Rural Health Transformation Grant Guide — Mississippi

VERSION: 1.0

DATE: 2025-10-14

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Mississippi's large rural footprint and financially stressed delivery system make it a strong candidate for the CMS Rural Health Transformation (RHT) Program cooperative agreement (CMS-RHT-26-001). The NOFO offers a one-time application with funding across five budget periods beginning in FY 2026; applications are due November 5, 2025, with awards expected by December 31, 2025. Funding is split 50% baseline (equal among approved states) and 50% "workload" based on a point system that mixes rural facility/population factors and technical factors; the workload amount each period is proportional to points earned relative to peers. States may claim conditional points for proposed policy changes, but points (and associated funds) are at risk if actions are not finalized by 12/31/2027 (12/31/2028 for two preventive nutrition measures). (files.simpler.grants.gov)

The Rural Health Transformation Collaborative (the "Collaborative") can support Mississippi to assemble a compliant, evidence-based plan and to operationalize initiatives across prevention, workforce, technology, payment, and partnerships. Capabilities include: statewide virtual hospital support (tele-ER/ICU/hospitalist/behavioral health), remote physiologic monitoring, retail-integrated screening and care navigation, payer-aligned analytics, and cyber-secure data platforms. These are documented in the Collaborative's internal catalogue and member appendices (Avel eCare, BioIntelliSense, Microsoft, Viz.ai, Walgreens, Teladoc, NACHC, Cibolo Health, Accenture/KPMG/PwC/AVIA). Implementation would be subject to Mississippi procurement, contracting, and integration requirements.

Mississippi's rural profile underscores the opportunity. In 2020, 53.7% of Mississippians lived in rural areas, among the highest shares nationally. In 2025, Mississippi's rural healthcare assets included 29 Critical Access Hospitals (CAHs), 6 Rural Emergency Hospitals (REHs), 245 Rural Health Clinics (RHCs), and 238 rural-located FQHC sites (HRSA data as compiled by RHIhub). Medicaid is delivered statewide through managed care (MississippiCAN/CHIP) with Magnolia Health, Molina Healthcare, and TrueCare as Coordinated Care Organizations (effective July 1, 2025), which positions alignment with value-based models. (ncsl.org)

The guide that follows interprets NOFO requirements for Mississippi, maps them to Collaborative capabilities, and presents program design options that can improve access, stabilize rural facilities, and deliver measurable outcomes under the NOFO's scoring framework and funding limitations (e.g., caps on provider payments, capital, EMR replacement, and administrative costs). (files.simpler.grants.gov)

— One-page printable summary —

Mississippi and the CMS Rural Health Transformation Program (CMS-RHT-26-001)

- Key NOFO dates (ET): Optional LOI 9/30/2025; Application due 11/5/2025 11:59 p.m.; Expected award/earliest start 12/31/2025. One application per state; no cost sharing. (files.simpler.grants.gov)
- Funds and distribution: ~$50B total FY26–FY30 across up to 50 states. Annual funds: 50% baseline (equal split), 50% workload based on points from rural facility/population factors (50%) and technical factors (50%). (files.simpler.grants.gov)
- Critical caps/limits: Provider payments ≤15% of a period's award; capital & infrastructure (minor renovations/equipment) ≤20%; EMR replacement ≤5% if a HITECH-certified EMR existed on 9/1/2025; "Rural Tech Catalyst Fund"-like initiatives ≤ the lesser of 10% or $20M per period; admin (incl. indirects) ≤10%. (files.simpler.grants.gov)
- Mississippi context (latest available): Rural population share 53.7% (2020); CAHs 29; REHs 6; RHCs 245; rural-located FQHC sites 238 (2025). Medicaid MCOs (from 7/1/2025): Magnolia, Molina, TrueCare. (ncsl.org)
- Collaborative fit (examples, subject to contracting):
    - Tele-ER/ICU/hospitalist and 24/7 behavioral consults (Avel eCare).
    - Continuous remote monitoring for chronic and post-acute care (BioIntelliSense BioButton).
    - AI-supported detection and care coordination for time-sensitive conditions (Viz.ai).
    - Retail-based screening, chronic care support, and workforce pipelines (Walgreens/CVS/Walmart).
    - Cyber-secure data exchange, analytics, and program dashboards (Microsoft; SI partners).
    - Rural provider High Value Networks (Cibolo Health) for accountable governance.

