Rural Health Transformation Grant Guide — Alabama

VERSION: 1.0

DATE: 2025-10-13

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary Alabama can leverage the Rural Health Transformation (RHT) Program to stabilize rural access, strengthen workforce capacity, modernize digital infrastructure, and reduce avoidable morbidity in high-need regions such as the Black Belt—subject to State priorities, procurement, and data-sharing agreements. The RHT Collaborative's members can support Alabama with coordinated virtual specialty backup for rural hospitals and EMS (Avel eCare), continuous physiologic monitoring and exception-based care for chronic disease (BioIntelliSense), population analytics and multilingual digital front doors (Humetrix), AI-assisted time-critical diagnosis (Viz.ai), retail-pharmacy–enabled outreach and adherence programs (Walgreens, CVS), and governance models for provider networks (Cibolo Health). These capabilities align with the RHT NOFO's allowable uses, technical scoring factors, and evaluation framework.

The RHT NOFO is a cooperative agreement for States only; applications are due November 5, 2025, with optional LOI by September 30, 2025, and awards expected December 31, 2025. Funds are distributed over five budget periods (FY26–FY30); 50% is baseline (equal among approved States) and 50% is workload-based using a points system that combines rural facility/population factors and technical factors. Program-specific caps include: provider payments ≤15%/year; capital & infrastructure ≤20%/year; EMR replacement (if a HITECH-certified system was in place as of 9/1/2025) ≤5%; administrative costs (including indirect) ≤10%/year. Construction and cosmetic expansions are unallowable, and household broadband subsidies are not fundable under this NOFO. (files.simpler.grants.gov) (files.simpler.grants.gov) (files.simpler.grants.gov)

Alabama's starting position underscores both need and opportunity. In 2020, 42.3% of Alabamians lived in rural areas; 55 of 67 counties are classified rural by ADPH's Office of Primary Care & Rural Health (OPCRH). Rural labor-and-delivery capacity is thin (15 rural counties have L&D units), ambulance response differentials persist, and infant mortality was 7.8 per 1,000 in 2023 with pronounced racial disparities. Targeted RHT investments—e.g., statewide tele-ER/ICU networks, maternal tele-perinatal support, pharmacy-anchored hypertension/diabetes management, and home telemonitoring—can support measurable improvements, contingent on contracting and integration with Alabama Medicaid's ACHN model. (ncsl.org) (alabamapublichealth.gov) (alabamapublichealth.gov) (medicaid.alabama.gov)

Alabama's broadband plan (BEAD) received federal approval for a $1.4B deployment to close remaining gaps; RHT can complement (not duplicate) these investments by funding cybersecurity, clinical data platforms, connected devices, and telehealth equipment for rural providers. The NOFO allows IT advances and cybersecurity, but not household internet subsidies; alignment with ADECA's BEAD build-out and HIE/HIPAA/FHIR practices is critical. (adeca.alabama.gov) (files.simpler.grants.gov)

One-page printable summary

- Opportunity: CMS RHT cooperative agreement for States (FY26–FY30; application due Nov 5, 2025). Funds: ~$50B across five periods; equal baseline + points-weighted workload. (files.simpler.grants.gov)
- Key NOFO limits: Provider payments ≤15%; Capital & infrastructure ≤20%; EMR replacement ≤5% (if prior HITECH-certified EMR); Admin including indirect ≤10%; no construction; banned items per 2 CFR and 45 CFR 156.400; no household broadband subsidies. (files.simpler.grants.gov)
- Alabama need snapshot (latest available): 42.3% rural (2020) and 55 rural counties; only 15 rural counties with L&D units; 2023 infant mortality 7.8/1,000; high opioid dispensing (71.4 per 100 in 2023). (ncsl.org) (alabamapublichealth.gov) (alabamapublichealth.gov) (cdc.gov)
- Primary supports the Collaborative can provide (conditional on procurement/agreements): • Virtual hospital services: tele-ER, tele-ICU, tele-pharmacy; transfer decision support (Avel eCare). • Continuous vitals and exception-based chronic care (BioIntelliSense). • Consumer engagement, multilingual triage, claims/EHR analytics (Humetrix). • Stroke AI/risk detection and care coordination triggers (Viz.ai). • Retail pharmacy outreach, adherence, tele-services (Walgreens/CVS).
  • High Value Networks (HVNs) governance and stewardship (Cibolo Health). • Program management, value tracking, cybersecurity, and data platforms (Accenture/Microsoft).

