 2023 ACS 5-year estimates.

Source: U.S. Census Bureau.

Maine's Demographic Characteristics by County (2)

Geography	Insurance Coverage				Special Populations			
	Uninsured Rate for Population Under 65 (%)	Uninsured Rate for Population 18 and Under (%)	Uninsured Rate for Population 18 to 64 (%)	MaineCare (Medicaid) Enrollment (%)	Veterans in Civilian Population (%)	Veterans with Service Disability of 70% or Over (%)	Persons with a Disability (%)	American Indian/Alaska Native Population (%)
United States	9.46%	5.30%	11.02%		6.44%	11.66%	13.04%	0.88%
Maine	7.75%	4.60%	8.76%	28.12%	8.71%	12.21%	15.59%	0.45%
Fully Rural Counties* (12)	8.91%	5.46%	10.02%	31.62%	10.42%	14.22%	17.18%	0.64%
Partially Rural Counties (4)	6.93%	3.98%	7.87%	24.90%	7.91%	11.25%	14.41%	0.34%
(1) Androscoggin County	7.84%	4.80%	8.94%	35.58%	8.83%	12.99%	17.10%	0.19%
(2) Aroostook County*	9.02%	5.96%	10.10%	39.05%	10.01%	17.04%	20.83%	1.32%
(3) Cumberland County	6.19%	3.43%	7.04%	20.82%	6.72%	10.74%	11.28%	0.22%
(4) Franklin County*	9.26%	5.60%	10.43%	32.28%	8.83%	10.25%	18.37%	0.18%
(5) Hancock County*	10.36%	6.16%	11.59%	24.57%	8.28%	13.34%	13.71%	0.41%
(6) Kennebec County*	7.39%	4.16%	8.45%	28.91%	9.80%	15.58%	16.43%	0.23%
(7) Knox County*	10.16%	6.56%	11.33%	27.42%	8.60%	10.55%	12.65%	0.25%
(8) Lincoln County*	8.58%	5.45%	9.56%	24.30%	11.00%	10.19%	16.08%	0.36%
(9) Oxford County*	10.10%	6.34%	11.23%	35.43%	9.52%	9.91%	17.77%	0.18%
(10) Penobscot County	8.09%	4.38%	9.23%	30.68%	8.27%	13.46%	18.49%	0.92%
(11) Piscataquis County*	8.64%	5.26%	9.71%	37.11%	10.32%	14.88%	21.96%	0.22%
(12) Sagadahoc County*	6.88%	4.81%	7.53%	20.07%	10.93%	10.53%	13.54%	0.19%
(13) Somerset County*	9.42%	5.85%	10.57%	40.01%	11.03%	14.25%	18.91%	0.14%
(14) Waldo County*	8.46%	4.98%	9.58%	31.89%	7.91%	11.61%	16.31%	0.17%
(15) Washington County*	11.20%	6.34%	12.90%	42.57%	12.24%	13.60%	23.37%	4.79%
(16) York County	6.71%	4.01%	7.54%	21.02%	8.86%	9.42%	14.54%	0.19%

Notes: Stratified fully/partially rural county statistics are weighted by respective dataset population. Data are 2023 ACS 5-year estimates (except MaineCare).

Sources: U.S. Census Bureau; Maine Department of Health and Human Services.

Maine Health Outcomes by County (1)

Geography	Chronic Conditions								
	Asthma (%)	Arthritis (%)	Chronic Obstructive Pulmonary Disease (%)	Coronary Heart Disease (%)	Diabetes (%)	High Blood Pressure (%)	Obesity (%)	Depression, Lifetime (%)	Adult Tooth Loss (%)
United States	9.9%	26.6%	6.8%	6.8%	12.0%	32.4%	32.6%	20.7%	13.50%
Maine	12.8%	32.6%	8.8%	8.9%	11.1%	33.9%	33.9%	26.3%	17.60%
Fully Rural Counties* (12)	13.0%	34.7%	9.8%	9.2%	11.5%	35.7%	34.3%	24.9%	20.51%
Partially Rural Counties (4)	12.7%	30.7%	8.1%	7.5%	10.0%	32.0%	32.2%	26.0%	15.44%
(1) Androscoggin County	13.7%	28.2%	8.8%	7.6%	11.1%	31.8%	36.1%	28.9%	19.70%
(2) Aroostook County*	13.2%	38.8%	11.2%	10.4%	13.7%	40.2%	41.6%	24.3%	26.90%
(3) Cumberland County	11.4%	29.5%	7.4%	7.2%	9.1%	30.3%	29.5%	24.8%	12.40%
(4) Franklin County*	12.7%	30.7%	8.5%	8.3%	10.6%	31.3%	32.5%	26.3%	21.10%
(5) Hancock County*	10.8%	33.0%	8.7%	9.0%	10.5%	33.6%	28.5%	23.9%	12.40%
(6) Kennebec County*	13.2%	32.5%	9.3%	8.4%	10.7%	34.2%	33.6%	25.8%	17.40%
(7) Knox County*	10.0%	34.9%	8.7%	8.8%	10.4%	33.7%	27.8%	23.5%	14.10%
(8) Lincoln County*	11.6%	34.6%	9.1%	9.5%	11.0%	33.2%	31.7%	23.6%	16.80%
(9) Oxford County*	15.1%	33.6%	11.3%	9.7%	12.4%	37.0%	37.4%	25.6%	27.10%
(10) Penobscot County	14.8%	33.7%	8.5%	7.7%	10.6%	34.1%	38.4%	29.0%	20.50%
(11) Piscataquis County*	13.6%	38.2%	11.2%	10.3%	13.1%	38.1%	36.7%	24.5%	23.60%
(12) Sagadahoc County*	10.7%	33.5%	8.2%	8.6%	10.7%	35.4%	30.7%	25.4%	15.30%
(13) Somerset County*	16.3%	37.5%	11.4%	10.1%	12.2%	38.3%	37.8%	25.5%	25.90%
(14) Waldo County*	12.7%	33.3%	9.3%	8.7%	10.5%	34.7%	34.0%	24.0%	20.80%
(15) Washington County*	14.9%	39.9%	11.3%	10.5%	13.1%	40.4%	37.9%	25.5%	29.40%
(16) York County	12.6%	31.6%	8.4%	7.9%	10.2%	33.1%	29.8%	24.0%	14.00%

Notes: Stratified fully rural/partially rural county statistics are population-weighted by respective population datasets. Chronic conditions Behavioral Risk Factor Surveillance System (BRFSS) data correspond to survey year 2021 (high blood pressure) and 2022 (others).

Sources: U.S. Center for Disease Control and Prevention; Maine Center for Disease Control and Prevention.

Maine Health Outcomes by County (2)

Geography	Overall Mortality Rate (per 100,000)	Chronic Disease Mortality			Behavioral Causes Mortality			Maternal and Child Health			
		Cancer (per 100,000)	Cardiovascular Disease (per 100,000)	Chronic Lower Respiratory Disease (per 100,000)	Alcohol-induced Deaths (per 100,000)	Drug-Induced (per 100,000)	Suicide (per 100,000)	Low Birth Weight (<2,500 g) (%)	Total Infant Deaths (per 1,000)	Infant Breastfeeding at time of Discharge (%)	Smoking During Pregnancy (%)
United States	750.5	141.8	162.1	33.4	12.6	32.4	14.1	8.60%	5.60	84.80%	3.00%
Maine	807.8	158.8	207.9	40.6	16.8	45.1	18.4	8.12%	5.68	88.04%	5.92%
Fully Rural Counties* (12)	855.7	166.1	212.6	46.6	17.1	47.6	20.6	8.00%	6.05	86.35%	7.95%
Partially Rural Counties (4)	768.8	152.7	203.9	35.5	16.6	42.1	16.7	8.18%	5.43	89.17%	4.55%
(1) Androscoggin County	934.9	164.1	238.8	54.2	20.3	54.4	18	10.75%	7.24	90.50%	6.61%
(2) Aroostook County*	906.7	166.7	232.3	57.2	14.2	52.9	19.1	7.11%	6.01	77.97%	8.89%
(3) Cumberland County	715.1	142	171.5	32.2	15	34.9	13	7.91%	5.08	92.37%	2.63%
(4) Franklin County*	844.5	151.9	203.9	50.9	25.3	36.7	21.2	7.92%	9.10	90.23%	10.65%
(5) Hancock County*	757.7	149.4	195.1	34.7	13.6	37.2	19.6	4.92%	4.04	84.76%	5.28%
(6) Kennebec County*	871.2	169	224.1	43.9	17.9	47.4	17.7	8.05%	7.24	91.63%	5.02%
(7) Knox County*	755.6	154.9	197.9	32.6	16.8	42.3	22.2	8.73%	5.67	92.89%	6.27%
(8) Lincoln County*	709.4	163.9	159.6	30.2	17.8	42.6	22.4	7.22%	DSP	93.86%	5.19%
(9) Oxford County*	873.8	162.2	198.2	54.7	17.5	40.3	25.6	10.39%	6.39	83.33%	11.24%
(10) Penobscot County	915.2	164.2	234.8	46.3	15.7	59.2	16.9	6.11%	5.71	82.04%	8.58%
(11) Piscataquis County*	929.4	183.2	234.3	40.1	9.1	63.1	23.3	7.33%	DSP	80.99%	10.74%
(12) Sagadahoc County*	685.1	144.5	165.3	37.4	15.9	24.7	13.7	6.39%	4.70	92.96%	6.69%
(13) Somerset County*	982.2	188	254.7	66.2	19	56.4	26.4	8.56%	6.68	83.06%	10.30%
(14) Waldo County*	828.5	170.8	224.6	46.4	15.7	33.9	22	7.93%	5.44	87.96%	8.31%
(15) Washington County*	1073	201.7	270	55.1	22	77.8	25.9	11.03%	DSP	75.37%	12.27%
(16) York County	739.1	153.9	177.5	36.9	15.3	37.1	20.2	8.44%	4.63	88.76%	3.20%

Notes: Stratified fully rural/partially rural county statistics are population-weighted by respective population datasets. Age-adjusted mortality data for Maine and rural aggregation levels correspond to 2023, (except cancer mortality figures, which correspond to 2019-2023 for all aggregated estimates), and county-level estimates combine years 2019-2023 for statistical accuracy. Smoking during pregnancy rates for Lincoln, Piscataquis, and Sagadahoc County have a numerator of less than 20, and should be interpreted with caution. DSP: Data suppressed for privacy.

Sources: U.S. Center for Disease Control and Prevention; Maine Center for Disease Control and Prevention.

Maine Access to Healthcare by County (1)

Geography	Hospitals					Birth Units					Driving Distance to Birth Units		
	General Acute Care (# of Hospitals)	Critical Access (# of Hospitals)	Total Hospitals (# of Hospitals)	Total Beds (# of Beds)	Beds (per 1,000 population)	Birthing Units in 2014 (#)	Birthing Units in 2023 (#)	Birthing Units in 2025 (#)	Change (2014 to 2023) (%)	Change (2014 to 2025) (%)	Average Driving Distance in 2014 (Miles)	Average Driving Distance in 2023 (Miles)	Change (2014 to 2023) (%)
United States													
Maine	14	18	32	3,284	2.4	28	21	17	-25%	-39%	16.50	20.12	21.96%
Fully Rural Counties* (12)	5	15	20	915	1.5	18	15	11	-17%	-39%	21.43	27.21	26.94%
Partially Rural Counties (4)	9	3	12	2,369	3.0	10	6	6	-40%	-40%	12.86	15.17	17.93%
(1) Androscoggin County	2	0	2	470	4.2	2	1	1	-50%	-50%	9.39	15.80	68.32%
(2) Aroostook County*	2	2	4	204	3.0	4	3	2	-25%	-50%	21.76	34.88	60.31%
(3) Cumberland County	3	1	4	1,068	3.5	4	3	3	-25%	-25%	9.80	10.76	9.78%
(4) Franklin County*	0	1	1	25	0.8	1	1	1	0%	0%	20.45	25.35	23.97%
(5) Hancock County*	1	2	3	114	2.0	2	2	1	0%	-50%	26.36	29.10	10.38%
(6) Kennebec County*	1	0	1	198	1.6	2	2	1	0%	-50%	16.02	18.43	15.03%
(7) Knox County*	1	0	1	99	2.4	1	1	1	0%	0%	16.41	23.81	45.09%
(8) Lincoln County*	0	1	1	25	0.7	1	1	1	0%	0%	23.73	22.18	-6.55%
(9) Oxford County*	0	2	2	75	1.3	2	1	1	-50%	-50%	21.59	30.40	40.77%
(10) Penobscot County	2	2	4	573	3.7	2	1	1	-50%	-50%	16.20	18.26	12.72%
(11) Piscataquis County*	0	2	2	50	2.9	1	1	1	0%	0%	28.39	33.88	19.34%
(12) Sagadahoc County*	0	0	0	0	0.0	0	0	0			15.01	17.21	14.60%
(13) Somerset County*	0	2	2	50	1.0	1	1	1	0%	0%	26.40	30.19	14.33%
(14) Waldo County*	0	1	1	25	0.6	1	1	0	0%	-100%	24.08	26.05	8.19%
(15) Washington County*	0	2	2	50	1.6	2	1	1	-50%	-50%	33.34	52.37	57.09%
(16) York County	2	0	2	258	1.2	2	1	1	-50%	-50%	18.04	20.87	15.66%

Notes: All hospital counts are for year 2025.