2. Eligibility and RFP Fit

2.1 What the NOFO requires (selected highlights)

- Eligible applicant: One of the 50 U.S. states; DC/territories ineligible. Governor designates the lead agency; AOR must sign. One official application per state; latest on-time submission counts. (files.simpler.grants.gov)
- Key dates/deliverables: Optional LOI (9/30/2025); application due (11/5/2025); award/earliest start (12/31/2025). Project narrative ≤60 pages; budget narrative ≤20 pages; governor's endorsement letter; business assessment; program duplication assessment; standard forms (SF-424/424A/LLL; site locations). (files.simpler.grants.gov)
- Funding distribution and scoring: Baseline (equal share) + Workload (point-based). Points combine rural facility/population factors and technical factors, weighted 50/50 per Table 3, with detailed factor weights. (files.simpler.grants.gov)
- State policy actions and timing: Conditional points for proposed policy changes; must finalize by 12/31/2027 (or 12/31/2028 for two preventive nutrition factors) or face point loss and potential fund recovery. (files.simpler.grants.gov)
- Funding limits (selected): Provider payments ≤15%; capital & infrastructure ≤20%; EMR replacement ≤5% (if a HITECH EMR existed 9/1/2025); any "Rural Tech Catalyst Fund"-type initiative ≤ the lesser of 10% or $20M; administrative expenses (incl. indirects) ≤10%. Program follows 2 CFR Part 200 and Part 300; 2 CFR 200.216 covered telecom/video surveillance restrictions apply. (files.simpler.grants.gov)

2.2 Requirement–Capability mapping (illustrative)

- Requirement: Telehealth/remote care expansion; measurable outcomes.
    - Collaborative capability: Virtual hospital services and specialty backup for rural facilities (tele-ER/ICU/hospitalist; behavioral health). Evidence: Avel eCare's Joint Commission–accredited virtual hospital model for rural settings.
- Requirement: Chronic disease prevention and management using consumer-facing tech.
    - Capability: Retail-based risk screening (Higi/Topcon), multilingual triage/navigation (Humetrix), remote monitoring (BioIntelliSense), and tele-consults (Teladoc/Avel). Evidence: Collaborative portfolio and member descriptions.
- Requirement: Cybersecurity and data interoperability.
    - Capability: HIPAA/FHIR-aligned cloud data platforms and cybersecurity initiatives (Microsoft) with systems integration and program dashboards (SI partners). Evidence: Collaborative catalogue and member descriptions.
- Requirement: Strategic partnerships and governance for sustainability.
    - Capability: Provider-owned High Value Networks (HVNs) to pool resources and steward funds (Cibolo Health). Evidence: Collaborative appendix.

3. Mississippi Context Snapshot

- Rural population share: 53.7% (2020), among the highest in the U.S., signaling broad potential reach for statewide rural interventions. (ncsl.org)
- Rural facility mix (2025): 29 CAHs; 6 REHs; 245 RHCs; 238 rural-located FQHC sites (HRSA). Collaborative offerings can slot as shared services (e.g., tele-ER/ICU for CAHs/REHs; RPM for RHCs/FQHCs). (ruralhealthinfo.org)
- Medicaid delivery (2025): MississippiCAN/CHIP managed care through Magnolia Health, Molina Healthcare, and TrueCare (effective 7/1/2025), enabling value-based contracting pathways. (medicaid.ms.gov)
- Hospital distress: Mississippi has pursued state financing strategies to stabilize hospital finances (e.g., managed care rate reforms; public communications in 2023–2025). The RHT Program can complement, not supplant, these efforts. (apnews.com)
- Maternal and infant health: MSDH publishes maternal mortality reviews and infant mortality surveillance. Targeted

rural OB access and remote monitoring can align with these indicators and associated disparities. (msdh.ms.gov)

Table 3.1 Selected Mississippi metrics and matching Collaborative capability

- Rural population share 53.7% (2020, Census via NCSL). Fit: Statewide digital front door and RPM at scale (Humetrix, BioIntelliSense). (ncsl.org)
- Rural-located facilities (2025): 29 CAHs; 6 REHs; 245 RHCs; 238 rural FQHC sites (HRSA/RHIhub). Fit: Tele-ER/ICU and hospitalist coverage network; rural shared analytics; HVN governance. (ruralhealthinfo.org)
- Medicaid managed care (2025): Magnolia, Molina, TrueCare statewide. Fit: Value-based arrangements; claim analytics; payment integrity and program dashboards. (medicaid.ms.gov)
- Maternal/infant surveillance (MSDH reports portal). Fit: Remote maternity care bundles; tele-OB coverage; retail BP/glucose screening and CHW follow-up. (msdh.ms.gov)