2. Eligibility and RFP Fit 2.1 Snapshot of the RHT NOFO

- Applicant: One State government (50 States eligible; DC/territories ineligible). Governor designates a lead agency; AOR signs. Single official application; latest on-time submission counts. (files.simpler.grants.gov)
- Key dates: Optional LOI 9/30/2025; application due 11/5/2025 11:59 p.m. ET; expected award/earliest start 12/31/2025. Webinars Sept 19 & 25, 2025. Maintain SAM/UEI; submit via Grants.gov. (files.simpler.grants.gov)
- Distribution: Baseline 50% (equal), Workload 50% (relative points). Rural facility/population factors and technical factors weighted per Table 3. (files.simpler.grants.gov)

- Selected limits: Provider payments ≤15%; Capital/infrastructure ≤20%; EMR replacement ≤5% (if HITECH EMR in place 9/1/2025); Admin (incl. indirect) ≤10%; no construction/cosmetic buildouts; no household broadband subsidies. (files.simpler.grants.gov)

2.2 Scoring detail (Table 3 highlights)

- Rural facility & population (50% total): A.1 rural population size 10%; A.2 proportion of rural facilities 10%; A.3 uncompensated care 10%; A.4 % population rural 6%; A.5 frontier metric 6%; A.6 land area 5%; A.7 % hospitals receiving Medicaid DSH 3%. (files.simpler.grants.gov)
- Technical factors (50% total): B–F categories including population health, partnerships, EMS, licensure compacts, scope of practice, provider incentives, duals, STLDI policy, remote care, data infrastructure, consumer tech. Conditional credit in Year 1 for proposed policy changes; must finalize by Dec 31, 2027 (Dec 31, 2028 for B.2/B.4) or points drop to 0 and related funds are recovered. (files.simpler.grants.gov)

2.3 Compliance checkpoints

- 2 CFR Part 200/300 apply; lobbying and covered telecom restrictions; program-specific unallowables as listed; salary rate cap; program income rules; noncompliance remedies include withhold/recovery and points reductions. (files.simpler.grants.gov)

2.4 Requirement → Collaborative capability → Evidence (examples)

- Provider network partnerships (C.1): Member-owned rural HVNs with spend tracking and compliance support (Cibolo Health) → past deployments and governance toolkits.
- Remote care services (F.1): Statewide tele-ER/ICU, tele-pharmacy, tele-behavioral backup (Avel eCare) → Joint Commission–accredited virtual hospital model.
- Data infrastructure (F.2): Secure cloud, PHI security, analytics, dashboards (Microsoft + advisors) → cybersecurity and outcomes/value tracking references.
- Consumer-facing tech (F.3): Multilingual triage, patient-facing PHR and risk guidance (Humetrix); pharmacy outreach and adherence (Walgreens/CVS) → product descriptions and program metrics.

3. Alabama Context Snapshot 3.1 Demography and facility mix (selected indicators, latest available)

- Rural share: 42.3% (2020 Census). (ncsl.org)
- Rural counties: 55 of 67; only 15 rural counties with L&D units; 54 rural county hospitals serve 42 of the 55 rural counties (ADPH, 2025). (alabamapublichealth.gov)
- Infant mortality: 7.8 per 1,000 (2023), with Black infant mortality 13.2 vs 5.7 for White infants. (alabamapublichealth.gov)
- CAHs: Six critical access hospitals (ADPH "At a Glance," 2025). (alabamapublichealth.gov)
- FQHCs: 17 awardees reporting (UDS 2024). (data.hrsa.gov)
- RHCs: Multiple sources suggest >100 RHCs (e.g., HRSA COVID testing allocation listed 121 in 2020; counts vary by year/data system). (hrsa.gov)
- EMS response: rural 11–15 minutes on average; up to 30 minutes in some counties (ADPH, 2025). (alabamapublichealth.gov)
- Overdose/behavioral health: Opioid dispensing 71.4 per 100 persons (2023), among the highest states; drug-overdose mortality 33.9 per 100,000 (2023 provisional). (cdc.gov) (cdc.gov)
- Broadband: Alabama's BEAD plan approved for $1.4B; 2025 final plan submitted to NTIA, targeting >101,000 eligible locations. (adeca.alabama.gov) (broadband.alabama.gov)
- Medicaid delivery system: Alabama Coordinated Health Network (ACHN) is a State-run, regional care management model (seven regions); not full-risk managed care. Recent SPA (AL-25-0003) increased ACHN-related bonus-enhanced payments. (medicaid.alabama.gov) (medicaid.gov)
- Maternal/OB access: In rural Alabama, 89.8% of women live >30 minutes from a birthing hospital (ADPH). (alabamapublichealth.gov)
- Recent closure risk: Thomasville Regional Medical Center suspended operations in Sept 2024; sale approved May 2025 with intent to reopen—illustrates fragility and the value of regional networks. (stateline.org)