Sources: U.S. Census Bureau; Maine Department of Health and Human Services Division of Licensing and Certification; Maine Center for Disease Control and Prevention.

Maine Access to Healthcare by County (2)

Geography	Nursing Homes				Provider Ratios			Internet and Transportation	
	Nursing Home Facilities in 2015 (#)	Nursing Home Facilities in 2025 (#)	Change (2015 to 2025) (%)	Beds per 1,000 People Aged 65+ (2025)	Population to Primary Care Physician Ratio (2022)	Population to Mental Health Providers Ratio (2025)	Population to Dentist Ratio (2022)	Households without Internet Subscription (%)	Workers 16 and Older that take Public Transportation to Work (%)
United States					1,007	287	1,642	10.13%	3.51%
Maine	103	78	-24.27%	19.1	804	171	1,785	10.83%	0.49%
Fully Rural Counties* (12)	54	35	-35.19%	16.1	983	217	2,331	12.65%	0.18%
Partially Rural Counties (4)	49	43	-12.24%	21.8	707	160	1,518	9.42%	0.70%
(1) Androscoggin County	6	6	0.00%	21.2	1,130	187	2,216	10.71%	0.39%
(2) Aroostook County*	11	7	-36.36%	25.5	862	149	2,587	19.55%	0.04%
(3) Cumberland County	20	17	-15.00%	24.8	480	110	1,060	8.27%	0.98%
(4) Franklin County*	3	3	0.00%	22.0	896	301	3,047	15.26%	0.03%
(5) Hancock County*	4	0	-100.00%	0.0	886	205	2,700	10.58%	0.46%
(6) Kennebec County*	9	7	-22.22%	26.3	709	163	1,443	9.95%	0.15%
(7) Knox County*	3	2	-33.33%	13.9	895	171	1,372	9.47%	0.04%
(8) Lincoln County*	3	2	-33.33%	11.4	929	437	3,622	12.83%	0.16%
(9) Oxford County*	7	5	-28.57%	18.9	1,526	319	3,500	13.78%	0.03%
(10) Penobscot County	13	11	-15.38%	26.1	725	141	1,787	12.15%	0.46%
(11) Piscataquis County*	1	1	0.00%	20.2	1,451	364	3,483	16.05%	0.01%
(12) Sagadahoc County*	1	1	0.00%	8.1	1,289	379	1,870	6.92%	0.35%
(13) Somerset County*	6	4	-33.33%	17.6	1,419	424	5,678	14.12%	0.06%
(14) Waldo County*	2	1	-50.00%	4.1	1,118	284	5,030	10.53%	0.55%
(15) Washington County*	4	2	-50.00%	11.2	2,096	142	2,620	16.67%	0.18%
(16) York County	10	9	-10.00%	15.3	1,306	209	2,306	8.45%	0.58%

Notes: Stratified fully rural/partially rural county statistics are population-weighted by respective population datasets. Internet and Transportation data are ACS 5-year estimates for 2023.

Sources: U.S. Census Bureau; Maine Department of Health and Human Services Division of Licensing and Certification; U.S. Department of Health and Human Services; County Health Rankings.

Maine Rural Hospitals' Financial Position (1)

Maine Rural Hospital Financial Performance

Rural Hospitals (n=23)	Performance Target	2023 Only	2021-2023 3-year average
Below Target for Days Cash on Hand) n (%)	Could operate for at least 110 Days without new income	19 (82.6%)	15 (65.2%)
Below Target for Operating Margin n (%)	>=1.0%	10 (43.4%)	6 (26.1%)
Below Target for Total Margin n (%)	>=2.5%	13 (56.5%)	8 (34.8%)
Below Target for Average Age of Plant n (%)	<=12 years	17 (73.9%)	23 (100%)
Off Target for all Four Financial Metrics± n (%)	(Does not meet any above)	8 (34.8%)	6 (26.1%)

Notes: Performance targets for hospital financial metrics were derived from S&P Global Ratings' methodology for assigning credit ratings to not-for-profit hospital and health systems. S&P Global standard credit ratings methodology assesses the financial performance of not-for-profit hospitals and health systems by measuring their performance on multiple financial metrics to established performance targets. Performance targets were generated from S&P Global analysis of 173 not-for-profit hospitals and health systems within the U.S. and Canada. Financial performance metric targets reported here represent the threshold that S&P Global considers adequate financial performance for hospitals.

Definitions:

Excess (Total) Margin: *Are the hospital's total activities profitable (including investment income and fundraising)?*

Operating Margin: *Are the hospital's core activities profitable?*

Average Age of Plant: *How old are the hospital's fixed assets?*

Days Cash on Hand Including Board Designated & Undesignated Investments: *How long could the hospital operate and pay its bills without additional income?*

Source: Maine Health Data Organization.

Maine Rural Hospitals' Financial Position (2)

Trends in Utilization by Payor Mix in Maine Rural Hospitals

Inpatient Service Categories			Outpatient Service Categories		
	Change 2017 to 2023 (%)			Change 2017 to 2023 (%)	
Payor Type	**Non-Rural**	**Rural**	**Payor Type**	**Non-Rural**	**Rural**
Commercial	-32.43%	-50.94%	Commercial	-15.14%	-21.85%
Commercial and Medicare	-15.70%	-25.06%	Commercial and Medicare	-13.05%	-17.62%
Dual Eligible (Medicare-MaineCare)	4.81%	-12.54%	Dual Eligible (Medicare-MaineCare)	-2.05%	-1.54%
MaineCare (Medicaid)	12.89%	19.88%	MaineCare (Medicaid)	34.42%	45.69%
Medicare	-6.04%	-20.01%	Medicare	11.32%	8.89%
Total	-3.94%	-17.24%	Total	6.40%	2.59%

Notes: The data source used for this analysis is the Maine Health Data Organization's (MHDO) All-Payer Claims Data (APCD) medical claims and medical eligibility records for the time-period January 1, 2017 – December 31, 2023. These data represent payments made from insurance carriers to Maine-based providers. The claims reported to the MHDO include all MaineCare and Medicare (both Original Medicare and Medicare Advantage) members and approximately 84% of the fully insured individual and fully insured employer-sponsored coverage and approximately 26% of the self-funded ERISA plans (referred to as Commercial). These data do not capture uninsured patients; since hospitals who have a larger share of uninsured patients relative to insured paitents take on more financial risk, omission of uninsured patient utilization likely underestimates the financial instability of Maine's rural hospitals. These data also only capture one quarter of the self-insured ERSIA plans. To generalize trends in these data to the broader commercial market, we assume that commercial plans who submit to the ACPD have member pools that are representative of the greater commercial market.

Inpatient days are calculated as the number of days of hospitalization at one of Maine's hospitals, based on the admission and discharge dates that are submitted by the payor for each inpatient stay. Inpatient stays with same day discharges are counted as one inpatient day. Note that transfers from one Maine hospital to another Maine hospital are counted as distinct inpatient stays, therefore the number of days at Hospital A is attributed to Hospital A, and then the number of days of hospitalization post transfer to Hospital B are attributed to Hospital B.

Outpatient services are defined as distinct combinations of HCPCS/CPT codes, date of service and MHDO deidentified Person ID, across multiple claim lines or even multiple claims. Quantity information or number of units of service recorded on the claim are not considered.

Source: Maine Health Data Organization.

State of Maine RHTP CCBHC Data Submission Template

Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
Madawaska Outpatient Clinic	88 Fox St.	Madawaska	ME	04756	Aroostook Mental Health Center	Y	Y	Y	Y
Fort Kent Outpatient Clinic	104 East Main St.	Fort Kent	ME	04743	Aroostook Mental Health Center	Y	Y	Y	Y
Caribou Outpatient Clinic	43 Hatch Dr.	Caribou	ME	04736	Aroostook Mental Health Center	Y	Y	Y	Y
Presque Isle Outpatient Clinic	180 Academy St., Suite 2	Presque Isle	ME	04769	Aroostook Mental Health Center	Y	Y	Y	Y
Houlton Outpatient Clinic	11 Mill St.	Houlton	ME	04730	Aroostook Mental Health Center	Y	Y	Y	Y
Calais Outpatient Clinic	127 Palmer St.	Calais	ME	04619	Aroostook Mental Health Center	Y	Y	Y	Y
Machias Outpatient Clinic	14 Stevens Ln.	Marshfield	ME	04654	Aroostook Mental Health Center	Y	Y	Y	Y
Ellsworth Outpatient Clinic	70 Kingsland Crossing	Ellsworth	ME	04605	Aroostook Mental Health Center	Y	Y	Y	Y
Bangor Clinic	42 Cedar Street	Bangor	ME	04401	Community Health and Counseling Services	Y	Y	Y	N
Ellsworth Clinic	52 Christian Ridge Rd	Ellsworth	ME	04605	Community Health and Counseling Services	Y	Y		Y
Dover Clinic	1093 W Main St	Dover	ME	04426	Community Health and Counseling Services	Y	Y		Y
Lincoln Clinic	313 Enfield Rd	Lincoln	ME	04457	Community Health and Counseling Services	Y	Y	Y	Y
Augusta Clinic	66 Stone Street	Augusta	ME	04330	Kennebec Behavioral Health	Y	Y		Y
Augusta Clinic	10 Caldwell Rd.	Augusta	ME	04330	Kennebec Behavioral Health	Y	Y		Y
Augusta Clinic	11 Caldwell Rd.	Augusta	ME	04330	Kennebec Behavioral Health	Y	Y		Y
Skowhegan Clinic	5 Commerce Drive	Skowhegan	ME	04976	Kennebec Behavioral Health	Y	Y	Y	Y
Waterville Clinic	67 Eustis Parkway	Waterville	ME	04901	Kennebec Behavioral Health	Y	Y		Y
Brunswick Clinic	329 Bath Road	Brunswick	ME	04011	Sweetser	Y	Y	Y	Y
Lewiston Clinic	26 Mollison Way	Lewiston	ME	04240	Sweetser	Y	Y	Y	N
Sanford Clinic	863 Main Street	Sanford	ME	04073	Sweetser	Y	Y	Y	Y
Portland Clinic	62 Elm Street	Portland	ME	04101	Spurwink		Y	Y	N
Portland Clinic	901 Washington Avenue	Portland	ME	04101	Spurwink		Y	Y	N
Bridgton Clinic	32 N High ST	Bridgton	ME	04009	Spurwink		Y	Y	Y
Belfast Clinic	15 MidCoast Dr.	Belfast	ME	04915	Maine Behavioral Healthcare			Y	Y
Rockland Clinic	12 Union St.	Rockland	ME	04841	Maine Behavioral Healthcare			Y	Y
Biddeford Clinic	2 Springbrook Dr.	Biddeford	ME	04005	Maine Behavioral Healthcare			Y	N
Springvale Clinic	474 Main St.	Springvale	ME	04083	Maine Behavioral Healthcare			Y	Y

State of Maine

Rural Health Transformation Program

Acronyms: Quick Reference

ACO	Accountable Care Organization	**CHW**	Community Health Worker	**EMT**	Emergency Medical Technician	**OTP**	Opioid Treatment Program
AEMT	Advanced Emergency Medical Technician	**CNA**	Certified Nurse Aid	**FQHC**	Federally Qualified Health Center	**PRTF**	Psychiatric Residential Treatment Facility
AI	Artificial Intelligence	**CRNA**	Certified Residential Medication Aid	**GME**	Graduate Medical Education	**RFA**	Request for Applications
AHEC	Area Health Education Centers	**CP**	Community Paramedicine	**HTFM**	Healthcare Training for Maine	**RFP**	Request for Proposal
AI	Artificial Intelligence	**DA**	Dental Assistant	**IPDH**	Independent Practice Dental Hygienist	**RHTP**	Rural Health Transformatio n Plan
APM	Alternative Payment Model	**DSNP**	Dual Special Needs Plan	**MA**	Medical Assistant	**RPM**	Remote Patient Monitoring
APCD	All-Payer Claims Database	**DHHS**	Department of Health and Human Services	**MCCS**	Maine Community College Systems	**SBHC**	School-Based Health Center
BH	Behavioral Health	**EBP**	Evidence-Based Practice	**MaineCare**	Maine Medicaid Program	**SUD**	Substance Use Disorder
CAH	Critical Access Hospital	**EFDA**	Expanded Function Dental Assistant	**MHA**	Maine Hospital Association	**TA**	Technical Assistance
CCBHC	Certified Community Behavioral Health Clinic	**EMR**	Electronic Medical Record	**MHDO**	Maine Health Data Organization	**TMaH**	Transforming Maternal Health
CHET	Consortium for Healthcare Education & Training	**CNA**	Certified Nurse Aid	**MHRT**	Mental Health Rehabilitation Technician	**UMS**	University of Maine System

State of Maine

Rural Health Transformation Program
Program Duplication Assessment Form

A. Confirm your responsibility to avoid program duplication.

The Maine Department of Health and Human Services (DHHS) Commissioner's Office confirms its full responsibility to prevent program duplication. The Office will ensure that Rural Health Transformation Program (RHTP) funds are used exclusively for non-duplicative activities that fill identified gaps and are allowable for RHTP cooperative funding.

