Rural Health Transformation Grant Guide — Georgia

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AUDIENCE: State health agencies, Medicaid, rural providers, collaboratives

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Georgia can use the CMS Rural Health Transformation (RHT) Program to stabilize rural access, modernize infrastructure, and accelerate quality, equity, and financial sustainability. CMS will award five years of cooperative-agreement funding to states, with $10B per year across FY2026–FY2030; half is distributed equally to approved states and half by workload metrics defined in the NOFO. Applications are due November 5, 2025; awards are expected by December 31, 2025. [1][2]

The Rural Health Transformation Collaborative (the Collaborative) can support Georgia as an implementation partner across CMS's pillars (prevention, sustainable access, workforce, innovative care, technology). Its members provide virtual acute-specialty care (Avel eCare), remote patient monitoring (BioIntelliSense), consumer-facing engagement/triage and analytics (Humetrix, Pangaea Data), cybersecurity and interoperable cloud data platforms (Microsoft), program integration/PMO (Accenture, KPMG, PwC), governance for rural provider High Value Networks (Cibolo Health), and retail-health access (CVS, Walgreens, Walmart). These capabilities align with RHT allowable uses and technical scoring factors and have documented deployments nationally and in rural settings.

Near-term, three high-yield opportunities stand out for Georgia: (a) tele-ER/tele-ICU coverage and tele-pharmacy to keep patients local, particularly in counties with no hospital; (b) statewide RPM plus analytics for cardiometabolic disease and maternal risk, integrated with GaHIN and retail pharmacies; (c) rural provider networks (HVNs) to coordinate right-sizing of service lines and enable value-based payment with Medicaid directed-payment alignment. These options address acute access gaps while building sustainable capacity for CMS metrics (access, outcomes, financial stability, data).

The guide below outlines eligibility and fit to the NOFO, summarizes Georgia's context, presents strategy and program design options, and provides implementation, risk, and draft narrative language. It is explicitly conditional; all activities are subject to state procurement, contracting, integration with state systems/HIE (GaHIN), and Medicaid policy alignment. [1][3]

— One-page printable summary (for distribution) —

- What RHT funds can support: Prevention/chronic disease; payments for health services; consumer technology; tech adoption/TA; workforce; IT/cyber; right-sizing services; behavioral health (OUD/SUD, MH); innovative care/payment models; capital/infrastructure; partnerships. States must use ≥3 categories. [1]
- Georgia fit at a glance (selected 2024–2025 metrics) • 120 rural counties identified by Georgia Rural Health Innovation Center (threshold ≤50,000 population). [4] • 30 Critical Access Hospitals; 54 counties without a rural hospital; ~37 rural PPS hospitals. [5][6] • 35 HRSA Health Center Program awardees (2024 UDS). [7] • ~98 Rural Health Clinics received HRSA testing allocations (2022). [8] • Medicaid managed care enrollment 1.59M (July 2025); three CMOs under Georgia Families. [9] • Pathways to Coverage 1115 (expanded adult group ≤100% FPL; activity reporting features; 2025 extension through 12/31/2026). [10][11][12] • Broadband: GA BEAD allocation ≈$1.307B; 161,301 unserved locations as of FCC 2022 fabric update (reported May 2025). [13][14] • Maternal/infant: U.S. maternal mortality 22.3 per 100,000 (2022); Georgia has prioritized postpartum coverage and maternal initiatives; infant mortality rate 10.74 per 1,000 (2023). [15][16][17]
- Collaborative fit: virtual acute/behavioral specialty coverage, statewide RPM and analytics, consumer engagement (multi-language triage, kiosks), cybersecurity, provider network governance, program PMO and evaluation.