3.2 Metric-to-capability matching (illustrative)

- OB deserts and infant mortality → maternal tele-perinatal hub-and-spoke, pharmacy-enabled postpartum supports, remote BP/diabetes monitoring (Avel eCare, Walgreens/CVS, BioIntelliSense).

- High opioid dispensing/overdose → pharmacy naloxone/adherence programs and behavioral tele-care; AI to flag risks, multilingual engagement (Walgreens; Avel; Humetrix).
- EMS response differentials → tele-EMS consults and decision support; trauma routing analytics (Avel eCare).
- Broadband buildout → secure cloud, device hardening, and zero-trust posture for rural providers (Microsoft/advisors) without duplicating BEAD funding. (files.simpler.grants.gov)

Assumptions and Open Questions (for validation)

- Frontier metric: Using <6 persons/mi² definition, no Alabama county appears frontier in 2020 densities; the lowest (e.g., Perry, Wilcox, Greene) are above 11/mi². Confirm CMS's frontier methodology for RHT scoring. (law.cornell.edu) (beautifydata.com)
- RHC count: sources vary by year and method (e.g., 115–143). OPCRH/CMS POS extract should be the authoritative 2025 baseline for the application. (hrsa.gov)
- HPSA counts: State-level primary care HPSA population from HRSA dashboards should be pulled directly for the application tables; interim summaries were used here. (data.hrsa.gov)

4. Strategy Aligned to RFP 4.1 Transformation model (conditional)

- Regional Rural Provider High Value Networks (HVNs) to steward funds, pool shared services, and coordinate tele-specialty coverage while preserving local control—supported by Cibolo Health's governance toolkits and program stewardship methods.
- Hospital-to-home continuum for chronic disease and post-acute care: continuous wearable monitoring (BioIntelliSense) tied to ACHN care management and pharmacy adherence programs, with exception alerting and multilingual outreach for beneficiaries.
- Time-critical condition safety net: stroke and other acute AI triage (Viz.ai) connected to tele-ER/ICU specialists (Avel eCare) to reduce door-to-decision times in CAHs and small PPS hospitals.
- Digital foundation: secure data platform, HIPAA/FHIR interoperability, analytics dashboards, and rural cybersecurity hardening (Microsoft + advisors), integrated with State reporting to satisfy NOFO evaluation and continuation criteria.

4.2 Alignment to NOFO pillars and technical scoring

- B.1/B.2 population health: RPM + retail screening + ACHN QI measures. (medicaid.alabama.gov)
- C.1 partnerships: HVNs formalized with transparent fund stewardship.
- C.2 EMS: tele-EMS consults, rural protocols, and trauma routing.
- D.1 workforce: ambient documentation tools and tele-mentoring to ease burnout and support recruitment/retention.
- D.2 licensure compacts: Alabama participates in IMLC and the Nurse Licensure Compact; PSYPACT enacted—positions rapid cross-state coverage with appropriate licensing and privileging. (albme.gov) (abn.alabama.gov) (psypact.gov)
- D.3 scope of practice: pharmacy-enabled chronic disease support can be expanded where permitted; programs are configurable to State policy.
- E.1 provider incentives & E.2 duals: analytics to structure bonus-enhanced payments and track dual-eligible outcomes; ACHN alignment. (medicaid.gov)
- E.3 STLDI: Alabama allows STLDI under federal limits (3-month initial, max 4 months effective Sept 1, 2024); analytic tools can quantify impacts on uncompensated care and coverage gaps. (insurance.alabama.gov) (aha.org)
- F.1–F.3 remote/data/consumer tech: statewide virtual services, secure cloud, multilingual engagement and patient-facing PHR apps.

