State of Maine

Rural Health Transformation Program

Project Narrative

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. 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 Materials**.

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 Materials**.

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 Materials**.

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 and Implementation

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.

Maine has identified a range of strategies to help small rural providers develop and sustain the capacity needed to participate in Alternative Payment Models (APMs) that will be developed and/or implemented through our RHTP efforts. Importantly, we will build on the State's statutory framework and considerable experience to date both in implementing MaineCare's (Medicaid) structured reimbursement review and development process and designing and implementing a range of MaineCare APMs for services such as its Health Homes, Primary Care Plus, and Accountable Communities programs. Over the last six years, MaineCare has increased the percentage of MaineCare reimbursement tied to performance from about 20% to over 55%.

Supporting the capacity of rural providers to participate in these programs begins in the planning and design phase, for which Maine will use a statutorily mandated collaborative planning process to design and evaluate value-based care arrangements. Building on Maine's 2021 statute establishing a comprehensive rate reform process for MaineCare provider payments, we will ensure the use of a transparent and data-driven process, including sharing of data, convening of interested parties, soliciting public comments, and developing a comprehensive response to public input. This process ensures development of payment models that are both responsive to provider needs and designed to be economic, efficient, and adequate to cover reasonable costs. Under RHTP we will further ensure that this process includes establishing goals

of reform, principles of importance, and further emphasis on effective working relationships with providers, vendors, provider associations, and other interested parties.

Additionally, we will provide technical assistance and supportive strategies during the APM planning process, including engaging vendors to facilitate effective meetings with providers and supporting provider-level impact analyses that will help providers assess the feasibility of adopting new payment models. Additionally, we will partner with statewide provider associations to provide logistic and consultation support to rural providers, many of which often have limited staff capacity for engagement.

Through our technical assistance and collaborative learning opportunities, we will work with rural providers to illustrate how APM models can help them make changes needed to transform their current systems of care to support their long-term financial sustainability. Many rural providers, for example, serve low volumes/small numbers of patients and face challenges with staffing and covering costs for on-call providers, as well as having limited back-office resources and often facing weather and transportation related challenges for patients and staff. APM models can include financial support and incentives to mitigate these challenges, such as building in payment for stable base costs that enable a critical access hospital to provide core operational services, regardless of volume. Additionally, APM payments tied to performance and value for these providers can account for small sample sizes and variation in populations, while phasing in accountability expectations over time.

Moving forward to planning for APM implementation, Maine will provide support to rural providers by offering RHTP funding for start-up costs, as well as for costs related to targeted care delivery services and time spent in rural regional planning efforts, including the following:

Maine's RHTP "Sustainable Rural Health Ecosystems" Initiative will provide direct financial supports to rural providers for their time spent participating in regional planning and collaboration efforts, including identifying financial risk sharing opportunities as a potential avenue to sustainability and value-based care. Funding will be available to cover significant costs related to developing legal agreements (e.g. for collaborative management, shared space, releases of information/combined consent), building back-end systems integrations and health IT improvements, and adopting shared population health tools. Rural providers will be expected to develop a roadmap of what it will take to develop and sustain accountability networks (across or within organizations) for the purposes of APM adoption.

In addition to this funding, there are numerous initiatives within Maine's RHTP which are specifically designed to support rural providers in adopting changes needed to transform their care models, including wider use of telehealth and e-consult platforms, community paramedicine and shared workforce models, and investments in participating in Maine's health information exchange. Rural providers will be encouraged to leverage RHTP opportunities widely to meet organizational needs and to transition to team-based care models that are essential to ensuring success in APMs.

RHTP funding will also be used to support regional convenings of rural providers to promote peer learning and sharing of best practices. Maine has a long history of offering such collaborative learning opportunities and will build off our experience with previous successful efforts.