2. Eligibility and RFP Fit

2.1 Program overview (public sources)

- Applicant: Only the 50 U.S. States (DC and territories ineligible). [1]
- Type and timing: Cooperative agreements; $10B/year FY2026–FY2030; half baseline-equal, half workload-based. [1]
- Timeline: NOFO posted; application due November 5, 2025; awards on/around December 31, 2025. [2][3]
- Goals/Pillars: Prevention; sustainable access; workforce; innovative care; technology innovation. [1][2]
- Uses of funds: States must select ≥3 eligible categories (see one-page summary). [1]

2.2 Requirements-to-Capabilities mapping (evidence-aligned)

Table: Key NOFO requirement → Collaborative capability → Evidence

- Interoperable data and privacy/cybersecurity → Azure-based health data platforms; identity, security posture mgt; TEFCA/QHIN connectivity via partners (e.g., PRISMA/PRISMANet), GaHIN integration → Collaborative tech description and member list; GaHIN state designation. [18][19]
- Remote/virtual specialty support (ED/ICU/hospitalist, behavioral) → Avel eCare's virtual hospital services 24/7; tele-behavioral/crisis support → Collaborative appendix and capability narrative.
- RPM and home monitoring → BioIntelliSense BioButton RPM and care pathways; integration to analytics; training for digital health navigators → Collaborative appendix.
- Consumer-facing tech and multi-language intake/triage → Humetrix triage and personal health record apps; kiosks (Higi/Topcon) via partners; retail-engagement programs → Collaborative narrative.
- Workforce training and burnout reduction → Ambient clinical documentation (Microsoft), provider-to-provider tele-mentoring (Avel), pharmacist workforce initiatives (Walgreens/CVS) → Collaborative narrative.
- Governance and program integration → PMO, economic modeling, multi-stakeholder governance; rural provider High Value Networks (HVNs) via Cibolo Health → Collaborative sections.

Compliance checkpoints and scoring notes

- CMS uses equal baseline plus workload/technical scoring over the performance period; CMS public pages describe pillars, timing, and distribution approach; detailed factors/weights are in the NOFO. [1][2][3]
- Application format, page limits, and budget caps (e.g., provider payments, capital, administrative cap) are specified in the NOFO; confirm the latest posted NOFO text on Grants.gov CMS-RHT-26-001 before finalizing the state submission. [3]

3. Georgia Context Snapshot

Table: Metric (year) → Value → Source → Collaborative capability match

- Rural counties (und. ≤50,000) → 120 (undated portal, current as of 2025) → Georgia Rural Health Innovation Center "By the Numbers" → Network design and service-line right-sizing via HVNs; regional tele-ER/ICU. [4]
- Critical Access Hospitals (2025) → 30 CAHs supported by GA Flex; SHIP supports 55 small rural/CAHs → GA SORH Hospital Services Program → Virtual hospital services, SHIP-aligned IT/cyber upgrades. [5]
- Counties without a rural hospital (2023 hearing) → 54 counties; rural PPS ≈37; CAH = 30 → GPB report from Senate study committee → Tele-ER, EMS support, transfer coordination; retail/pharmacy access. [6]
- FQHC awardees (2024) → 35; patients 748k → HRSA UDS GA state profile → RPM for cardiometabolic disease; behavioral integration; analytics. [7]
- Rural Health Clinics (~2022) → 98 clinics received HRSA testing allocations → HRSA RHC COVID testing allocation table → RPM and care management toolkits; telehealth enablement. [8]
- Medicaid coverage & CMOs (July 2025) → Medicaid CMO 1,587,559; FFS 598,061; 3 CMOs (Amerigroup, CareSource, Peach State) → DCH managed care dashboard → Actuarial modeling; SPA/DPP alignment; analytics. [9]
- 1115 waiver—Pathways to Coverage → Eligibility ≤100% FPL; activity verification; extensions/updates effective Oct 1, 2025 with retro coverage; runs through 12/31/2026 → Pathways site and Governor release → Analytics, reporting, and member engagement supports. [10][11][12]
- Broadband (2023–2025) → NTIA BEAD ≈$1.307B for GA; unserved locations ≈161,301 (FCC 2022 fabric, aggregated May 2025) → NTIA/BEAD and Broadband Expanded → Telehealth reach planning; device and connectivity targeting; security baselines. [13][14]
- Maternal & infant health → U.S. maternal mortality 22.3 (2022); GA infant mortality 10.74 per 1,000 (2023); GA postpartum extensions and maternal focus → CDC/NCHS; GA Governor/DCH releases → CCBHC tie-ins, remote monitoring in prenatal/postpartum; tele-MFM consultation. [15][16][17]
- Data exchange → GaHIN is state-designated HIE; connections to Carequality; social care integration initiatives (2024–2025) → DCH/GaHIN → Architecture for measures, ADT alerts, SDOH integration. [18][19]