All RHTP expenses and program activities will undergo review by the Commissioner's Office in coordination with the Office of MaineCare Services (OMS), Maine Center for Disease Control and Prevention (Maine CDC) and other impacted state offices, all of which operate under the Commissioner's authority. Maine DHHS will assess duplication across broader funding within the state through the RHTP governance structures and financial controls. DHHS offices maintain well-established systems for duplication prevention, program integrity, and fiscal oversight. Their expertise and existing review mechanisms will be leveraged to verify that no RHTP expenditures overlap with current State or Federal funding sources.

B. Confirm that you will ensure RHTP award funds are not used to duplicate or supplant current federal, State, or local funding, or be used for the nonfederal share of Medicaid payments.

The DHHS Commissioner's Office confirms that RHTP award funds will not be used to duplicate or supplant existing federal, State, or local funding sources, and will not be applied toward the nonfederal share of Medicaid payments.

To ensure compliance, the Commissioner's Office will coordinate across its divisions to conduct comprehensive funding and program reviews. These reviews will verify that no proposed activity or expense under the RHTP is already supported by another funding source such as Medicaid, Medicare, Title V block grant funds, local health departments, or other federal innovation models. For each expenditure, our internal Initiative Leads will document that the cost of each activity that is within their initiative is not reimbursed or financed by any other federal, State, or local program.

All proposed services will also be evaluated to confirm that they do not replicate services already provided directly to attributed beneficiaries under existing programs, such as those covered by current Medicaid benefits. RHTP funding will be used to enhance existing systems and address gaps in service delivery. This ensures that all activities complement rather than duplicate ongoing efforts.

This coordinated approach, supported by established RHTP oversight mechanisms, will ensure that every RHTP-funded activity is unique, non-duplicative, and compliant with federal and State funding integrity standards.

C. Explain how this funding builds upon current State and Federal programs and initiatives, if applicable, while avoiding duplication.

RHTP funding will build upon the impact of existing State and Federal initiatives rather than duplicate them. The Commissioner's Office will coordinate with OMS, Maine CDC, and other State offices to identify opportunities to build upon established rural health programs. Through this coordination, the Commissioner's Office will ensure that activities funded by RHTP fill service or infrastructure gaps, rather than duplicate services already provided to eligible beneficiaries. This will be continuously re-assessed to ensure timeline of funding start/stops and scopes are appropriate. Please also see response to Part B above.

The State's RHTP initiatives build upon current state and federal funding in the following ways:

Initiative	**How Activities Build upon Current State and Federal Program/Initiatives without Duplication**
Population Health	Funding for several activities within this Initiative leverage infrastructure and/or foundational work previously developed with state or federal funding; however, RHTP funds will be used only to support incremental innovations that are being implemented beyond existing programs (e.g. innovations within Certified Community Behavioral Health Clinics that are not funded by Medicaid or SAMHSA, implementing new and expanded CHW/Peer/Community Paramedicine/Mobile Health/School-based Health Center/Behavioral Health models not currently supported by state or federal funding). Additionally, several activities in this Initiative will newly bring resources to focus on the coordination and systems-building to support improved planning and efficiencies that are not otherwise funded by more siloed or pilot-based efforts. Other activities will be funded solely by new RHTP funding (e.g. specific Evidence-Based Practices, nutrition education and clinical integration, several aspects of the Community Paramedicine and CHW work).
Workforce	Funding for this Initiative will expand or build new workforce activities and will leverage existing infrastructure to do so where possible. When building on current state-funded efforts, RHTP funding for these activities will be used specifically to extend the scope and/or reach of workforce efforts in rural communities. Additionally, several activities in this Initiative will use funding to develop new RHTP-specific pilots that do not have other sources of state or federal funding.

Technology & Innovation	Funding for activities in this initiative will be used predominantly to support new uses of technology and innovations are not currently supported by existing state or federal funding. Additionally, some funds will be used to allow expand technology programs that have had past or current state or federal funding specifically to ensure full statewide reach to rural areas and/or to new populations or providers (e.g. HIE expansion to more practices in rural areas, e-consults, tele-behavioral health, remote patient monitoring). Maine will work closely with state partners, CMS, and implementation partners/providers to continuously assess technology policies and programs and ensure proper accounting of funding pathways. All funding will be evaluated against existing state/federal funding, including but not limited to payments that already exist through Medicare and Medicaid.
Access	Funding for activities in this initiative has specifically been designed to fill gaps where other state/federal funding is not available. Activities and spending will be carefully allocated to meet these identified uses (e.g. provider payments, transportation). For other areas, RHTP funding will be fully leveraged for distinct access improvement activities during the five-year period (e.g. provider enrollment systems, consumer transparency tools).
Sustainability	Funding to support activities in this initiative will predominantly be used to support new innovations and financial supports that do not directly build on existing state/federal funding. These activities will build off a foundation of past years of work with health care providers and state/federal efforts to improve the healthcare ecosystem, but RHTP activities will not have other sources of state or federal funding. RHTP funds to support the development of a facility to provide high-acuity care for children with behavioral health (Pediatric Residential Treatment Facility, or PRTF) will build on other finite state support but will be appropriately allocated for non-duplication and is not duplicated by Medicaid funding.

D. Summarize your standard operating procedures and best practices for avoiding program duplication. If available, please include these standards in this attachment.

The DHHS Commissioner's Office will apply both its own internal controls in addition to the State Medicaid Agencies established procedures for avoiding program duplication. These combined practices include:

- **Expense and Program Review:** Each proposed expense and activity will undergo a structured review to confirm that it is not already funded under another federal, State, or local source.
- **Cross-Agency Coordination:** Ongoing collaboration with OMS, Maine CDC, and other State offices ensures awareness of existing funding streams, grant applications, and ongoing initiatives.
- **Provider and Partner Education:** Providers and partners involved in RHTP activities will receive written guidance clarifying allowable costs and the process for identifying potential duplication.
- **Time and Cost Allocation Controls:** For staff or contractors partially funded by multiple programs, time tracking and activity reporting will be used to ensure appropriate allocation of costs.
- **Retrospective Review and Program Integrity:** The Commissioner's Office, will perform retrospective reviews and audits to detect potential duplication or supplanting. Findings will be promptly corrected and documented.

These procedures will be codified in RHTP operating policies, ensuring consistent oversight throughout the funding period.

Conclusion

Through careful coordination, transparent accounting, and adherence to established duplication prevention standards, the DHHS Commissioner's Office will ensure that funds are used responsibly to enhance rural health outcomes while avoiding duplication of any existing federal, State, or local programs. OMS, Maine CDC and other State offices will provide technical and operational support in alignment with its ongoing responsibilities to the Commissioner's Office.

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

OMB Number: 4040-0013
Expiration Date: 06/30/2028

1. * Type of Federal Action:

- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:

- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:

- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

- [x] Prime
- [ ] SubAwardee

** Name:* Maine Department of Health and Human Services

** Street 1:* 109 Capitol St *Street 2:* 11 SHS

** City:* Augusta *State:* ME: Maine *Zip:* 04330

Congressional District, if known: ME-01

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

Centers for Medicare & Medicaid Services

7. * Federal Program Name/Description:

Rural Health Transformation Program

Assistance Listing Number, *if applicable:*

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$ 93.79

10. a. Name and Address of Lobbying Registrant:

Prefix: ** First Name:* N/A *Middle Name:*

** Last Name:* N/A *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

b. Individual Performing Services (including address if different from No. 10a)

Prefix: ** First Name:* N/A *Middle Name:*

** Last Name:* N/A *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Bethany L. Hamm

***Name:** *Prefix:* ** First Name:* Bethany *Middle Name:* L

** Last Name:* Hamm *Suffix:*

Title: Deputy Commissioner **Telephone No.:** 207-624-4062 **Date:** 11/03/2025

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

OMB Number: 4040-0004
Expiration Date: 11/30/2025

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier: DHHS-Maine

5a. Federal Entity Identifier:

5b. Federal Award Identifier: CMS-RHT-26-001

State Use Only:

6. Date Received by State: 09/15/2025

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Department of Health and Human Services, Maine State of

* b. Employer/Taxpayer Identification Number (EIN/TIN): 01-6000001

* c. UEI: GJEPWTMKF5A3

d. Address:

* Street1: 109 Capitol St.
Street2: SHS 11
* City: Augusta
County/Parish: Kennebec
* State: ME: Maine
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 04333-0011

e. Organizational Unit:

Department Name: DHHS

Division Name: Commissioner's Office

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: Margaret
Middle Name:
* Last Name: Reynolds
Suffix:

Title: Director of Program Implementation

Organizational Affiliation: DHHS, Commissioner's Office

* Telephone Number: (207) 215-9034
Fax Number:

* Email: margaret.reynolds@maine.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Centers for Medicare & Medicaid Services

11. Assistance Listing Number:

93.798

Assistance Listing Title:

Rural Health Transformation Program

*** 12. Funding Opportunity Number:**

CMS-RHT-26-001

* Title:

Rural Health Transformation Program

13. Competition Identification Number:

CMS-RHT-26-001-117822

Title:

Rural Health Transformation Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Maine’s Rural Health Transformation Plan proposes a new approach to delivering rural health care so that rural Mainers will have a resilient and integrated rural healthcare system accessible to all.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: ME-001

* b. Program/Project: ME-001

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 12/31/2025

* b. End Date: 09/30/2030

18. Estimated Funding ($):

* a. Federal	1,000,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:

* First Name: Bethany

Middle Name:

* Last Name: Hamm

Suffix:

* Title: Deputy Commissioner

* Telephone Number: 2076244062

Fax Number:

* Email: bethany.l.hamm@maine.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission.

* Date Signed: Completed by Grants.gov upon submission.

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2028

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Assistance Listing Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Rural Health Transformation Program	93.798	$ 0.00	$ 0.00	$ 1,000,000,000.00	$ 0.00	$ 1,000,000,000.00
2.						
3.						
4.						
5. Totals		$ 0.00	$ 0.00	$ 1,000,000,000.00	$ 0.00	$ 1,000,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	Rural Health Transformation Program				
a. Personnel	$ 16,845,431.00	$	$	$	$ 16,845,431.00
b. Fringe Benefits	11,249,928.00				11,249,928.00
c. Travel	39,220.00				39,220.00
d. Equipment	1,500,000.00				1,500,000.00
e. Supplies	1,297,920.00				1,297,920.00
f. Contractual	752,451,498.00				752,451,498.00
g. Construction	0.00				0.00
h. Other	205,252,093.00				205,252,093.00
i. Total Direct Charges (sum of 6a-6h)	988,636,090.00				$ 988,636,090.00
j. Indirect Charges	11,363,910.00				$ 11,363,910.00
k. TOTALS (sum of 6i and 6j)	$ 1,000,000,000.00	$	$	$	$ 1,000,000,000.00
7. Program Income	$ 0.00	$	$	$	$ 0.00

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Rural Health Transformation Program	$ 0.00	$ 0.00	$ 0.00	$ 0.00
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 200,000,000.00	$ 0.00	$ 50,000,000.00	$ 75,000,000.00	$ 75,000,000.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 200,000,000.00	$ 0.00	$ 50,000,000.00	$ 75,000,000.00	$ 75,000,000.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Rural Health Transformation Program	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 988,363,090.00

22. Indirect Charges: 11,363,910.00

23. Remarks: In the RHTP budget, the State of Maine acknowledges the 20% limitation for administration, the 10% limitation for capital, the 15% limitation on provider payments, and the 5% limitation on electronic medical record (EMR) upgrades.

State of Maine

Rural Health Transformation Program

Budget Narrative

A. (Personnel) Salaries and Wages

	Year 1	Year 2	Year 3	Year 4	Year 5
Salary Total	$1,887,829	$3,424,112	$3,694,737	$3,842,526	$3,996,227
Grant	**$1,887,829**	**$3,424,112**	**$3,694,737**	**$3,842,526**	**$3,996,227**
Recipient Share*	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

*Cost sharing only.