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** **SS**: State Staff • **V**: Vendor • **SR**: Subrecipient	Milestone stage in yr.				
		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 Uncomp'ed 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	
	Develop Mobility Management Plan. *V*	1				

Coordinated Transportation to meet Health & Wellness Needs	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

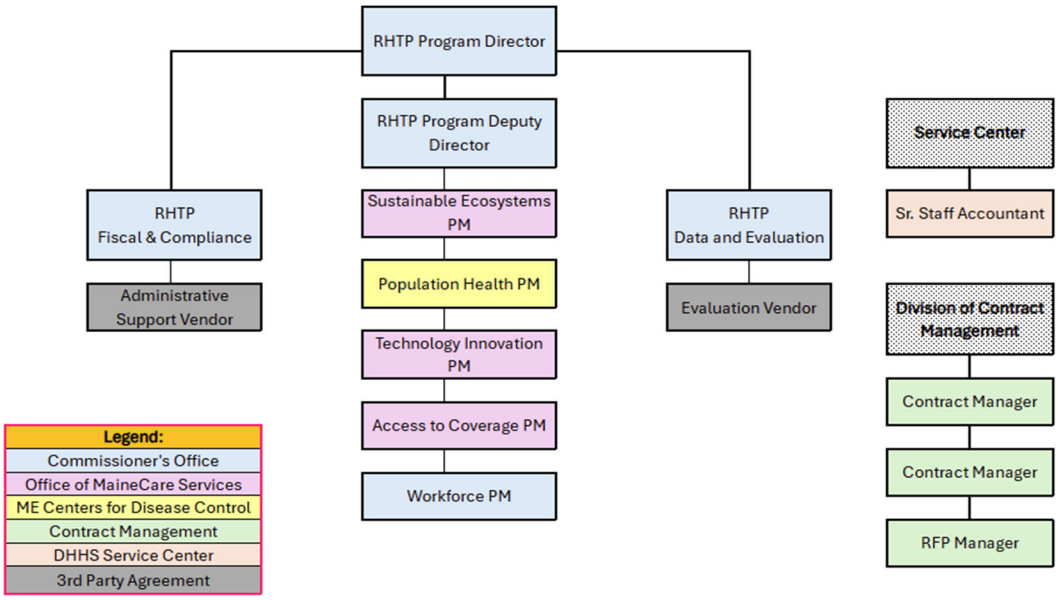
Governance: Maine's RHTP will be governed by the RHTP Governance Committee, consisting of high-level leadership across Maine state government, representing the key Departments and Offices that are affected by the initiatives and activities of the RHTP. The RHTP Governance Committee will be responsible 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 a 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 Materials.**

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 timely reporting)/ Annual	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
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 participating in Maine Regional Coordinated Services Pilot	App vendor/Annual	State	Goal: 10 additional providers per year
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.

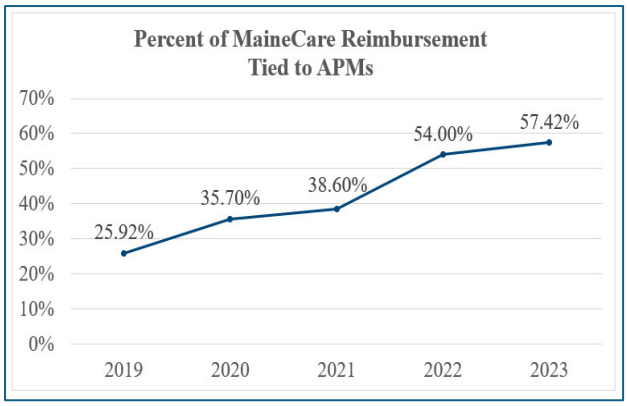
- ***Informing sustainability planning*** to ensure that gains and improvements achieved through the RHTP continue beyond the final funding year. The state views constructive annual evaluations as a critical tool for supporting ongoing progress both during the funding period and after the program concludes. 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*
	Alternative Sites of Care	2; 3; 4

Population Health	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