Narrative highlights

- Access gaps: 54 rural counties without a hospital and 231 primary care HPSAs (586 practitioners needed) indicate significant geographic shortages (HRSA summary via Health Guide USA, March/July 2025). [20][21]

- Behavioral health: DBHDD is phasing CCBHCs statewide, with multiple CSBs targeted to begin Medicaid CCBHC billing in January 2026. [22]
- Payment and sustainability: Georgia operates multiple Medicaid directed-payment programs (PDPP, HDPP public/private, GA-AIDE, GA-STRONG) that can be analytically aligned to support RHT initiatives and rural networks. [23][24][25][26]

Assumptions and Open Questions (for validation before submission)

- NOFO specifics (e.g., page limits; scoring weights; caps such as provider payments, capital, EMR replacement, administrative) should be validated against the final CMS-RHT-26-001 NOFO attachments on Grants.gov; this guide cites CMS public pages for program structure and deadlines where available. [2][3]
- Frontier county definition and counts in Georgia (likely none by HRSA frontier criteria) require confirmation if used for scoring.
- Latest county-level ABAWD waiver status under SNAP (B.3 factor) should be referenced from FNS FY2025 materials for Georgia. [27][28]

4. Strategy Aligned to RFP

Georgia rural transformation model (architecture)

- Regionalized acute and specialty access layer: Tele-ER, tele-ICU, tele-hospitalist, tele-pharmacy and crisis behavioral/988 integration to stabilize local care, reduce transfers, and support lone clinicians (Avel eCare; Cibolo).
- Community-first primary and chronic care layer: FQHC/RHC practice enablement with RPM (BioIntelliSense), multi-language intake/triage and PHR tools (Humetrix), and pharmacy-based monitoring/adherence programs (CVS/Walgreens/Walmart), coordinated with GaHIN and county EMS for alerts/paramedicine.
- Data and cybersecurity backbone: Azure-based data lakehouse, analytics, identity and threat protection, integration with GaHIN/Carequality; CMS Blue Button/claims ingestion; program dashboards for RHT KPIs. [18][19]
- Governance and value pathway: Rural High Value Networks (HVNs) convened by Cibolo Health for shared services (staffing pools, tele-on-call rosters, vendor panels), standard outcomes, and payment model readiness (e.g., Medicaid value components, DPP alignment).

Alignment to RHT pillars and technical factors

- Prevention/chronic disease: RPM + pharmacy adherence + retail screening; predicted impact on ED visits and readmissions; documented partner deployments (Viz.ai, RPM, kiosk screening).
- Sustainable access and EMS: Tele-ER/ICU coverage; stroke AI for rapid triage; tele-pharmacy; rural transfers minimization.
- Workforce: Ambient scribing; tele-mentoring; recruitment pipelines with schools and pharmacist scope optimization.
- Innovative care/payment: HVNs to negotiate/value-share; claims exchange and payment integrity analytics (Accenture) to support fair reimbursement and cost-of-care tracking.
- Technology innovation and cyber: Security program and identity governance; structured integration with GaHIN and Carequality; TEFCA/QHIN connections via members. [18][19]

Equity strategy (rural, Tribal, vulnerable)

- Target risk stratification leveraging claims/HIE plus community screening; multi-language triage; mobile outreach with retail/faith partners; pharmacist-led chronic disease programs in underserved counties; alignment with Pathways populations and maternal health initiatives. [10][11][15]

Data use and privacy

- Minimum necessary data; HIPAA/FedRAMP-aligned controls; GaHIN data-sharing agreements; patient consent tools through consumer apps; role-based access with audit trails. [18][19]