Assumptions and Open Questions (for discussion, not commitments)

- Final counts of CCBHCs operating in Mississippi as of 9/1/2025 will be compiled from SAMHSA's locator and verified with MSDH prior to submission (not included here due to time-of-draft constraints).
- Broadband availability and BEAD/BEAM project locations will be referenced from Mississippi's broadband office and FCC maps to define priority counties; numbers are not quoted here pending verification.
- The budget illustrations below use an example envelope for clarity; CMS will determine actual award amounts during the award cycle.

4. Strategy Aligned to the RFP

4.1 Transformation model for Mississippi (conceptual)

- Organize an independent, provider-owned rural High Value Network (HVN) as the convening and accountability vehicle (with Mississippi as funder/grantor). The HVN can distribute shared services (tele-ER/ICU, virtual behavioral health, RPM, pharmacy-enabled chronic care, and cyber/data services) to CAHs/REHs/RHCs/FQHCs, paired with payer-aligned incentives.
- Emphasize three result chains: (a) KEEP CARE LOCAL (stabilize emergency and inpatient access via tele-specialty backup), (b) MANAGE CHRONIC DISEASE (RPM + team-based primary care + retail support), (c) CONNECT DATA TO PAYMENT (claims/HIE/EHR unification; performance analytics; payment integrity).

4.2 NOFO pillars and scoring dimensions

- Prevention/chronic disease: Consumer screening (retail kiosks/ophthalmic AI), multilingual intake/triage, RPM with exception-based alerts; outcomes include A1c/BP control and ED visits avoided.
- Workforce: Tele-mentoring and on-demand provider-to-provider consults; ambient documentation tools to reduce burnout; rural pharmacist and CHW integration.
- Partnerships: Rural–tertiary linkages and regional HVN governance for durable shared services investments.
- Data/cybersecurity: HIPAA/FHIR-aligned cloud stack; dashboards; program monitoring for CMS-required reporting.
- Scoring: Address both the rural facility/population factors and technical factors per Table 3; track conditional policy actions for the 2027/2028 deadlines to retain points/funds. (files.simpler.grants.gov)

4.3 Equity strategy

- Deploy screening, navigation, and RPM through rural FQHCs, RHCs, and retail sites in high-need counties; pair with CHW support, language access, and transportation arrangements to mitigate rural access barriers. Evidence and operational details are in Collaborative member materials (Humetrix, Walgreens, NACHC) and will be refined with Mississippi's PCAs and local partners.

4.4 Data use and privacy

- Use a state-authorized, HIPAA-compliant architecture with data-sharing agreements, minimum-necessary access,

audit logging, and zero-trust cyber controls; avoid 2 CFR 200.216 covered telecom/video surveillance. (files.simpler.grants.gov)

5. Program Design Options (Mississippi-tuned; not prescriptive)

Option A. Rural emergency and inpatient access stabilization

- Target: CAHs/REHs and rural EDs with limited specialist coverage.
- Problem: Intermittent coverage leads to transfers, quality variance, and revenue leakage.
- Collaborative services: Tele-ER/ICU/hospitalist; tele-pharmacy; stroke/ACS AI activation; on-call tele-behavioral.
- Payment logic: Hospital shared-savings and avoidable transfer metrics; value-based add-ons within Medicaid managed care arrangements.
- Enabling policy: EMS/transfer protocols; quality reporting; no disruption to licensure scope.
- Pros/risks: Pros—care local; staffing resilience; quality lift. Risks—adoption/training load; connectivity variability; mitigated via onboarding and redundancy plans (SI partners).

Option B. Rural maternal–infant continuum (surveillance-guided)

- Target: Rural counties with elevated infant/maternal indicators per MSDH reports.
- Problem: Gaps in prenatal access and chronic disease control drive adverse outcomes/disparities. (msdh.ms.gov)
- Services: Retail BP/diabetes screening and referral; RPM bundles for high-risk pregnancies; tele-OB consults; CHW navigation and home monitoring; pharmacy medication management.
- Payment logic: Prenatal/postpartum episode metrics; avoidable ED/inpatient utilization; bundled incentives via MCO contracts.
- Enabling policy: Use of CHWs; pharmacist scope within Mississippi law (points under technical factor D.3 if expanded).
- Pros/risks: Pros—earlier detection; reduced travel burden. Risks—device adherence; patient digital literacy; addressed via CHW/digital navigator support.