Title	Name	RHTP Initiative	Salary	Time	Mths	Yr 1 mt	Yr 2 Amt	Yr 3 Amt	Yr 4 Amt	Yr 5 Amt
RHTP Director	Dr. Lisa Letourneau	Central Oversight	144,685	100%	60	144,685	150,472	156,491	162,751	169,261
RHTP Deputy Director	TBD	Central Oversight	131,518	100%	60	131,518	136,779	142,250	147,940	153,857
RHTP Fiscal & Compliance	TBD	Central Oversight	120,266	100%	60	120,266	125,077	130,080	135,283	140,694
RHTP Data and Evaluation	TBD	Central Oversight	120,266	100%	60	120,266	125,077	130,080	135,283	140,694
Sustainable Ecosystem PM	TBD	Sustainable Ecosystems	110,074	100%	60	110,074	114,477	119,056	123,818	128,771
Population Health PM	TBD	Population Health	110,074	100%	60	110,074	114,477	119,056	123,818	128,771
Technology & Innovation PM	TBD	Technology & Innovation	110,074	100%	60	110,074	114,477	119,056	123,818	128,771
Access PM	TBD	Access	110,074	100%	60	110,074	114,477	119,056	123,818	128,771
Workforce PM	TBD	Workforce	110,074	100%	60	110,074	114,477	119,056	123,818	128,771
DCM Contract Manager (2)	TBD	Central Oversight	81,078	100%	60	162,156	168,642	175,388	182,403	189,700
DCM RFP Manager	TBD	Central Oversight	81,078	100%	60	81,078	84,321	87,694	91,202	94,850

DHHS SC Senior Staff Accountant	TBD	Central Oversight	69,139	100%	60	69,139	71,905	74,781	77,772	80,883
DOL Director	Angelina Klouthis Jean	Workforce	102,900	50%	60	-	53,508	55,648	57,874	60,189
DOL Healthcare Program Manager	TBD	Workforce	83,000	100%	60	-	86,320	89,773	93,364	97,098
DOL Career Center Consultant (3)	Jonathan Lounsberry TBD (2)	Workforce	62,000	100%	60	-	193,440	201,178	209,225	217,594
HOPE Senior Planner	TBD	Workforce	76,315	100%	60	76,315	79,368	82,542	85,844	89,278
HOPE Eligibility Specialist II	TBD	Workforce	62,691	100%	60	62,691	65,199	67,807	70,519	73,340
Sr. Reimbursement Analyst	TBD	Sustainable Ecosystems	101,587	100%	60	101,587	105,650	109,876	114,272	118,842
Alternative Payment Model Coordinator	TBD	Sustainable Ecosystems	94,508	100%	60	94,508	98,288	102,220	106,309	110,561
Duals Coordinator	TBD	Sustainable Ecosystems	97,635	100%	60	97,635	101,540	105,602	109,826	114,219
Eligibility Specialists (18)	TBD	Access	62,691	100%	48	-	1,128,438	1,173,576	1,220,519	1,269,339
Comprehensive Health Planner II (2)	TBD	Access	78,998	100%	48	-	-	157,996	164,316	170,888
IT Project Coordinator	TBD	Access	93,600	25%	48	23,400	23,400	-	-	-
Project Coordinator	TBD	Access	52,215	100%	48	52,215	54,304	56,476	58,735	61,084
# of Positions						**25**	**43**	**44**	**44**	**44**
Total:						**1,887,829**	**3,424,112**	**3,694,737**	**3,842,526**	**3,996,227**

Justification:

Title	Name	Project Responsibilities
RHTP Director	Dr. Lisa Letourneau	The RHTP Director will oversee the strategy, operations, and execution of the Rural Health Transformation Program. They will manage the RHTP Deputy Director, RHTP Fiscal & Compliance, and RHTP Data & Evaluation positions and report to the Department of Health and Human Services Commissioner.
RHTP Deputy Director	TBD	Provides support to Director and staff on development and implementation of various strategies to improve rural health care in Maine. Manages the five initiative leads (PM) positions; reports to RHTP Director.

RHTP Fiscal & Compliance	TBD	Provides support to Director and oversees finances, administration, compliance, and reporting functions of this grant to ensure adherence to grant requirements. Oversees Administrative Support Vendor; reports to RHTP Director.
RHTP Data and Evaluation	TBD	Provides support to Director and oversees evaluation, data, and other coordination to ensure intended results are achieved. Oversees Evaluation Vendor; reports to RHTP Director.
Sustainable Ecosystem PM	TBD	Manages day-to-day delivery of component project programming for Sustainable Ecosystems Initiative. Oversees external vendors and/or subrecipients executing program activities, monitor performance metrics, track progress against workplans, and identify operational risks or bottlenecks; reports to RHTP Deputy Director.
Population Health PM	TBD	Manages day-to-day delivery of component project programming for Population Health Initiative. Oversees external vendors and/or subrecipients executing program activities, monitor performance metrics, track progress against workplans, and identify operational risks or bottlenecks; reports to RHTP Deputy Director.
Technology & Innovation PM	TBD	Manages day-to-day delivery of component project programming for Technology & Innovation Initiative. Oversees external vendors and/or subrecipients executing program activities, monitor performance metrics, tracks progress against workplans, and identifies operational risks or bottlenecks; reports to RHTP Deputy Director.
Access PM	TBD	Manages day-to-day delivery of component project programming for Access Initiative. Oversees external vendors and subrecipients executing program activities. Monitors performance metrics, tracks progress against workplans, identifies operational risks or bottlenecks; reports to RHTP Deputy Dir.
Workforce PM	TBD	Manages day-to-day delivery of component project programming for Workforce Initiative. Oversees external vendors and subrecipients executing program activities. Monitors performance metrics, tracks progress against workplans, identifies operational risks or bottlenecks; reports to RHTP Deputy Dir.
DCM Contract Manager (2)	TBD	Manages day-to-day delivery of contract management to support RHTP program. Will work with RHTP Initiative Leads and leadership to ensure adherence to procurement rules; acquire services in efficient and effective manner; report to Director of Contract Management within ME Department of Health and Human Services.
DCM RFP Manager	TBD	Manages day-to-day delivery of contract management to support RHTP program. Will work with RHTP Initiative Leads and Leadership to ensure adherence to procurement rules; acquire services in efficient and effective manner; will report to Director of Contract Management within ME Department of Health and Human Services.
DHHS SC Senior Staff Accountant	TBD	Apply advanced accounting skills to ensure proper functioning and accountability of fiscal operations; consult with agency program managers and internal/external accounting staff to identify business needs, compliance, and reporting requirements; reports to ME Director of the Department of Health and Human Services' Service Center.
DOL Director	Angelina Klouthis Jean	This position is part of Healthcare Training for ME Partnership & directs overall operation of healthcare navigators and training teams; responsible for overseeing implementation of project activities, coordination with employers, other agencies and educational partners to identify and meet unmet training needs; providing strategic directions to apprenticeship team to create seamless healthcare pathways to retain and upskill staff. Year 1 costs are paid with Maine Jobs and Recovery Funding.
DOL Healthcare Program Manager	TBD	This position is part of Healthcare Training for ME Partnership & directly oversees navigators to ensure jobseekers are connected to healthcare jobs and training; responsible for data collection, analysis and reporting on healthcare initiatives; work directly with training providers to fill industry training needs; manage contracts with training providers for new and incumbent healthcare workers including apprenticeship and pre-apprenticeship program development. Year 1 costs are paid with Maine Jobs and Recovery Funding.

DOL Career Center Consultant (3)	Jonathan Lounsberry TBD (2)	Positions are part of Healthcare Training for ME Partnership & conducts outreach to employers and jobseekers, connecting jobseekers with healthcare training and career opportunities, and employers with recruitment and retention resources including support with apprenticeship program development. Position provides range of services including individualized support for jobseekers, re-employment, career counseling, connection to training, wraparound supports, and apprenticeship connections. Year 1 costs are paid with Maine Jobs & Recovery Funding.
HOPE Senior Planner	TBD	Position, as part of Workforce Initiative, will process participants' support service requests to eliminate barriers faced by healthcare students; report to Higher Opportunity for Pathways to Employment (HOPE) Program Manager within Office for Family Independence (OFI).
HOPE Eligibility Specialist II	TBD	Position is part of Workforce Initiative determines eligibility for participants' support service requests to eliminate barriers faced by healthcare students; reports to HOPE Program Manager within Office for Family Independence.
Sr Reimbursement Analyst	TBD	Position is part of Sustainable Ecosystems Initiative, will ensure efficient, sustainable, high value reimbursement of care; reports to Sustainable RH Ecosystems Initiative Lead.
Alternative Payment Model Coordinator	TBD	Position is part of Sustainable Ecosystems Initiative, will oversee and coordinate the development of alternative payment models; will report to Sustainable RH Ecosystems Initiative Lead.
Duals Coordinator	TBD	Position is part of Sustainable Ecosystems Initiative, will coordinate efforts to align and improve value of care related to members dually enrolled in Medicare and Medicaid. This position will report to the Sustainable RH Ecosystems Initiative Lead.
Eligibility Specialists (18)	TBD	Positions are part of Access Initiative, will determine participant's eligibility for limited essential benefit plan for the uninsured. Positions will report to Family Independence Unit Supervisors within Office for Family Independence.
Comprehensive Health Planner II (2)	TBD	Positions are part of Access Initiative, will provide coordination between Maine Department of Transportation (DOT), Office of MaineCare Services (OMS), and Non-Emergency Transportation brokers to expand access to ride sharing opportunities; will report to Associate Directors of Operations within OMS and DOT.
IT Project Coordinator	TBD	This position, as part of Access Initiative, will provide project management to implement a new uninsured coverage group. This position will report to Medicaid Management Information System manager within Office of MaineCare Services.
Project Coordinator	TBD	Position is part of Access Initiative, provides project management to implement new coverage comparison tool; reports to Deputy Dir within Office of Health Insurance Marketplace.

B. Fringe Benefits

	Year 1	Year 2	Year 3	Year 4	Year 5
Fringe Benefits Total	$1,260,754	$2,286,734	$2,467,466	$2,566,164	$2,668,811
Grant	**$1,260,754**	**$2,286,734**	**$2,467,466**	**$2,566,164**	**$2,668,811**
Recipient Share*	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

*Cost sharing only.

		Year 1		Year 2		Year 3		Year 4		Year 5	
Fringe Benefit	Rate	Salary	Amt Requested	Salary	Amt Requested	Salary	Amt Requested	Salary	Amt Requested	Salary	Amt Requested
FICA	1.45%	1,887,829	27,374	3,424,112	49,650	3,694,737	53,574	3,842,526	55,717	3,996,227	57,945
Workers' Comp	$1,674 annual/ FTE	25 FTE	41,850	43 FTE	71,982	44 FTE	73,656	44 FTE	73,656	44 FTE	73,656
Normal Retirement	4.81%	1,067,105	51,328	1,109,789	53,381	1,154,181	55,516	1,200,348	57,737	1,248,362	60,046
Unfunded Retirement	16.05%	1,887,829	302,997	3,424,112	549,570	3,694,737	593,005	3,842,526	616,725	3,996,227	641,394
Retiree Health	9.30%	1,887,829	175,568	3,424,112	318,442	3,694,737	343,611	3,842,526	357,355	3,996,227	371,649
Pick-Up Retirement	4.80%	1,887,829	90,616	3,424,112	164,357	3,694,737	177,347	3,842,526	184,441	3,996,227	191,819
Health Insurance	Salary <$50K $26,626 Salary >$50K< $100K $25,898 Salary> $100K $25,169	25 FTE	551,440	43 FTE	1,045,579	44 FTE	1,136,099	44 FTE	1,185,799	44 FTE	1,237,487
Dental Insurance	$744/ FTE	25 FTE	18,600	43 FTE	31,992	44 FTE	32,736	44 FTE	32,736	44 FTE	32,736
Life Insurance	$.52/ 000s of salary	1,888	982	3,424	1,781	3,695	1,921	3,843	1,998	3,996	2,078
Total:			**1,260,754**		**2,286,734**		**2,467,466**		**2,566,164**		**2,668,811**

C. Travel

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**

Travel Total	$7,844	$7,844	$7,844	$7,844	$7,844
Grant	**$7,844**	**$7,844**	**$7,844**	**$7,844**	**$7,844**
Recipient Share*	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

*Cost sharing only

			Year 1	Year 2	Year 3	Year 4	Year 5
Purpose of Travel	Item	Rate	Cost	Cost	Cost	Cost	Cost
Site Visits	Mileage	$0.56 x 2400 miles	1,344	1,344	1,344	1,344	1,344
Annual Conference	Airfare	$400/ flight x 5 persons	2,000	2,000	2,000	2,000	2,000
Annual Conference	Per Diem	$184 x 5 persons	920	920	920	920	920
Annual Conference	Lodging	$600 x 5 persons	3,000	3,000	3,000	3,000	3,000
Annual Conference	Mileage	$0.56 x 200 miles	280	280	280	280	280
Annual Conference	Taxi	$60 x 5 persons	300	300	300	300	300
Total:			**7,844**	**7,844**	**7,844**	**7,844**	**7,844**

Justification

The RHTP Director, Deputy Director, & three Initiative Leads will travel from Portland, ME to Washington DC to attend CMS annual RHTP conference. Attending this conference is directly linked to project goals/objectives and is a necessity to learn from other States. The information and tools we will gather from attending this conference will help us to carry out project objectives by applying best practices. The Technology & Innovation Lead will also make periodic visits to rural communities and providers to assess their needs and experience in using RHTP supported technology and innovation initiatives. Visiting rural sites is directly linked to project goals and objectives and is necessary to directly assess progress, as well as potential barriers to implementation of RHTP activities. The information and feedback gathered will help us carry out RHTP activities more effectively and ensure cross-initiative success.