5. Program Design Options (Georgia-tuned)

Option A (Primary) — Rural Acute Access and Stabilization Network

- Target: Counties without hospitals and CAHs at risk (54 counties lacking hospitals; 30 CAHs). [5][6]

- Problem: ED boarding, avoidable transfers, delays in stroke/AMI/sepsis intervention.
- Components: Tele-ER/ICU/hospitalist; tele-pharmacy; stroke AI; EMS tele-consult; nursing/physician tele-mentoring.
- Payment logic: Short-term service payments (≤ NOFO caps), CAH support under Flex/SHIP complements; Medicaid value components measured via DPP quality metrics. [23][25]
- Enabling policy: DPH EMS protocols; facility privileging; CMO contracting.
- Partners/staffing: Avel eCare; participating CAHs/PPS; DPH/EMS; GaHIN; CMOs; SI partners.
- Pros/risks: Rapid impact on access; staffing relief vs. credentialing/tele-privileging timelines.

Option B — Statewide Cardiometabolic RPM + Retail-Enabled Care

- Target: Adults with HTN/diabetes/HF; maternal hypertension risk; FQHC/RHC panels.
- Components: BioIntelliSense RPM; pharmacist adherence programs; Humetrix triage; GaHIN alerts; retail kiosks/screenings.
- Payment logic: Medicaid coverage (state policy for CGM and RPM where applicable), CMOs care-management incentives, limited direct service payments within caps. [29]
- Policy: Telehealth parity and licensure compacts (IMLC, NLC, PSYPACT) ease access across scarce specialties. [30][31][32]
- Pros/risks: Broad reach via retail/pharmacies; requires device logistics and data operations.

Option C — Rural Behavioral Health and CCBHC Acceleration

- Target: CSBs moving to CCBHC certification/billing (2026 targets); counties with high OUD/MH need. [22]
- Components: Tele-psych and crisis support; CCBHC data and quality reporting; patient-facing risk alerts for opioid safety (Humetrix).
- Payment logic: CCBHC Medicaid state plan benefit/ demonstration; CMS quality measures. [33][34]
- Pros/risks: High-need focus; requires DBHDD certification timelines.

Option D (Backup) — Rural High Value Networks (HVNs) and Shared Services

- Target: Independent rural hospitals/clinics organizing for shared operations and value-based models.
- Components: HVN governance; revenue-cycle shared services; clinical engineering; group purchasing of RPM/telehealth/cyber; VBC analytics.
- Payment logic: Align with GA DPPs; test global/episode components in Medicaid managed care; commercial payer pilots. [23][24][25]

6. Governance and Collaborative Roles

- Structure: State PMO (DCH/SORH/Medicaid) provides direction; HVN(s) provide provider governance; GaHIN manages data connectivity; CMOs align incentives; the Collaborative provides integration, technology, clinical virtual services, and measurement support. RACI (illustrative)
- Accountable: DCH (PMO, compliance, funds flow).
- Responsible: HVN(s) and participating providers (operations), Collaborative members for specific deliverables: Avel (tele-acute), BioIntelliSense (RPM), Humetrix (consumer apps/analytics), Microsoft (cloud/cyber), Accenture/KPMG/PwC (PMO/evaluation), Cibolo (HVN governance), retail (access programs).

7. Payment and Funding

- Alignment with Georgia Medicaid: Use DPPs (PDPP, HDPP public/private, GA-AIDE, GA-STRONG) as sustainable complements to RHT-funded start-up activities; ensure no duplication or supplanting; link RHT pilots to DPP quality targets where feasible. [23][24][25][26]
- Example funding table (ROM, illustrative; confirm NOFO caps before final): • Workstream (tele-ER/ICU): service contracts, devices, credentialing, analytics → RHT categories F, G, H; DPP/CMO quality incentives. • RPM: devices/operations/training → RHT A, C, D, F; CMO disease-mgt incentives; FQHC/RHC Medicare/Medicaid RPM codes where covered. [29] • Cyber/data: cloud tenancy, identity, SIEM/SOC, GaHIN integration → RHT F; state IT/cyber programs.