Option C. Rural chronic care and retail integration

- Target: Adults with diabetes/hypertension/CVD in RHCs/FQHCs and retail hubs.
- Services: Kiosk and ophthalmic AI screening; RPM for physiologic trends; pharmacist-led adherence and therapy management; multilingual triage and care navigation.
- Payment logic: Primary care capitation with pay-for-performance; adherence/ED-avoidance incentives via MCOs.
- Pros/risks: Pros—scale, convenience. Risks—data interoperability; mitigated through standards-based exchange on a state platform.

Option D. Data and cybersecurity "rural health nerve center"

- Target: State lead agency + HVN for analytics, reporting, and cyber hardening.
- Services: Cloud data platform; claims/EHR/HIE integration; program dashboards; vulnerability management and incident response playbooks; grant reporting automation.
- Pros/risks: Pros—performance transparency; compliance. Risks—change management; mitigated through SI partner enablement.

6. Governance and Collaborative Roles

6.1 Conceptual structure

- State (lead agency designated by Governor): Grantee; sets policy direction; oversees award; executes subawards.
- HVN (provider-owned): Operates shared services; tracks outcomes; peer accountability.
- Medicaid agency: Aligns managed care contracts, analytics, and payment incentives with program goals.
- SI partners: Program management office (PMO), procurement support, analytics, reporting, cybersecurity enablement.

6.2 RACI (illustrative)

- Strategy and NOFO application: State (R), Medicaid (A), HVN (C), SI (C), Collaborative members (I).
- Subaward framework and compliance: State (A), Medicaid (C), HVN (R), SI (C).
- Clinical services (tele-ER/ICU/behavioral): HVN (A/R), facility leaders (R), Avel eCare (R), State (I).
- RPM deployment and monitoring: HVN (A), BioIntelliSense (R), facilities (R), State (I).
- Retail integration and workforce: Walgreens/CVS/Walmart (R), HVN (A), NACHC/PCA (C), State (I).
- Data/cyber and dashboards: State (A), Microsoft (R), SI partners (R), HVN (C).

7. Payment and Funding

7.1 Alignment with NOFO funding policies

- Respect caps: Provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% if applicable; Catalyst-type initiatives ≤ the lesser of 10% or $20M; admin (including indirects) ≤10%. (files.simpler.grants.gov)
- Avoid duplication: No reimbursement for services otherwise billable under Medicaid/CHIP/Medicare unless gap-filling/transformative per NOFO. (files.simpler.grants.gov)

7.2 Medicaid opportunities (subject to State determinations)

- Managed care levers with Magnolia, Molina, TrueCare (from 7/1/2025): quality withholds/earn-backs; primary care capitation; chronic care RPM reimbursement; hospital avoidable transfer metrics; DSNP integration for duals. (medicaid.ms.gov)

7.3 Illustrative cost categories and deliverables (example, not a budget request)

- Clinical shared services (tele-ER/ICU; tele-behavioral) → Avel eCare coverage schedules, facility onboarding, KPI reports.
- RPM kits and clinical hub → BioIntelliSense devices, navigator training, alert protocols, outcomes dashboards.
- Retail/community screening and pharmacist services → MOUs, SOPs, adherence metrics, referral closure rates.
- Data/cyber platform and analytics → Cloud tenancy, data pipelines, KPI dashboarding, cyber hardening (without 2 CFR 200.216-covered equipment). (files.simpler.grants.gov)
- PMO and evaluation → SI-led workplan tracking, risk management, and independent evaluation support.

8. Data, Measurement, and Evaluation

- Core outcomes: Access (tele-consults, transfer rates), quality (e.g., stroke door-to-needle via AI activation), chronic disease control (A1c/BP), utilization (ED/inpatient), patient experience, workforce (vacancy/turnover), cybersecurity posture, and program implementation milestones.
- Data sources: Medicaid claims (MCO feeds), facility EHRs, RPM streams, EMS run data, HIE, retail/pharmacy systems, and social service referrals; all via HIPAA/FHIR integrations on the state platform.
- Reporting: Establish dashboards for monthly program management and meet CMS post-award reporting expectations (progress, financial, and performance) per Step 6 (Post-award requirements). (files.simpler.grants.gov)
- Evaluation: SI partners provide outcomes/value tracking toolsets and economic modeling; cooperate with CMS/third-party evaluators as required.