4.3 Equity strategy Focus on Black Belt counties with higher infant mortality and limited OB access; leverage FQHCs and retail pharmacies as trusted access points; deploy multilingual tools and remote monitoring kits with digital literacy supports; use dashboards to monitor disparities by race/ethnicity and geography and adjust interventions. (alabamapublichealth.gov)

4.4 Data use and privacy Use HIPAA-compliant, FHIR-based platforms, role-based access, consent management, and audit logging; adopt zero-trust security controls. Where RHT funds support IT, align to State CIO standards and 2 CFR requirements; exclude household broadband subsidies per NOFO. (files.simpler.grants.gov)

5. Program Design Options (tailored to Alabama; all subject to contracting/integration) Option A: Rural Acute Care Safety Net

- Target: CAHs/small PPS hospitals in rural counties with high transfer rates.

- Problem: ER coverage gaps and delayed specialty access; example closure risk (Thomasville) underscores fragility. (stateline.org)
- Solution set: 24/7 tele-ER/ICU/hospitalist and tele-pharmacy; AI stroke detection; transfer coordination; EMS tele-consult. (Avel eCare, Viz.ai).
- Payment logic: ≤15% provider payment cap via gap-filling bundles (e.g., standby coverage), paired with quality incentives; capital ≤20% for devices/tele-ICU carts. (files.simpler.grants.gov)
- Policy enablers: Maintain CON compliance; consider EMS protocol updates. (alabamapublichealth.gov)
- Pros/risks: Rapid access lift; risk of low adoption without local champions; mitigated via HVN governance and on-site training.

Option B: Chronic Disease@Home + Pharmacy Integration

- Target: Medicaid/dual-eligible adults with diabetes/HTN/COPD in Black Belt counties.
- Problem: High mortality drivers; limited primary care access; adherence challenges. (alabamapublichealth.gov)
- Solution set: Wearable RPM + ACHN case management; pharmacist BP checks, MTM, and tele-visits; multilingual engagement and PHR apps. (BioIntelliSense, Walgreens/CVS, Humetrix).
- Payment logic: RHT supports device/services (not duplicating billable services); incentives through ACHN quality measures; ≤15% provider payments. (files.simpler.grants.gov) (medicaid.alabama.gov)
- Pros/risks: Avoided ED visits/readmissions; risk of digital divide—mitigated by device kitting, training, and leveraging BEAD progress. (adeca.alabama.gov)

Option C: Maternal Tele-Perinatal and Postpartum Care

- Target: Rural moms, especially in OB deserts.
- Problem: Long travel times, limited OB coverage; 2023 IMR 7.8; postpartum risks. (alabamapublichealth.gov)
- Solution set: Tele-MFM consults, remote BP/BG monitoring, pharmacy BP cuffs and counseling, presumptive Medicaid eligibility support messaging; ACHN postpartum visit focus. (Avel eCare, BioIntelliSense, Walgreens/CVS; ACHN). (medicaid.alabama.gov)
- Payment logic: Use RHT for devices/TA; align with ACHN incentives; consider non-construction minor renovations ≤20%. (files.simpler.grants.gov)
- Pros/risks: Improves timeliness of care; risk: privacy and consent—mitigated via robust consent workflows and secure data exchange.

Option D: Rural EMS-to-Home Community Paramedicine

- Target: High-utilizers and post-discharge patients in counties with longer response times.
- Problem: Avoidable transports and readmissions; delayed follow-up. (alabamapublichealth.gov)
- Solution set: Tele-enabled community paramedicine, remote monitoring kits, care navigation handoffs to ACHN. (Avel eCare, BioIntelliSense, ACHN).
- Payment logic: RHT funds for training/equipment; explore Medicaid SPA for community paramedicine if desired. (files.simpler.grants.gov)

6. Governance and Collaborative Roles 6.1 Partner map (illustrative)

- Lead agency (designated by Governor): Program oversight, policy interface, reporting to CMS.
- Alabama Medicaid: ACHN alignment, incentives, SPA coordination, duals/quality analytics. (medicaid.alabama.gov)
- Cibolo Health: HVN design, member agreements, compliance tracking, spend transparency.
- Avel eCare: Virtual hospital/EMS services; protocols; training.
- BioIntelliSense: RPM devices, clinical dashboards, training packages, outcomes reporting.
- Humetrix: Consumer apps, claims analytics, multilingual intake/triage.
- Walgreens/CVS: MTM/adherence, tele-enabled pharmacy services, community screening.
- Advisors (Accenture/KPMG/PwC): PMO, value tracking, cybersecurity/data platforms, procurement support.