8. Data, Measurement, and Evaluation

- Data sources: Medicaid claims/encounters (CMOs), GaHIN query/ADT, provider EHRs, retail/consumer apps, EMS CAD/EPCR, DBHDD CCBHC reporting.
- Measures (examples): • Access: time-to-specialist; tele-ER coverage hours; EMS on-scene consults. • Quality/outcomes: HTN control; diabetes A1c; readmissions; maternal hypertension follow-up; MH/SUD engagement. • Financial: avoidable transfers; bed-day utilization; net cost per beneficiary.
- Enablers: GaHIN connectivity and Carequality exchange; cloud analytics; consent and privacy workflows. [18][19]

9. Implementation Plan (12–24 months; indicative)

Gantt-style table (months are relative to award)

- Workstream | Start | End | Owner | Outputs • PMO setup & governance | M0 | M2 | DCH+SI | Charter, RACI, reporting plan • GaHIN integration & cloud landing zone | M0 | M6 | GaHIN+Microsoft | Data pipes, security baselines • Tele-ER/ICU wave 1 (10 sites) | M3 | M12 | Avel+Hospitals | 24/7 coverage, KPIs live • RPM phase-in (FQHC/RHC cohorts) | M4 | M18 | BioIntelliSense+FQHCs | Panels enrolled, alerts live • Retail screening pilots (10 counties) | M5 | M14 | Retail partners | Kiosk+app engagement reports • HVN formation & shared services | M2 | M10 | Cibolo+Providers | Bylaws, service catalog • Behavioral/CCBHC enablement | M6 | M18 | DBHDD+Providers | Reporting, tele-BH capacity • Evaluation baseline & dashboards | M0 | M6 | PMO+SI | KPI baseline and targets • Wave 2 scale-up | M12 | M24 | PMO+All | Expanded coverage, KPI gains

Procurement/legal actions (illustrative): statewide multi-vendor telehealth/RPM master contracts; BAA/DUA with GaHIN; CMO contract amendments for incentives; facility credentialing/tele-privileging; interstate compacts usage (IMLC/NLC/PSYPACT) for specialty coverage. [30][31][32]

10. Risk Register (selected)

- Credentialing/privileging delays → Mitigation: standardized tele-privileging templates and HVN credentialing hub; Owner: PMO/HVNs.
- Data-sharing friction → Mitigation: GaHIN participation agreements; consent workflows in apps; Owner: GaHIN/Providers. [18][19]
- Device logistics/adherence → Mitigation: navigator training; pharmacist follow-up; automated reminders; Owner: Providers/Retail.
- Cyber incidents → Mitigation: zero-trust identity, SOC monitoring, tabletop exercises; Owner: PMO/IT.
- Workforce acceptance → Mitigation: ambient scribe rollout, tele-mentoring; Owner: Providers/PMO.
- Payment misalignment → Mitigation: DPP alignment/quality addenda; actuarial modeling with CMOs; Owner: Medicaid/DCH. [23][24][25]
- Broadband gaps → Mitigation: BEAD coordination and device-alternatives (cellular RPM); Owner: PMO/Broadband Office. [13][14]
- Pathways reporting burden → Mitigation: automation of verifications, data feeds; Owner: Medicaid/IT. [10][11]
- Licensure barriers for cross-site specialty → Mitigation: use IMLC/NLC/PSYPACT; Owner: PMO/Boards. [30][31][32]
- NOFO cap noncompliance → Mitigation: budget guardrails and reviews tied to caps; Owner: PMO/Finance. [3]

11. Draft RFP Response Language (paste-ready excerpts; Georgia-tailored; conditional)

11.1 Project Summary (abstract)

The State of Georgia, through its Department of Community Health (DCH), proposes a Rural Health Transformation initiative to improve access, outcomes, and sustainability in rural counties through coordinated virtual specialty coverage, community-based chronic care, and a secure data and cybersecurity backbone integrated with the Georgia Health