D. Equipment

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Equipment Total	$1,500,000	$0	$0	$0	$0
Grant	**$1,500,000**	**$0**	**$0**	**$0**	**$0**
Recipient Share*	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

*Cost sharing only

		Year 1	Year 2	Year 3	Year 4	Year 5

Item(s)	Rate	Cost	Cost	Cost	Cost	Cost
OB Adult and Infant Simulators	4 @ $125,000	500,000	-	-	-	-
Adult Simulators- EMS	4 @ $125,000	500,000	-	-	-	-
5-year-old Child Simulators- EMS	4 @ $125,000	500,000	-	-	-	-
Total:		**1,500,000**	**-**	**-**	**-**	**-**

Justification

As part of the Workforce Initiative, Maine will expand upon their current mobile simulation lab capacity by adding four OB Adult & Infant Simulators, four Adult Simulators, and four 5-year-old Child Simulators. This new equipment will allow the delivery of realistic and safe training for healthcare students and professionals throughout the State, increasing accessibility to hands-on practice of critical skills in a controlled environment, especially for those living in rural areas.

E. Supplies

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Supply Total	139,120	292,208	298,864	298,864	298,864
Grant	**139,120**	**292,208**	**298,864**	**298,864**	**298,864**
Recipient Share*	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

*Cost sharing only

		Year 1	Year 2	Year 3	Year 4	Year 5
Item(s)	Rate	Cost	Cost	Cost	Cost	Cost
Laptop Computer	$3,548/Year/FTE	70,960	152,564	156,112	156,112	156,112
General office supplies	$600/Year/FTE	12,000	25,800	26,400	26,400	26,400
Employee Training	$2508/Year/FTE	50,160	107,844	110,352	110,352	110,352
CoverME.gov User Guides	6,000 copies @ $1 each/Year	6,000	6,000	6,000	6,000	6,000
Total:		**139,120**	**292,208**	**298,864**	**298,864**	**298,864**

Justification

General office supplies will be used by staff members to carry out daily activities of the program. Employee training is a standard annual budget line for staff members. The price of the laptop computer is consistent with those acquired from the Maine Office of Information Technology (MaineIT) for other employees of the organization and is based upon rates established by MaineIT for SFY26. The pricing of the selected computer is necessary because it includes the following tools: Standard Laptop, Software Subscription, Network Access & Support. The CoverME.gov User Guides will be purchased from a vendor selected through the competitive bidding process. These guides will be used to promote the Plan Comparison Tool and the use of CoverME.gov's consumer technology for enrollment decisions, contributing to the goals of the Access Initiative.

F. Consultant/Subrecipient/Contractual Costs

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Contract/Subaward Total	151,645,118	150,570,412	150,235,429	150,070,316	149,930,223
Grant	**151,645,118**	**150,570,412**	**150,235,429**	**150,070,316**	**149,930,223**
Recipient Share*	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

*Cost sharing only

					Year 1	Year 2	Year 3	Year 4	Year 5
Organization Name or Service	Contract/ Sub award	RHTP Initiative	Procurement	Start/ End	Cost	Cost	Cost	Cost	Cost
Administrative Support Agreement	Contract	Central Oversight	Provider TBD via competitive procurement	4/1/26 - 9/30/30	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Scope: Maine will contract Administrative Support Vendor to provide operational and administrative capacity for RHTP Leadership Team. Vendor will support State's procurement and contracting process, drafting RFPs, RFQs, and subsequent agreements with outside entities, overseeing execution of scopes of work, reviewing budgets and invoices, monitoring expenditures, and supporting approvals and amendments. They will implement or use existing tools and dashboards to track progress, provide technical assistance to staff and subrecipients, and facilitate meetings with internal teams, grantees, and stakeholders.									
Accountability: RHTP Fiscal & Compliance lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Evaluation Agreement(s)	Contract	Central Oversight	Provider TBD via competitive procurement	4/1/26 - 9/30/30	1,250,000	1,250,000	1,250,000	1,250,000	1,250,000
Scope: Maine will contract with Evaluation Vendor to assess RHTP effectiveness. Vendor will establish reporting mechanisms, collect and structure data to track Maine RHTP metrics, design surveys, interviews, and other data collection tools, and will analyze quantitative and qualitative outcomes for translation into actionable recommendations. Vendor will develop dashboards and progress reporting tools internally and externally, supporting continuous improvement, informed decision-making, and stakeholder transparency. They will collaborate with the Administrative Support Vendor, Fiscal & Compliance Lead, and Data & Evaluation Lead to ensure data collection, reporting, and evaluation activities are aligned, accurate, and compliant with state and federal requirements.									

Accountability: RHTP Evaluation/Compliance/Data lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Medical Care Development (MCD) (federal NETRC contractor)	Sub award	Tech & Innovation	Sole Sourced based on Unique qualification	1/1/26 - 9/30/30	14,355,200	14,355,200	14,355,200	14,355,200	14,355,200
Scope: Building on their experience as federal NETRC contractor to support telehealth implementation, MCD will serve as Subrecipient to provide overall project leadership, management, contracting, and oversight of contractors needed to implement all non-"state-owned" RHTP Tech & Innovation activities. Additionally, they will directly deliver services for several Tech & Innovation activities: Train Telehealth Facilitators & Implement Maine Rural AI Hub.									
Accountability: Technology & Innovation Initiative Lead will oversee contract using contractual deliverable schedules and performance metrics.									
Telehealth Hubs & EMR Upgrades	Sub award	Tech & Innovation	Provider TBD via competitive procurement	4/1/26 - 9/30/30	33,549,199	15,947,330	20,508,364	22,123,319	25,012,298
Scope: Provider will distribute funds for providers & community organizations to create Telehealth Hubs and support EMR upgrades/enhancements, including cybersecurity enhancements & AI ambient documentation modules, or EMR replacements. Note: Max 5% cap on total annual budget (max $10M/Yr) will be used for replacement of EMR system(s) that are HITECH certified as of Sept 1, 2025									
Accountability: Technology & Innovation Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Maine's Five Tribal Nations	Sub award	Tech & Innovation	Sole Sourced based on Unique qualification	1/1/26 - 9/30/30	790,000	1,750,000	250,000	250,000	250,000
Scope: Information Technology equipment upgrades; broadband/network expansions; Information Technology consulting; EMR licensing; Integration & Training									
Accountability: Technology & Innovation Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Rural AI Innovation Institute	Sub award	Tech & Innovation	Provider TBD via competitive procurement	4/1/26 - 9/30/30	500,250	500,250	500,250	500,250	500,250
Scope: Funding for staff and researchers focused on working with rural health AI startups and technology developers new AI health innovations aimed at addressing needs of rural health populations.									
Accountability: Technology & Innovation Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Broadreach	Contract	Workforce	Continuation of Existing Agreement	1/1/26 - 9/30/30	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Scope: Expand existing workforce attraction marketing campaign									
Accountability: Workforce Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Finance Authority of Maine (FAME)	Sub award	Workforce	Sole Sourced based on Unique qualification	1/1/26 - 9/30/30	20,715,230	20,715,230	20,715,230	20,715,230	20,715,230
Scope: Recruitment awards. May be used for relocation, or educational expenses									

Accountability: Workforce Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
MaineHealth	Sub award	Workforce	Continuation of Existing Agreement	1/1/26 - 9/30/30	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000
Scope: Consortium for Healthcare Education & Training (CHET) To expand rural clinical training sites and rotations, support preceptors									
Accountability: Workforce Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Maine Health Data Organization	Contract	Workforce	Sole Sourced based on Unique qualification	1/1/26 - 9/30/30	250,000	250,000	250,000	250,000	250,000
Scope: To design and deploy a centralized health workforce dashboard.									
Accountability: Workforce Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Clinician Upskilling	Contract	Workforce	Provider TBD via competitive procurement	4/1/26 - 9/30/30	500,000	500,000	500,000	500,000	500,000
Scope: Recalibrate training, and customized support to help rural providers practice at the top of their license, adapt to new technology									
Accountability: Contract will be managed by Workforce Initiative Lead; ultimately accountable to RHTP Program Deputy Director and Director									
Rural Medical Workforce Transportation Pilot	Sub award	Workforce	Provider TBD via competitive procurement	4/1/26 - 9/30/30	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
Scope: Fund grants to providers to provide transportation to rural workers									
Accountability: Workforce Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Mobile Units Statewide Coordinator	Contract	Population Health	Provider TBD via competitive procurement	4/1/26 - 9/30/30	625,000	1,250,000	1,250,000	1,250,000	1,250,000
Scope: Develop a comprehensive inventory, implementation support toolkit, and assessment framework for mobile health units. Manage the RHTP funding to purchase and outfit new mobile units.									
Accountability: Population Health Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Aroostook Mental Health Services, Community Health & Counseling Services, Kennebec BH, Maine Behavioral	Contract 6 Providers	Population Health	Sole Sourced based on Unique qualification	1/1/26 - 9/30/26	4,500,000				

Healthcare, Spurwink, Sweetser									
Scope: Implement workflows, agreements, and physical space to embed primary care in each Certified Community Behavioral Health Clinic (CCBHC) service area.									
Accountability: Existing State staff will oversee this contract using contractual deliverable schedules and performance metrics for accountability.									
School Based Health Centers (SBHCs)	Contract 15 Providers	Population Health	Providers TBD via competitive procurement	4/1/26 - 9/30/30	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
Scope: Support current and new SBHCs with program management/oversight, tools and training to support billing, implementation, and infrastructure costs.									
Accountability: School-based Health Coordinator will oversee this contract using contractual deliverable schedules and performance metrics.									
Training Vendor	Sub award	Population Health	Provider TBD via competitive procurement	4/1/26 - 9/30/30	5,000,000	10,000,000	10,000,000	10,000,000	10,000,000
Scope: Responsible for training and implementation funding for Evidence Based Practices (EBPs) that align with the goals of Maine's RHTP.									
Accountability: Population Health Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics with support from the Children's BH Clinical Consultant and Coordinator.									
Nutrition Education Administrator	Sub award	Population Health	Provider TBD via competitive procurement	4/1/26 - 9/30/30	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000
Scope: Vendor to coordinate and administer directly, or subcontract with appropriate parties, nutrition education for rural communities and develop clinical linkages models with the Nutrition Education Coordinator.									
Accountability: Nutrition Education Coordinator will oversee this contract using contractual deliverable schedules and performance metrics.									
Community Paramedicine (CP) Implementation	Contract 10 Providers	Population Health	Provider TBD via competitive procurement	4/1/26 - 9/30/30	5,500,000	5,500,000	5,500,000	5,500,000	5,500,000
Scope: Funds for EMS agencies licensed to provide Community Paramedicine Services in alignment with Maine's RHTP goals.									
Accountability: Community Paramedicine Coordinator will oversee this contract using contractual deliverable schedules and performance metrics.									
Community Paramedicine (CP)/EMS Training Center	Contract	Population Health	Provider TBD via competitive procurement	4/1/26 - 9/30/27	500,000	500,000	-	-	500,000
Scope: Funds will help get Community Paramedicine educational training stood up in Maine.									
Accountability: Community Paramedicine Coordinator will oversee this contract using contractual deliverable schedules and performance metrics.									
Community Health Workers (CHWs)	Contract	Population Health	Provider TBD via competitive procurement	4/1/26 - 9/30/30	4,000,000	7,250,000	7,250,000	7,250,000	7,250,000

Scope: Funds for organizations that employ CHWs for incorporation of CHWs in innovative care delivery models in alignment with Maine's RHTP goals.									
Accountability: CHW Coordinators will oversee this contract using contractual deliverable schedules and performance metrics.									
Maine Behavioral Healthcare	Contract	Population Health	Amendment to current agreement to expand services	1/1/26 - 9/30/30	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
Scope: Funds the hiring and management of 23 additional Peer Recovery Coaches to ensure all Maine EDs have a Recovery Coach.									
Accountability: Peer Activity Coordinator lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Sweetser	Contract	Population Health	Agreement amendment to expand services	1/1/26 - 9/30/30	900,000	900,000	900,000	900,000	900,000
Scope: Funds the hiring and management of 10 additional adult Certified Intentional Peer Support Specialists in additional Maine EDs.									
Accountability: Peer Activity Coordinator lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Sweetser	Contract	Population Health	Agreement amendment to expand services	1/1/26 - 9/30/30	125,000	125,000	125,000	125,000	125,000
Scope: Development of trainings for the integration of Peers in multi-disciplinary settings Deliver Core trainings 2x annually years 2-5, Deliver Continuing ed 2 x annually years 2-5, Train OBH staff and per-diem trainers to deliver all trainings for sustainability									
Accountability: Peer Activity Coordinator will oversee this contract using contractual deliverable schedules and performance metrics.									
Medical Care Development (MCD)	Contract	Population Health	Sole Sourced based on Unique qualification	1/1/26 - 9/30/30	350,000	350,000	350,000	350,000	350,000
Scope: Community Health Worker Training and Community Health Worker Supervisor Costs Defrayed									
Accountability: CHW Coordinators will oversee this contract using contractual deliverable schedules and performance metrics.									
Maine Community Health Worker CHW Initiative	Contract	Population Health	Sole Sourced based on Unique qualification	1/1/26 - 9/30/30	120,000	120,000	120,000	120,000	120,000
Scope: Manage any RHT deliverables and scale CHW certification.									
Accountability: CHW Coordinators will oversee this contract using contractual deliverable schedules and performance metrics.									
Wabanaki Public Health & Wellness	Sub award	Population Health	Sole Sourced based on Unique qualification	1/1/26-9/30/30	956,961	956,961	956,961	956,961	956,961
Scope: Ensure that tribal populations have access to critical substance use treatment and mental health support.									
Accountability: Population Health Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Certified Community Behavioral Health Clinic (CCBHC)	Contract	Population Health	Provider TBD via competitive procurement	4/1/26-9/30/30	200,000	200,000	200,000	200,000	200,000