9. Implementation Plan

9.1 Gantt-style workplan (12–24 months; subject to contracting/integration)

Workstream | Start | End | Owner | Outputs

- Program governance (HVN formation, charters) | Jan 2026 | Apr 2026 | State/HVN | HVN bylaws, member agreements.
- Data/cyber platform setup | Jan 2026 | Jun 2026 | State/MS + SI | Cloud tenancy, data pipelines, security controls.
- Tele-ER/ICU deployment wave 1 (10–15 facilities) | Mar 2026 | Sep 2026 | HVN/Avel | Coverage schedules, SOPs, QA plan.
- RPM cohort launch (diabetes/CHF/COPD) | Apr 2026 | Dec 2026 | HVN/BioIntelliSense | Devices, navigator training, dashboards.
- Retail screening and pharmacist services pilots | May 2026 | Dec 2026 | HVN/Retail | Kiosk deployments, referral flows, adherence metrics.
- Managed care alignment and VBP contracting | Feb 2026 | Oct 2026 | Medicaid/MCOs | Incentive models, quality measures. (medicaid.ms.gov)
- Scale-up and optimization (waves 2–3) | Oct 2026 | Sep 2027 | HVN/State/SI | Expanded coverage; quarterly reports.

9.2 Milestones and gates

- Security ATO for state platform; facility onboarding certifications; payer contracts executed; first outcome reports within 90 days of go-live; policy checkpoints for 2027/2028 NOFO timelines. (files.simpler.grants.gov)

10. Risk Register (illustrative)

Risk | Mitigation | Owner

- Connectivity gaps delay tele-services | Redundant links; satellite failover; phased sites | HVN/State/SI
- Staffing adoption/burnout | Tele-mentoring; ambient documentation; training | HVN/Avel/MS partners
- Data-sharing hesitancy | Standard DSAs; minimum-necessary access; audit logs | State/SI
- Cyber incidents | Hardened architecture; 24/7 monitoring; IR playbooks | State/MS/SI
- RPM adherence | CHW/digital navigator support; escalation rules | HVN/BioIntelliSense
- Vendor integration delays | PMO gating; interface templates; testing sprints | SI
- Payment friction with MCOs | Early measure alignment; shared dashboards | Medicaid/MCOs/SI (medicaid.ms.gov)
- Capital scope creep | Enforce 20% cap; right-sizing reviews | State/HVN (files.simpler.grants.gov)
- Provider payment cap overrun | Track ≤15% line; document gap-filling | State/HVN (files.simpler.grants.gov)
- Policy points at risk (not finalized by 2027/2028) | State policy workplan; mid-course correction | State/HVN (files.simpler.grants.gov)

11. Draft RFP Response Language (Mississippi-tailored; insert into narrative sections as appropriate)

11.1 Rural health needs and target population (excerpt)

“Mississippi’s rural population share is 53.7% (2020), indicating a broad geography where residents face travel distances for emergency and specialty care and elevated chronic disease burden. The State will focus initial efforts on CAHs/REHs and RHCs/FQHCs in high-need counties, supported by tele-specialty coverage, remote monitoring, and retail-integrated screening to reduce avoidable transfers, address chronic disease, and improve maternal–infant outcomes.” (ncsl.org)

11.2 Rural Health Transformation Plan: goals and strategies (excerpt)

“Our plan deploys a provider-owned High Value Network to operate shared services across rural facilities: tele-ER/ICU/hospitalist and behavioral consults, RPM for chronic and post-acute care, retail-enabled screenings and pharmacist services, and a cyber-secure data platform for analytics and reporting. These initiatives address NOFO pillars and the technical scoring factors, with conditional policy actions tracked against the NOFO’s 2027/2028 deadlines.”