Information Network (GaHIN). DCH will partner—subject to procurement and contracting—with a multi-organization collaborative offering tele-acute services, remote patient monitoring, consumer engagement tools, cybersecurity, program management, and rural provider network governance. The program addresses at least three eligible uses (prevention/chronic disease, workforce and technology advancements, behavioral health/OUD/SUD) and aligns with CMS priorities and evaluation requirements. [1][18]

11.2 Goals and Strategies

Georgia will reduce avoidable transfers and stabilize ED/ICU coverage via virtual services; increase control of hypertension/diabetes with RPM and pharmacist-enabled adherence; and expand behavioral health access by supporting CCBHC readiness and tele-behavioral capacity. Data sharing will use GaHIN, Carequality connections, and a cloud analytics platform with privacy and security controls. [18][19]

11.3 Proposed Initiatives (examples)

- Rural Acute Access Network (tele-ER/ICU/hospitalist; stroke AI; tele-pharmacy). Sites: wave 1 CAHs and rural PPS hospitals; outcomes: 10% reduction in interfacility transfers and 15% improvement in time-to-stroke intervention within 12 months (baseline from hospital logs).
- Statewide Cardiometabolic RPM & Retail Engagement. Panels enrolled across 15 FQHCs/RHCs; outcomes: 10-point BP control improvement; 8% ED visit reduction for ambulatory-sensitive conditions by month 18.
- Behavioral Health Expansion via CCBHCs. Tele-psych coverage and crisis integration; outcomes: 20% increase in 7-day MH follow-up after ED and 15% increase in MOUD continuity at 90 days.

11.4 Implementation & Evaluation

The State will establish a PMO; execute phased deployments; and measure outcomes quarterly using Medicaid claims/encounters, GaHIN/ADT, hospital EHRs, and CCBHC metrics. Dashboards will track access, quality, equity, and financial indicators; Georgia will cooperate with CMS evaluation. [1][18][19]

11.5 Sustainability

Initiatives are designed to transition to Medicaid managed care incentives, directed-payment programs (HDPP, PDPP, GA-AIDE, GA-STRONG), and scalable provider-led HVNs post-grant. [23][24][25][26]

12. References

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Internal (Collaborative consensus document): Rural Health Transformation Collaborative. R1. 10-11-25.pdf. Selected citations appear inline using the special marker.

13. AI Generation Notice

This guide was generated by the gpt-5 model on 2025-10-14. It is AI-generated content. Readers must independently validate all facts, figures, NOFO requirements (including caps and page limits), and citations before use in any official submission.

Checklists

- Compliance (pre-award): • Verify CMS-RHT-26-001 NOFO caps, formats, page limits, and scoring references in Grants.gov attachments. [3] • Confirm Georgia data baselines (claims, hospital transfer rates, HPSA counts) and CMS measurement definitions. • Validate subrecipient monitoring plan and flow-down terms per 2 CFR and HHS GPS.
- Technical readiness: • GaHIN connectivity and BAA/DUA in place. [18] • Security controls (identity, logging, vulnerability management, data loss prevention) operational. • Tele-privileging and licensure pathways documented (IMLC/NLC/PSYPACT). [30][31][32]

- Budget guardrails: • Map each budget line to an initiative and an RHT allowable use; track administrative cost ratio and category caps; ensure non-duplication with DPP/other funds. [1][23]

Gantt-style workplan (condensed)

- M0–M2: PMO; governance; GaHIN/Cloud ATO (authority to operate).
- M2–M6: Tele-ER/ICU wave-1 contracts; RPM device logistics; retail MOUs.
- M6–M12: Behavioral/CCBHC enablement; HVN legal formation; dashboards live.
- M12–M24: Wave-2 expansion; evaluation cycles; sustainability/Medicaid alignment.

Note on style and language All implementation statements herein are conditional and subject to state procurement, contracting, and integration with Georgia's governance, Medicaid policy, and HIE infrastructure.

- Avel eCare virtual hospital and 24/7 services.
- BioIntelliSense RPM platform and training.
- HVN governance via Cibolo Health.
- Consumer-facing triage and PHR apps (Humetrix).
- AI stroke detection and workflow tools.
- Workforce supports (ambient AI, tele-mentoring, pharmacist pipeline).

End of guide.