Scope: CCBHC cost reporting processes for provider. Support modeling of CCBHC costs to support state sustainability and decision-making.									
Accountability: Existing State staff will oversee this contract using contractual deliverable schedules and performance metrics.									
Gainwell	Contract	Population Health	Agreement amendment to expand services	10/1/29-9/30/30	-	-	-	-	450,000
Scope: To fund MaineCare enrollment and claims processing systems to cover Community Paramedicine Services									
Accountability: Population Health Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Staff Augmentation	Contract	Population Health	Sole sourced via State's Master Agreement	1/1/26-9/30/30	1,034,278	1,034,278	1,034,278	1,034,278	1,034,278
Scope: Provides funding for administrative staff to provide operational and administrative support to the Population Health initiative, including School-based Health, Nutrition Education, Community Paramedicine, CHW, and Peer Activity Coordinators; the Children's BH Clinical Consultant and Coordinator.									
Accountability: Population Health Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics for accountability.									
Hospital Financial Management and Regional Planning (Oversight)	Contract	Sustainable Ecosystems	Provider TBD via competitive procurement	4/1/26-9/30/30	1,000,000	4,000,000	4,000,000	4,000,000	4,000,000
Scope: Manage Hospital Financial Improvement and Hospital Regional Planning Activities: includes development of hospital-specific financial management plans; provision of financial management technical assistance; distribution and oversight of hospital stabilization funding; planning, coordination and facilitation of regional rural health planning process; distribution and management of regional rural health planning funds.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Hospital Efficiency & Financial Management Funds (Capital)	Contract	Sustainable Ecosystems	Provider TBD via competitive procurement	1/1/26-9/30/28	30,000,000	40,000,000	20,000,000	-	-
Scope: Hospital Efficiency & Financial Improvement Funds: Provides Hospital payments to support senior hospital staff to participate in tailored financial sustainability planning, technical assistance, and transformation activities; and for capital and non-EMR technology needs for vulnerable hospitals.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Regional Planning Funds (Capital)	Contract	Sustainable Ecosystems	Provider TBD via competitive procurement	10/1/27-9/30/30	-	-	15,000,000	30,000,000	25,000,000
Scope: Rural Regional Planning Funds: Provides funds for providers to align with regional Health Ecosystem planning goals for capital and non-EMR technology costs, workforce recruitment incentives, and for support to establish new legal and business structures.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Maine Health Data Organization	Contract	Sustainable Ecosystems	Sole Sourced based on Unique qualification	1/1/26 - 9/30/30	900,750	497,288	514,652	532,885	552,028
Scope: Produce public dashboard related to hospital financial health and uncompensated care; develop robust provider database for regional health planning.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									

Manatt Health	Contract	Sustainable Ecosystems	Agreement amendment to expand services	1/1/26-9/30/27	285,000	570,000	-	-	-
Scope: Develop Alternative Payment Model (APM) for MaineCare PCPlus program, building off earlier work and phases.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Milliman	Contract	Sustainable Ecosystems	Agreement amendment to expand services	1/1/26 - 9/30/27	167,000	83,000	-	-	-
Scope: Develop adequate, economic and efficient reimbursement methodology for school-based health centers, that rewards high value care.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Multi-Payer Alternative Payment Model	Contract	Sustainable Ecosystems	Provider TBD via competitive procurement	10/1/27 - 9/30/30	-	-	1,000,000	1,000,000	1,000,000
Scope: Develop multi-payer Alternative Payment Model for rural hospital reimbursement									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Dental Reimbursement Development	Contract	Sustainable Ecosystems	Provider TBD via competitive procurement	4/1/26 - 9/30/26	250,000	-	-	-	-
Scope: Develop adequate, economic and efficient dental reimbursement to assist with dental access.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Durable Medical Equipment Development	Contract	Sustainable Ecosystems	Provider TBD via competitive procurement	10/1/26 - 9/30/27	-	400,000	-	-	-
Scope: Develop adequate, economic and efficient reimbursement methodology, as well as research and development of procurement solutions, for Durable Medical Equipment to help ensure access in a difficult rural market.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
MaineCare Rate Support	Contract	Sustainable Ecosystems	Provider TBD via competitive procurement	10/1/28 - 9/30/30	-	-	250,000	250,000	250,000
Scope: Support as needed to develop additional identified adequate, economic and efficient reimbursement for MaineCare covered services.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Gainwell	Contract	Sustainable Ecosystems	Agreement amendment to expand services	1/1/26 - 9/30/28	250,000	250,000	300,000	-	-
Scope: Implement Change Requests to MaineCare claims system to implement rates and Alternative Payment Models.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									

Sweetser	Contract	Sustainable Ecosystems	Agreement amendment to expand services	4/1/26 - 9/30/26	2,300,000	-	-	-	-
Scope: Support renovations of existing site. Accounted for under cost settlement process.									
Accountability: Sustainable Ecosystems Initiative lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Interagency Facility Transportation	Contract	Sustainable Ecosystems	Provider TBD via competitive procurement	4/1/26 - 9/30/30	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Scope: Provides funding to supports the expansion of the MedComm system throughout all hospitals, with coordination and oversight.									
Accountability: Access Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
University of Maine System / ME Lifelong Communities	Sub award	Access	Sole Sourced based on Unique qualification	1/1/26 - 9/30/30	440,750	881,500	881,500	881,500	881,500
Scope: Funds to partner with community-based organizations to strengthen and grow transportation programs. Funds would support needs such as standardized statewide training, stipends for transportation coordinators, trip scheduling software, volunteer promotion and recruitment activities, etc.									
Accountability: Access Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
MaineCare Non-Emergency Medical Transportation Brokers	Contract	Access	Agreement amendment to expand services	10/1/28-9/30/30	-	-	150,000	150,000	150,000
Scope: Provides funding for implementation of coordinated cost sharing model/ technical solution with transportation providers to enable coordinated ride sharing to boost access to transportation for health-related social needs.									
Accountability: Access Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Gainwell	Contract	Access	Agreement amendment to expand services	1/1/26-9/30/30	200,000	200,000	2,400,000	2,400,000	2,400,000
Scope: Provides funding to modify claims system for maintenance and operations of uninsured coverage group; change request costs.									
Accountability: Access Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Gainwell	Contract	Access	Agreement amendment to expand services	10/1/29-9/30/30	-	-	-	3,500,000	4,500,000
Scope: Provides funding for the Provider Enrollment Application upgrade									
Accountability: Access Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Mobility Management Plan	Contract	Access	Provider TBD via competitive procurement	4/1/26-9/30/26	500,000	-	-	-	-
Scope: Develop Implementation Plan focused on a mobility management approach									

Accountability: Access Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Ride Share App	Contract	Access	Provider TBD via competitive procurement	10/1/26-9/30/27	-	120,000	-	-	-
Scope: Development of a Medicaid transportation cost share app to enable ride sharing for non-Medicaid health related social needs in rural communities									
Accountability: Access Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Deloitte	Contract	Access	Agreement amendment to expand services	1/1/26 - 9/30/30	500,000	500,000	500,000	500,000	500,000
Scope: Eligibility System upgrades to enable provider payments for essential services to uninsured in year 1 and allocated portion of routine maintenance and operations cost for years 2 through 5.									
Accountability: Access Initiative lead will oversee this contract, in conjunction with Office for Family Independence Business Technology Associate Director, using contractual deliverable schedules and performance metrics.									
Maine Health Data Organization	Contract	Access	Sole Sourced based on Unique qualification	1/1/26 - 9/30/30	80,500	18,375	19,294	20,258	21,271
Scope: Expand data reporting on uncompensated care provided by Federally Qualified Health Centers and Certified Community Behavioral Health Clinics									
Accountability: Access Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Maine Health Data Organization	Contract	Access	Sole Sourced based on Unique qualification	10/1/27-9/30/30	-	56,000	14,700	15,435	16,207
Scope: Expand data reporting on uncompensated care provided by Federally Qualified Health Centers and Certified Community Behavioral Health Clinics									
Accountability: Access Initiative Lead will oversee this contract using contractual deliverable schedules and performance metrics.									
Market Research Focus Groups	Contract	Access	Provider TBD via competitive procurement	4/1/26 - 9/30/30	50,000	40,000	40,000	40,000	40,000
Scope: This funding will be used to support user experience testing of the plan comparison tool, as well as testing of updates and user guide tools. The funds will cover participant surveying and recruitment, focus group facilitation, stipends for participants and materials creation. The funds will also cover offsite stakeholder meetings room rental and materials.									
Accountability: Access Initiative lead will oversee this contract, in conjunction with Office of the Health Insurance Marketplace (OHIM), using contractual deliverable schedules and performance metrics.									
IdeaCrew	Contract	Access	Agreement amendment to expand services	10/1/27-9/30/30	-	500,000	150,000	150,000	150,000
Scope: To provide funding for the Plan Comparison Tool for use on CoverME.gov.									
Accountability: Access Initiative lead will oversee this contract, in conjunction with Office of the Health Insurance Marketplace (OHIM), using contractual deliverable schedules and performance metrics.									
Total:					**151,645,118**	**150,570,412**	**150,235,429**	**150,070,316**	**149,930,223**

Subrecipient Budgets

Provider	**Medical Care Development (MCD)**		**Telehealth Hubs & EMR Upgrades Provider TBD**		**Rural AI Innovation Institute Vendor TBD**		**Finance Authority of Maine**		**MaineHealth**	
Procurement Method	Sole-Sourced		Sole-Sourced		Competitive		Sole-Sourced		Contract Amendment	
	Total	Federal	Total	Federal	Total	Federal	Total	Federal	Total	Federal
Personnel	1,560,000	1,560,000	260,000	260,000	330,000	330,000	478,415	478,415	200,669	200,669
Fringe Benefits	468,000	468,000	78,000	78,000	99,000	99,000	143,525	143,525	60,201	60,201
Travel	10,000	10,000	4,000	4,000	2,000	2,000	-	-	-	-
Equipment	-	-	-	-	-	-	-	-	-	-
Supplies	10,000	10,000	4,000	4,000	4,000	4,000	-	-	-	-
Contractual	12,000,000	12,000,000	12,000,000	24,600,000	-	-	-	-	4,700,000	4,700,000
Construction (N/A)	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	20,000,000	20,000,000	-	-
Total Direct Charges	14,048,000	14,048,000	24,946,000	24,946,000	435,000	435,000	20,621,940	20,621,940	4,960,870	4,960,870
Indirect Charges	307,200	307,200	51,900	51,900	65,250	65,250	93,291	93,291	39,130	39,130
Total Subaward	**14,355,200**	**14,355,200**	**24,997,900**	**24,997,900**	**500,250**	**500,250**	**20,715,230**	**20,715,230**	**5,000,000**	**5,000,000**
Subrecipient Staffing Plan										
Name/Title of Employee	Role	Cost	Role	Cost	Role	Cost	Role	Cost	Role	Cost
Details will be available once final budget is determined										

Provider	**Population Health Training Vendor TBD**		**Nutrition Education Administrator Vendor TBD**		**University of Maine System / ME Lifelong Communities**		**Wabanaki Public Health and Wellness**		**Wabanaki Public Health and Wellness**	
Procurement Method	Competitive		Competitive		Sole-Sourced		Sole-Sourced		Sole-Sourced	
	Total	Federal	Total	Federal	Total	Federal	Total	Federal	Total	Federal
Personnel	500,000	500,000	720,000	720,000	133,125	133,125	200,000	200,000	46,154	46,154
Fringe Benefits	150,000	150,000	216,000	216,000	39,940	39,940	60,000	60,000	13,846	13,846
Travel	50,000	50,000	100,000	100,000	1,500	1,500	-	-	-	-
Equipment	-	-	-	-	-	-	-	-	-	-

Supplies	100,000	100,000	143,000	143,000	5,000	5,000	-	-	-	-
Contractual	4,080,000	4,080,000	3,638,350	3,638,350	675,000	675,000	26,000	26,000	2,000	2,000
Construction (N/A)	-	-	-	-	-	-	-	-	-	-
Other	-	-	5,800	5,800	-	-	70,000	70,000	15,690	15,690
Total Direct Charges	4,880,000	4,880,000	4,823,150	4,823,150	854,565	854,565	356,000	356,000	77,690	77,690
Indirect Charges	120,000	120,000	176,850	176,850	26,935	26,935	53,400	53,400	11,654	11,654
Total Subaward	**5,000,000**	**5,000,000**	**5,000,000**	**5,000,000**	**881,500**	**881,500**	**409,400**	**409,400**	**89,344**	**89,344**
Subrecipient Staffing Plan										
Name/Title of Employee	Role	Cost	Role	Cost	Role	Cost	Role	Cost	Role	Cost
Details will be available once final budget is determined										

G. Construction (not applicable)

H. Other

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Other Total	41,693,161	40,929,302	40,898,737	40,866,962	40,833,930
Grant	**41,693,161**	**40,929,302**	**40,898,737**	**40,866,962**	**40,833,930**
Recipient Share*	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

*Cost sharing only.