(files.simpler.grants.gov)

11.3 Proposed initiatives and use of funds (excerpt)

"Initiative 1: Rural Emergency Access Stabilization. Use-of-funds categories: F (IT advances), G (availability/right-sizing), H (behavioral health), K (regional partnerships). Outcomes: reduced avoidable transfers; improved ED coverage; reduced decision-to-transfer times. Funding will observe caps on provider payments (≤15%) and capital (≤20%)." (files.simpler.grants.gov)

11.4 Implementation plan and timeline (excerpt)

"Subject to contracting, Phase 1 (months 1–6) establishes HVN governance and the State data platform; Phase 2 (months 4–9) onboards 10–15 facilities for tele-ER/ICU; Phase 3 (months 6–12) deploys RPM cohorts and retail partnerships; subsequent waves scale statewide with continuous evaluation."

11.5 Metrics and evaluation (excerpt)

"We will report monthly via a dashboard backed by integrated claims/EHR/RPM data. Measures include ED transfer rates, time-critical condition activation, chronic disease control, patient experience, workforce indicators, and cyber posture; and we will cooperate with CMS/third-party evaluation."

11.6 Compliance statements (excerpt)

"We will adhere to all funding limits and unallowable cost provisions, including the 10% administrative cap (including indirects), the ≤15% provider-payment cap, ≤20% capital/infrastructure cap, and ≤5% EMR replacement cap (if applicable), and we will avoid duplication with other federal/state/local funds and 2 CFR 200.216 covered telecom/surveillance." (files.simpler.grants.gov)

12. References

Internal Collaborative sources

1. Rural Health Transformation Collaborative. R1. 10-11-25 (catalogue and member appendices). RHT Collaborative (internal). Accessed Oct 14, 2025.
2. Avel eCare – virtual hospital services (in Collaborative appendix). RHT Collaborative (internal). Accessed Oct 14, 2025.
3. BioIntelliSense – BioButton remote monitoring (in Collaborative appendix). RHT Collaborative (internal). Accessed Oct 14, 2025.
4. Microsoft – cybersecurity/data platform (in Collaborative catalogue). RHT Collaborative (internal). Accessed Oct 14, 2025.
5. Viz.ai – clinical AI for stroke/time-sensitive care (in Collaborative catalogue). RHT Collaborative (internal). Accessed Oct 14, 2025.
6. Walgreens – rural pharmacy initiatives and workforce pipeline (in Collaborative catalogue). RHT Collaborative (internal). Accessed Oct 14, 2025.

External sources 7) CMS. Rural Health Transformation Program (CMS-RHT-26-001) NOFO (cms-rht-26-001_final.pdf). Posted Sep 15, 2025. Accessed Oct 14, 2025. https://simpler.grants.gov (NOFO pages on eligibility, dates, distribution, scoring, caps/limits, admin cap, reporting). (files.simpler.grants.gov) 8) CMS. Current CMS Grants Program Funding Opportunities (listing CMS-RHT-26-001). Last modified Sep 16, 2025. Accessed Oct 14, 2025. https://www.cms.gov/about-cms/grants-cooperative-agreements/currentnts-funding-opportunities. (cms.gov) 9) CMS. RHT Program overview page (program structure; timelines). Last modified Sep 26, 2025. Accessed Oct 14, 2025. https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview. (cms.gov) 10) National Conference of State Legislatures (NCSL). Rural Population by State from the 2020 Census. Accessed Oct 14, 2025. https://www.ncsl.org/elections-and-campaigns/voting-for-all-americans-rural-voters. (ncsl.org) 11) Rural Health Information Hub (RHIhub). Mississippi — rural healthcare facilities counts (state guide). Last Updated Sep 11, 2025. Accessed Oct 14, 2025. https://www.ruralhealthinfo.org/states/mississippi.

(ruralhealthinfo.org) 12) Mississippi Division of Medicaid. Managed Care updates: Magnolia, Molina, TrueCare (effective July 1, 2025). Special Enrollment notice and Managed Care page. Accessed Oct 14, 2025. https://medicaid.ms.gov. (medicaid.ms.gov) 13) MSDH. Health Data and Research—Maternal/Infant reports landing page (maternal mortality and infant mortality reports). Accessed Oct 14, 2025. https://msdh.ms.gov (Health Data & Research sitemap). (msdh.ms.gov) 14) Associated Press. Federal government approves part of Mississippi's plan to help struggling hospitals (context on hospital finance). Dec 13, 2023. Accessed Oct 14, 2025. https://apnews.com. (apnews.com)

13. AI Generation Notice

This guide was generated by the gpt-5 model on 2025-10-14. It may contain errors or omissions. All facts, figures, and citations must be independently validated against primary sources (including the CMS NOFO and official Mississippi data) before use in any submission or public communication.