6.2 RACI (selected)

- Program strategy and NOFO compliance: State (R), Advisors (A/C), HVN (C), Collaborative vendors (C). (files.simpler.grants.gov)
- Clinical model design and protocols: State clinical leads (A), Avel (R), HVN hospitals (R), Pharmacy partners (C).

- Data, security, reporting: State CIO/data office (A), Advisors+Microsoft (R), ACHN (C), vendors (C).
- Fund stewardship & subrecipient monitoring: State (A), HVN (R), advisors (C).

7. Payment and Funding

- RHT compliant structures: Limit direct provider payments to ≤15%; tie to gap-filling or transformation; use incentives aligned to metrics. Capital/infrastructure ≤20%; admin (incl. indirect) ≤10%. No construction/expansion as direct cost; EMR replacement ≤5% if prior HITECH EMR existed (as of 9/1/2025). (files.simpler.grants.gov)
- Medicaid alignment: Use ACHN quality measures and bonus-enhanced payments; coordinate SPA updates where needed (e.g., community paramedicine or postpartum supports) using analytic justifications from program dashboards. (medicaid.gov)
- Illustrative cost ROM and deliverables (annual, subject to scoping) • Tele-ER/ICU coverage for X rural hospitals: services + carts + training → clinical uptime SLA, transfer KPIs. (Capex within ≤20% and services within ≤15% if classified as provider payments). (files.simpler.grants.gov) • RPM kits for Y high-risk patients: devices, onboarding, dashboards → HbA1c/BP control, ED visit reductions. • Pharmacy adherence/MTM: staff time, digital outreach → proportion with controlled BP; 30-day readmissions. • Data/cyber platform: licenses/services → reporting automation to CMS; SOC2-aligned controls.

8. Data, Measurement, and Evaluation

- Core measures: access (tele-visit availability, transfer avoidance), quality (HEDIS HbA1c<8, BP control), maternal (PPC), utilization (ED visits/1,000), opioid dispensing trends, readmissions, safety (stroke-to-notification time), program implementation milestones (initiation, adoption). (cdc.gov) (medicaid.alabama.gov)
- Data sources: Medicaid claims (ACHN), hospital EHR feeds, EMS CAD, pharmacy MTM systems, State HIE, vital stats; consumer tools (Humetrix) for patient-reported data.
- Cadence: monthly operational dashboards; quarterly KPI review; annual continuation application reporting per NOFO. (files.simpler.grants.gov)
- Evaluation: Independent analytics with transparent baselines, FSP (full score potential) documentation for initiatives, and relative-to-peer reporting where NOFO is “data-driven.” (files.simpler.grants.gov)

9. Implementation Plan (indicative 24-month workplan; contingent on award and contracting) Gantt-style table (calendar months)

- Workstream | Start | End | Owner | Outputs
- Program governance setup (HVN charters, PMO) | Jan 2026 | Mar 2026 | State/Cibolo/Advisors | Governance charter; risk plan.
- Data platform & cybersecurity hardening | Jan 2026 | Aug 2026 | Advisors+Microsoft | Data lake, connectors, SOC controls, reporting baseline.
- Tele-ER/ICU deployment wave 1 (X sites) | Mar 2026 | Sep 2026 | Avel/HVNs | Go-live; coverage rosters; protocols; training.
- RPM cohort 1 (Y patients) | Apr 2026 | Dec 2026 | BioIntelliSense/ACHN | Onboarded patients; exception pathways; KPI baselines.
- Pharmacy adherence pilots (select counties) | May 2026 | Dec 2026 | Walgreens/CVS | MTM workflows; adherence metrics; referral loops.
- Maternal tele-perinatal hub pilots | Jun 2026 | Mar 2027 | Avel/ACHN | Tele-OB coverage; postpartum RPM; PPC tracking.
- Wave 2 scale (all above) | Oct 2026 | Dec 2027 | State/HVNs | Expanded coverage; continuous improvement.
- Reporting & continuation app | Ongoing | Annual | State/Advisors | Quarterly/annual submissions per NOFO. (files.simpler.grants.gov)

Milestones/gates: contracting completed; data-use agreements signed; site readiness; clinical governance approval; cybersecurity acceptance.