			Year 1	Year 2	Year 3	Year 4	Year 5
Item(s)	Quantity	RHTP Initiative	Cost	Cost	Cost	Cost	Cost
New England Rural Health Association (NERHA)	1	Central Oversight	200,000	200,000	200,000	200,000	200,000
Telehealth Units (One-Time Purchase)	200 x $1000/unit	Technology & Innovation	200,000	-	-	-	-
MaineIT System Improvements	N/A	Technology & Innovation	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
MaineJobLink	1	Workforce	25,000	26,250	27,563	28,941	30,388
Healthcare Training for ME Partnership	N/A	Workforce	9,768,161	9,203,052	9,171,175	9,138,022	9,103,542

Health Career Academy	N/A	Workforce	500,000	500,000	500,000	500,000	500,000
Direct Provider Payments (Uncompensated Care)	N/A	Access	30,000,000	-	-	-	-
Direct Provider Payments (Essential Benefits for Uninsured)	N/A	Access	-	30,000,000	30,000,000	30,000,000	30,000,000
Total:			**41,693,161**	**40,929,302**	**40,898,737**	**40,866,962**	**40,833,930**

Justification

We are requesting funds for the development of New England Rural Health Association (NERHA)'s proposed New England Rural Health Transformation Center, a cross-state collaborative that will provide technical assistance on RHTP issues faced across the states, including policy and regulatory issues, data sharing, and opportunities for shared services. We plan on partnering with the Maine Department of Public Safety, Emergency Medical Services, and are requesting funds to provide telehealth units to the remaining ~200 EMS agencies to enable emergency communications with providers and increase telehealth capacity. We also plan on partnering with the Maine Center for Disease Control (MeCDC) and Office for Child and Family Services (OCFS) to implement or modernize in-house data systems to improve healthcare, e.g. CHARM; EMR upgrade & iPads for ME Public Health Nurses. We are requesting funds to expand MaineJobLink, which is a case management platform that will capture individual trainee, apprentice and pre-apprentice information of participants enrolled in Maine Department of Labor (MDOL) healthcare workforce programs to monitor enrollment, completion, employment and wage outcomes to include in overall grant reporting. We are requesting funds for the Healthcare Training for ME partnership, which is a partnership with DHHS Office for Family Independence, Higher Opportunities for People and Education (HOPE), Office of Aging & Disabilities, MDOL, Department of Education (DOE), Maine Community College System (MCCS), University of Maine System (UMS) and employers offering "earn while you learn" trainings. Finally, we are requesting funds for direct payments to hospitals for uncompensated care, in Year 1, and for the new uninsured coverage group, beginning in Year 2. These payments will mirror Medicaid reimbursement rates for limited essential coverage.

I. Total Direct Costs

	Year 1	Year 2	Year 3	Year 4	Year 5
Direct Total	198,133,826	197,510,612	197,603,077	197,652,676	197,735,899
Grant	**198,133,826**	**197,510,612**	**197,603,077**	**197,652,676**	**197,735,899**
Recipient Share*	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

*Cost sharing only.

	Year 1	Year 2	Year 3	Year 4	Year 5
A. Personnel	1,887,829	3,424,112	3,694,737	3,842,526	3,996,227
B. Fringe Benefits	1,260,754	2,286,734	2,467,466	2,566,164	2,668,811
C. Travel	7,844	7,844	7,844	7,844	7,844
D, Equipment	1,500,000	-	-	-	-
E. Supplies	139,120	292,208	298,864	298,864	298,864
F. Contractual	151,645,118	150,570,412	150,235,429	150,070,316	149,930,223
G. Construction	-	-	-	-	-
H. Other	41,693,161	40,929,302	40,898,737	40,866,962	40,833,930
Total Direct Charges	198,133,826	197,510,612	197,603,077	197,652,676	197,735,899

J. Indirect Costs

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Indirect Total	1,866,174	2,489,388	2,396,924	2,347,324	2,264,101
Grant	**1,866,174**	**2,489,388**	**2,396,924**	**2,347,324**	**2,264,101**
Recipient Share*	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

*Cost sharing only.

		Year 1	Year 2	Year 3	Year 4	Year 5
Item(s)	Rate/Base	Cost	Cost	Cost	Cost	Cost
StaCap	3.126%	1,614,050	2,202,301	2,110,500	2,062,603	1,975,973
Di-Cap	Approved PACAP Plan	252,124	287,087	286,424	284,720	288,127
Total:		1,866,174	2,489,388	2,396,924	2,347,324	2,264,101

Justification

Sta-Cap is the State Cost Allocation Plan which is charged at a rate of 3.126% and is computed on the following direct cost base of $51,633,075 in Year 1, $70,451,089 in Year 2, 67,514,397 in Year 2, $65,982,195 in Year 4, and $63,210,918 in Year 5. These direct costs are all expenditures except those that are categorized as public assistance grants. Di-Cap is the Departments of Health and Human Services' allocation plan computed in accordance with the federally approved PACAP.

State of Maine

Rural Health Transformation Program
Business Assessment Form

A. General Information

1. **Provide organization's**
    a. **Legal name**: Maine Department of Health and Human Services Department
    b. **EIN**: 01-6000001
    c. **Organizational Type**: Office of MaineCare Services
2. **What percentage of the organization's capital is from Federal funding?** Total gross revenues for the MaineCare program in FY 2024 were $4,529,462,677. Federal revenues received for MaineCare (including CHIP) totaled $3,010,362,463. Using these figures, 66.46% of funding received for the MaineCare program was from Federal Funding. For Maine DHHS as a whole, please refer to the "Notes to the Financial Statements" starting on page B-49 of our single audit report, as accessed here: https://www.maine.gov/audit/osa-reports/2024SingleAuditReport.pdf
3. **Does/did the organization receive additional oversight from a Federal agency within the past 3 years due to past performance or other programmatic or financial concerns with the organization?** No
4. **Does the organization currently manage grants with other U.S. Department of Health and Human Services components or other Federal agencies?** Yes, the Department manages grants with several U.S. Department of Health and Human Services components and Federal agencies.
5. **Explain your organization's process to ensure annual renewal in System for Award Management (to include FAPIIS).** The organization uses Dynamics that monitors and supports the process from start to finish within the Grant as well as management of all aspects of the grant award.
6. **Explain your organization's process to comply with (a) 45 CFR 75.113 Mandatory Disclosures and (b) your organization's process to comply with FFATA requirements.**
    a. The State of Maine Department of Health and Human Services utilizes standard riders in all client service contracts that vendors attest to upon contract signature. Within our Rider B we have the following disclosure: "DEBARMENT, PERFORMANCE, AND NON-COLLUSION CERTIFICATION: By signing this Contract, the Provider certifies to the best of Provider's knowledge and belief that the aforementioned organization, its principals and any subcontractors named in this Contract:
        i. Are not presently debarred, suspended, proposed for debarment, and declared ineligible or voluntarily excluded from bidding or working on contracts issued by any governmental agency.

ii. Have not within three years of submitting the proposal for this contract been convicted of or had a civil judgment rendered against them for:
    1. Fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a federal, state or local government transaction or contract.
    2. Violating Federal or State antitrust statutes or committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or Local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
    4. Have not within a three (3) year period preceding this proposal had one or more federal, state or local government transactions terminated for cause or default.

iii. Have not entered into a prior understanding, agreement, or connection with any corporation, firm, or person submitting a response for the same materials, supplies, equipment, or services and this proposal is in all respects fair and without collusion or fraud. The above-mentioned entities understand and agree that collusive bidding is a violation of state and federal law and can result in fines, prison sentences, and civil damage awards."

b. It is also standard practice for the DHHS Division of Contract Management to conduct an annual review of vendor debarment status within SAM.gov.

7. **Do you have conflict of interest policies? Does your organization or any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds? If yes, please explain and provide a mitigation plan.** Department staff attest to the following as part of our procurement justification form that is submitted with each contract.

PART V: CONFLICTS OF INTEREST (COI); CONTRACT WITH THE STATE
Maine law contains Conflict of Interest statutes directed to State Departments, State Officers, and Employees Generally under MRS Title 5, §18 and §18-A, in harmony with MRS Title 17, §3104.
☐ The requesting department signatory understands and acknowledges Maine's Conflict of Interest statutes.

The Department's Conflict of Interest policy resides within two of our standard riders for client services contracts.

Rider B: EMPLOYMENT AND PERSONNEL. The Provider shall not engage on a full-time, part-time or other basis during the period of this Contract, any executive employee who participated in any way in the solicitation, award or administration of this

Agreement according to MRS Title 5 §18-A, 2 and in harmony with MRS Title 17 §3104. Any contract made in violation of these sections is void.

RIDER D: The Provider covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Provider further covenants that in the performance of this Agreement, no person having any such known interests shall be employed.

Neither the Department nor any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds.

8. **Does your organization currently, or in the past, had delinquent Federal debt in the last 3 years? If yes, please explain.** Not to the knowledge of the Department's Financial Service Center team.
9. **Have you filed bankruptcy or entered into proceedings for bankruptcy, whether voluntarily or involuntarily?** No.
10. **Has the organization obtained fidelity bond insurance coverage for responsible officials and employees of the organization in amounts required by statute or organization policy? What is that amount?** Yes, the Department has an employee bond with a per occurrence limit. The limit for this policy is established by the State's Risk Management Division. The Department also has a Public Guardianship and Conservatorship Bond established by statute with probate court approved limits.
11. **Do you have (and briefly describe) policies and procedures in place to meet the requirements below? If not, explain your plan and estimated timeline for establishing these policies and procedures if selected for award.**
    a. **Make determinations between subrecipients versus contracts in accordance with 45 CFR 75.351?** As part of normal operating procedures, the Department makes case-by-case determinations on whether each agreement should be considered a subrecipient or a contractor, based upon the goods or services to be provided.
    b. **Compliance with 2 CFR 200.332 "Requirements for pass-through entities"?** Yes, our requirements meet all aspects of 2 CFR 200.332 and exist in program offices, Department of Contract Management, and Division of Audit. Each subrecipient contract contains the vendor's name, their Unique Entity Identifier and performance period for the award. The contract also contains a Federal Funding and Award notification. This section provides the total amount of federal funds allocated, the FAIN number, award date, HHS awarding agency, CFDA number and name. Should this information change over the course of the contract an updated notification would be provided to the vendor. Our standard riders address compliance with all applicable federal statutes, and regulations. The rider A of each contract specifies the terms and conditions of the federal award that must be abided by. Within our budget section the provider indicates their federally recognized indirect cost rate, or notes the negotiated rate, if one does not exist.

c. **Manage, assess risk, review audits, and monitor the subrecipients as necessary to ensure that subawards are used for authorized purposes in compliance with laws, regulations, and terms and conditions of the award and that established subaward performance goals are achieved (2 CFR 200.331-200.333)?** Contract compliance is monitored at the programmatic level with required performance reports, meetings and site visits, as well as through the Division of Contract Management (DCM) regularly via financial reporting and the Division of Audit both at budget approval and a thorough review at the close of the agreement. Program reviews compliance with terms and conditions as well as progress toward goals outlined in the contract. DCM works with the provider, the program and the Division of Audit to compose a budget that aligns with the outlined terms, conditions and goals of the contract. DCM and program review all invoices and monthly financial reports prior to payment to ensure they align with the associated budget. Quarterly financial reports are reviewed at DCM and shared with program. A closeout report is also completed by the provider and reviewed by DCM to review all expenditures at the close of the contract. The Division of Audit also reviews the totality of the agreement upon its completion.