10. Risk Register (selected)

- Adoption risk at rural sites → Mitigation: HVN governance, local champions, phased training (Owner: HVN/State).
- Workforce burnout/turnover → Mitigation: tele-mentoring, ambient documentation tools (Owner: Avel/Advisors).
- Data-sharing delays → Mitigation: early DUAs, standardized FHIR APIs (Owner: State CIO/Advisors).

- Cyber incidents → Mitigation: zero-trust, MDR/SIEM, tabletop exercises (Owner: State/Advisors).
- Financing classification errors vs NOFO caps → Mitigation: pre-award budget scrub; continuous cap monitoring dashboards (Owner: State/Advisors). (files.simpler.grants.gov)
- Policy conditional-points lapse (2027/2028) → Mitigation: legislative liaison calendar, checkpoint reviews (Owner: State). (files.simpler.grants.gov)
- Telehealth licensure/credentialing delays → Mitigation: leverage IMLC/NLC/PSYPACT; credentialing by proxy where permitted (Owner: State/Providers). (albme.gov) (abn.alabama.gov) (psypact.gov)
- Overlap with BEAD or other funds → Mitigation: funding matrix; exclude household broadband; coordinate with ADECA (Owner: State/ADECA). (files.simpler.grants.gov) (adeca.alabama.gov)
- EMS protocol variability across counties → Mitigation: standardized medical control protocols and tele-EMS SOPs (Owner: ADPH/Avel).
- Vendor performance variance → Mitigation: SLAs, performance-based payments, exit clauses (Owner: State/HVNs).

11. Draft RFP Response Language (pasting boilerplate; customize figures and site lists) 11.1 Project Narrative excerpt—Goals & strategies (Alabama) "Alabama's Rural Health Transformation Plan will improve timely access to essential services, reduce avoidable transfers, strengthen maternal and chronic disease outcomes, modernize rural cybersecurity and data analytics, and stabilize provider finances through networked delivery models. The State will deploy regional High Value Networks (HVNs) of rural hospitals and clinics to coordinate shared virtual services (tele-ER/ICU, tele-pharmacy, tele-behavioral), continuous home monitoring for chronic disease, and pharmacy-enabled adherence programs. These activities align to the RHT Program's strategic goals, allowable uses A, D, F, H, I, J, and K, and to technical factors B.1–F.3. All activities are subject to contracting, site readiness, and data-use agreements." (files.simpler.grants.gov)

11.2 Application compliance paragraph—Funding policy adherence "We will adhere to program-specific limitations including: provider payments not to exceed 15% of total annual award; capital and infrastructure not to exceed 20%; EMR replacement expenditures not to exceed 5% (where prior HITECH-certified EMR existed as of 9/1/2025); administrative expenses including indirect costs not to exceed 10%. No construction or cosmetic expansions will be charged to the award; covered telecom restrictions and lobbying prohibitions will be observed. Household broadband costs will not be charged to the award." (files.simpler.grants.gov)

11.3 Technical scoring alignment paragraph "Relative to Table 3 weighting, Alabama's plan addresses: (A) rural population/facility metrics and uncompensated care; (B–F) initiative-based and policy-action factors through HVN partnerships (C.1), EMS improvements (C.2), compacts (D.2), scope updates (D.3), Medicaid provider incentives (E.1), duals data/arrangements (E.2), remote care and data/consumer technology (F.1–F.3). Conditional points for policy actions will be finalized by Dec 31, 2027 (Dec 31, 2028 for B.2 and B.4) to avoid point and fund recovery." (files.simpler.grants.gov) (files.simpler.grants.gov)

11.4 Sustainability paragraph "We will document full-score potential (FSP) and sustainability for each initiative with baseline, milestones, and post-grant funding pathways (e.g., ACHN quality incentives, payer agreements, value-based arrangements). Annual continuation requests will evidence performance and financial sustainability per NOFO." (files.simpler.grants.gov) (files.simpler.grants.gov)

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