B. Accounting System

1. **Does the organization have updated (last two years) written accounting policies and procedures to manage federal awards in accordance with 45 CFR Part 75?** The State of Maine conforms with all federal rules and regulations detailed within each grant award and applicable CFR citations. The State has an established State Administrative and Accounting Manual and conforms to Generally Accepted Accounting Principles (GAAP).
    a. **If no, please provide a brief explanation of why not.** N/A
    b. **Describe the management of federal funds and how funds are separated (not co-mingling) from other organizational funds.** Federal funds are separated into different fund accounts within the State of Maine's accounting system. They are budgeted separately, spent separately, and revenues are deposited separately. Various federal grant awards are tracked in our accounting system utilizing a series of unique account codes allowing our accounting staff to determine revenue and spending specific to each grant.
2. **Briefly describe budgetary controls in effect to preclude incurring obligations more than:**
    a. **Total funds available for an award.** Funds are encumbered. Also, the Program Managers have a budget set up for them to track their budget to actual spending to the grant award.
    b. **Total funds available for a budget cost category.** These budget to actual reports are set up by category and called object codes/groups.
3. **Has any government agency rendered an official written opinion within the last 3 years concerning the adequacy of the organization's accounting system for the collection, identification, and allocation of costs under Federal awards?** No

   a. **If yes, please provide the name and address of the Agency that performed the review.**
   b. **Provide a summary of the opinion.**
   c. **How did your organization resolve any concerns?**
4. **How does the accounting system provide for recording the non-Federal share and in-kind contributions (if applicable)?** The accounting system provides recording keeping for non-Federal share that is matched by state funds or other funds. In-kind contributions are not always recorded in the accounting system. That would depend on the type of in-kind contribution. The agency is responsible for maintaining records of the in-kind contributions if applicable. There are instances when specific codes are used to identify costs associated with In-Kind/Shared costs in order to ensure proper match and accounting in the accounting system.
5. **Does the organization's accounting system provide identification for award funding by federal agency, pass-through entity, Assistance Listing (CFDA), award number and period of funding? If yes, how does your organization identify awards? If not, please explain why not.** Yes, the State of Maine files periodic SEFA Reports outlining a total Schedule of Expenditures of Federal Awards. Grant funding awarded by the federal government to Maine DHHS is also tracked within the Payment Management System for purposes of drawdown; funding received by external non-federal entities are accounted for separately and are deposited to specific accounts for tracking. All grant awards are also tracked in our accounting system utilizing a series of unique account codes allowing our accounting staff to determine revenue and spending specific to each grant.

C. Budgetary Controls

1. **What are the organization's controls utilized to ensure that the Authorized Organizational Representative (AOR), as identified on the SF-424, approves all budget changes for the federal award?** The State has a portal called Dynamics that tracks each step in the process and automatically sends to the Authorized Organizational Representative for review and sign off on all budget changes for federal award during the submission process.
2. **Describe the organization's procedures for minimizing the time between transfer of funds from the U.S. Treasury (e.g. Payment Management System) and disbursement for grant activities (See 45 CFR §75.305, "Payment.").** Per the State's Cash Management Improvement Act (CMIA) agreement with the US Treasury, the transfer of funds from Medicaid grant awards are done on a weekly actual basis ensuring there is never more than 1 week between actual spend and federal drawdown. A 7-day cash on hand policy is also applied to grants that require a transfer of funds prior to spending and are based upon incurred costs.

D. Personnel

1. **Does the organization have a current organizational chart or similar document establishing clear lines of responsibility and authority? If yes, please provide a copy.**

If no, how are lines of responsibility and authority determined? The DHHS organizational chart is located here: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/DHHS%20Overall%20Organizational%20Chart_0.pdf

2. **Does the organization have updated (last two years) written Personnel and/or Human Resource policies and procedures? If no, provide a brief explanation.** Yes, the State maintains an internal website/intranet that contains updated policies and procedures wherever it applies.
3. **Does the organization pay compensation to Board Members?** N/A; DHHS is a Department in the Executive Branch of the State of Maine
4. **Are staff responsible for fiscal and administrative oversight of HHS awards (Grants Manager, CEO, Financial Officer) familiar with federal rules and regulations applicable to grants and Cooperative Agreements (e.g. 45 CFR Part 75)?** Yes.
5. **Please describe how the payroll distribution system accounts for, tracks, and verifies the total effort (100%) to determine employee compensation.** The State's automated system (PRISM) accounts for all compensation, including shift differentials, stipends, and overtime.

E. Payroll

1. **In preparation of payroll is there a segregation of duties for the staff who prepare the payroll and those that sign the checks, have custody of cash funds and maintain accounting records? Please describe.** Yes, checks are signed and processed through the Office of the State Controller. All information is preloaded into the automated system and cannot be changed without payroll department authorization. Payments are automatically made by direct deposit per State policy.

F. Consultants

1. **Are there written policies or consistently followed procedures regarding the use of consultants which detail the following (include explanation for each question below)?** Yes. See below.
    a. **Briefly describe the organization's method or policy for ensuring consultant costs and fees are allowable, allocable, necessary and reasonable.** DHHS has written procedures for purchasing services, which includes consulting. As with other programmatic needs, the Department may contract for consulting services when there is a lack of expertise with existing resources or when there is sufficient urgency such that the existing staff cannot fit within their workload. Written procedures for purchasing provide guidance for all stages of the purchasing processing, including competitive procurement requirements, waiver to competitive bids, general polices and guidance, swim lane process diagrams, and detailed procedures for putting contracts into place and for making payments. The

procedures consider business need, availability of Department resources, value (fair and reasonable costs), competition, and sourcing nature.

b. **Briefly describe the organization's method or policy to ensure prospective consultants prohibited from receiving Federal funds are not selected.** Every contract that DHHS enters into has language to which the provider is attesting to the fact that they are not debarred from doing work for the federal government. DHHS also spot checks providers that receive federal funding from the Department. The spot checking is performed by checking the SAM.GOV website for exclusion information for the given provider.

G. Property Management

1. **Briefly describe the system for property management (tangible or intangible) utilized for maintaining property records consistent with 45 CFR 75.320(d). Refer to (45 CFR 75.2) for definitions of property to include personal property, equipment, and supplies.** Fixed assets are maintained in the State's accounting system. The Departments that are responsible for the property and equipment perform an annual inventory, which then is balanced against the State's accounting system, and records are checked against physical inventory annually.
2. **Does the organization have adequate insurance to protect the Federal interest in equipment and real property (see 45 CFR §75.317, "Insurance coverage.")? How does the organization calculate the amount of insurance?** Insurance is obtained as necessary; DHHS does not maintain many fixed assets.

H. Property Standards

1. **Describe the organization's property standards in accordance 2 CFR 200.310-327 "Procurement Standards")? If there are no procurement procedures, briefly describe how your organization handles purchasing activities.**
    a. **Include individuals responsible and their roles.** Responsibilities for purchasing are divided within the department. The program offices develop and define the need for procurement, the Division of Contract Management (DCM) manages the purchasing of services, including the quality reviews of the paperwork and facilitating approvals. DCM also facilitates final approval from the State's central procurement agency – the Office of State Procurement Services under Department of Administrative and Financial Services (DAFS), and DCM facilitates the Department approval of equipment purchases.
    b. **Describe the competitive bid process for procurement purchases of equipment, rentals, or service agreements that are over certain dollar amounts.** Generally speaking, the State has three basic levels, listed below. Certain services, such as interpreting services and conference room rental, have master agreements that must be used. For other services, DHHS offices can request a waiver to the competitive bidding process. These must first be approved by DCM, and then by DAFS Office of State Procurement Services.

- Up to $5,000 – No competition required.
- $5,001 to $25,000 – Written bids required.
- Over $25,000 – full competitive procurement required.

I. Transportation Costs

1. **Describe your organization's written travel policy. Ensure, at minimum, that:**
    a. **Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates (see 45 CFR §75.474, "Travel costs.").** Procedures for all the areas listed here and below are documented in the State Administrative and Accounting Manual (SAAM), which is managed by the State Controller's Office. Please use the following link to access the SAAM: https://www.maine.gov/osc/sites/maine.gov.osc/files/inline-files/10.10revised%2020190806.pdf
    b. **Receipts for lodging and meals are required when reimbursement is based on actual cost incurred**. See above: I.1.a.
    c. **Subsistence and lodging rates are equal to or less than current Federal per diem and mileage rates.** See above: I.1.a.
    d. **Commercial transportation costs incurred at coach fares unless adequately justified. Lodging costs do not exceed GSA rate unless adequately justified (e.g. conference hotel).** See above: I.1.a.
    e. **Travel expense reports show purpose and date of trip.** See above: I.1.a.
    f. **Travel costs are approved by organizational official(s) and funding agency prior to travel.** See above: I.1.a.

J. Internal Controls

1. **Provide a brief description of the applicant's internal controls that will provide reasonable assurance that the organization will manage award funds properly. (see 2 CFR 200.303, "Internal controls.")** Grant funding awarded to the Department of Health and Human Services (DHHS) are accounted for by the DHHS Financial Service Center (DHHS-DAFS SC), a separate division under the Department of Administrative and Financial Services. DHHS works in tandem with the DHHS-DAFS SC to setup an accounting structure for both the identification of qualifying expenditures and the drawdown of funding for said expenditures. There are established systems in place to account for a variety of grant rules.
2. **What is your organization's policy on separation of duties as well as responsibility for receipt, payment, and recording of cash transactions?** Within the DHHS Financial Service Center there is a separate group of accountants that process accounts payable and those staff are separate for those receiving in cash, who is separate from depositing the cash received. Checks are signed and processed through the Office of the State Controller.
3. **Does the organization have internal audit or legal staff? If not, how do you ensure compliance with the award? Please describe.** DHHS has a Division of Audit which

contains Internal Audit functions. DHHS also has legal counsel in the Commissioner's Office.

4. **If the organization has a petty cash fund, how is it monitored?** Procedures are documented in the State Administrative and Accounting Manual, which is managed by the State Controller's Office.
5. **Who in the organization reconciles bank accounts? Is this person familiar with the organization's financial activities? Does your organization authorize this person to sign checks or handle cash?** This is managed through the Office of the State Controller and State Treasury.
6. **Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?** This is managed through the Office of the State Controller and State Treasury.

K. Audit

1. **What is your organization's fiscal year?** July 1st-June 30th
2. **Did the organization expend $750,000 or more in Federal awards from all sources during its most recent fiscal year?** Yes
3. **Has your organization submitted:**
    a. **An audit report to the Federal Audit Clearing House (FAC) in accordance with the Single Audit Act in the last 3 years? (see 2 CFR 200.501, "Audit requirements" and 2 CFR 300.218 "Special Provisions for Awards to for-profit organization as recipients.")** Yes, the State of Maine has submitted a compliant audit.
    b. An independent, external audit? If no, briefly explain. If yes, address the following: No – the
        i. **The date of the most recently submitted audit report.** Yes, March 27, 2025 (this was the single audit)
        ii. **The auditor's opinion on the financial statement. Opinion:** Unmodified
        iii. If applicable, indicate if your organization has findings in the following areas:
            1. **internal controls –** Please see report findings at: https://www.maine.gov/audit/osa-reports/2024SingleAuditReport.pdf
            2. **questioned or unallowable costs –** See above.
            3. **procurement/suspension and debarment -** See above.
            4. **cash management of award funds -** See above.
            5. **subrecipient monitoring -** See above.
        iv. **Include (if applicable):**
            1. **A description of each finding classified as Material Weakness -** See above.
            2. **A description of each finding classified as Significant Deficiency -** See above.

WORKSPACE FORM

1-800-518-4726
SUPPORT@GRANTS.GOV

This Workspace form is one of the forms you need to complete prior to submitting your Application Package. This form can be completed in its entirety offline using Adobe Reader. You can save your form by clicking the "Save" button and see any errors by clicking the “Check For Errors” button. In-progress and completed forms can be uploaded at any time to Grants.gov using the Workspace feature.

When you open a form, required fields are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message. Additional instructions and FAQs about the Application Package can be found in the Grants.gov Applicants tab.

OPPORTUNITY & PACKAGE DETAILS:

Opportunity Number:	CMS-RHT-26-001
Opportunity Title:	Rural Health Transformation Program
Opportunity Package ID:	PKG00291485
Assistance Listing Number:	93.798
Assistance Listing Title:	Rural Health Transformation Program
Competition ID:	CMS-RHT-26-001-117822
Competition Title:	Rural Health Transformation Program
Opening Date:	09/15/2025
Closing Date:	11/05/2025
Agency:	Centers for Medicare & Medicaid Services
Contact Information:	Please refer to the Notice of Funding Opportunity

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS01582839
Application Filing Name:	Rural Health Transportation Program
UEI:	GJEPWTMKF5A3
Organization:	Health And Human Services, Maine Department Of
Form Name:	Project/Performance Site Location(s)
Form Version:	4.0
Requirement:	Mandatory
Download Date/Time:	Nov 26, 2025 09:48:31 AM EST
Form State:	No Errors

FORM ACTIONS:

OMB Number: 4040-0010
Expiration Date: 12/31/2026

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Maine Department of Health and Human Services

UEI: GJEPWTMKF5A3

* Street1: 109 Capitol St.

Street2: SHS 11

* City: Augusta

County: Kennebec

* State: ME: Maine

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 04333-0011

* Project/ Performance Site Congressional District: ME-001

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Additional Location(s)

Add Attachment | Delete Attachment | View Attachment