title: Rural Health Transformation Grant Guide — Washington version: 1.0 date: 2025-10-14 audience: State health agencies, Medicaid, rural providers, collaboratives

1. Executive Summary

Washington can use the CMS Rural Health Transformation Program (RHT) to stabilize rural access, improve outcomes, and harden the digital and data backbone of care while meeting program scoring and compliance requirements. The RHT Collaborative offers a configurable portfolio across tele-emergency/ICU support, remote patient monitoring (RPM), retail-pharmacy enabled chronic disease management, cyber-secure cloud data platforms, analytics/AI, and network governance support—capabilities that align directly to the RHT NOFO's permissible uses and technical scoring factors.

Key near-term levers include: statewide virtual specialty backstop for CAHs and EMS (Avel eCare), continuous RPM for high-risk populations (BioIntelliSense), consumer-facing screening/triage and multilingual intake (Humetrix), pharmacy-enabled chronic disease management (CVS Health, Walgreens, Walmart) linked to primary care, and a secure cloud/HIE-aligned data layer with cybersecurity uplift (Microsoft plus OneHealthPort/HCA CDR integration). These components map to prevention/chronic disease (A), provider payments (B), consumer tech (C), workforce training (D), IT/cyber (F), right-sizing services (G), behavioral health (H), innovative payment models (I), and minor capital/equipment (J).

Washington's policy environment—statewide Apple Health managed care, nursing and physician licensure compacts, audio-only telemedicine reimbursement, active HIE/CDR infrastructure, BEAD-funded broadband buildout—positions the state to operationalize these capabilities quickly (subject to procurement and integration). The CMS NOFO's distribution (50% baseline / 50% workload) and technical factor framework reward credible statewide initiatives tied to measurable outcomes, supported by data reporting. (ohsu.edu) (hca.wa.gov) (nursing.wa.gov) (wmc.wa.gov) (codes.findlaw.com) (law.justia.com) (onehealthport.com) (doh.wa.gov) (ntia.gov)

The guide that follows translates the NOFO into a Washington-specific plan, connecting each requirement to practical options drawn from the Collaborative's catalog, state policies, and available funding pathways. It is expressly conditional and intended to support—not prescribe—state decision-making.

1.1 One-page printable summary

- What CMS is funding (FY26–FY30): cooperative agreements to states; applications due Nov 5, 2025; awards by Dec 31, 2025; equal baseline + points-based workload each budget period; no cost sharing; administrative cap 10%. (ohsu.edu)
- Highest-leverage Washington plays (illustrative, subject to contracting):
  - Tele-ER/ICU/hospitalist backstop to all CAHs and rural EDs (Avel eCare) with EMS tele-consults; RPM for CHF/COPD/diabetes (BioIntelliSense).
  - Pharmacy-enabled chronic care, vaccination, and screening workflows integrated with FQHCs/RHCs; multilingual intake and care navigation (Humetrix) tied to HIE/CDR. (onehealthport.com)
  - Secure cloud, analytics, and cyber uplift aligned with OneHealthPort HIE and HCA CDR; support for value-based and claims modernization (Microsoft; Accenture/KPMG/PwC).
- Why this fits Washington now:
  - 39 CAHs; 127 RHCs; 88 rural FQHC sites (July 2025). (ruralhealthinfo.org)
  - Apple Health managed care statewide (five MCOs) with aligned enrollment pathways for duals. (hca.wa.gov)
  - NLC (nursing), IMLC (physicians), PA Compact, and PSYPACT facilitate multi-site and cross-border coverage. (nursing.wa.gov)
  - Audio-only telemedicine parity under statute; rural response time standards (WAC) relevant to EMS redesign. (codes.findlaw.com) (lawfilesext.leg.wa.gov)
  - State-designated HIE (OneHealthPort) and HCA CDR underpin RHT reporting and analytics. (doh.wa.gov)

2. Eligibility and RFP Fit

2.1 Snapshot of the CMS-RHT-26-001 NOFO (what matters for Washington)

- Eligible applicant: one of the 50 states; DC/territories ineligible; governor-designated lead; AOR signature; one official application per state; latest on-time submission counts. (ohsu.edu)
- Key dates: optional LOI by Sep 30, 2025; application due Nov 5, 2025, 11:59 p.m. ET; awards/earliest start Dec 31, 2025; applicant webinars Sep 19 & 25, 2025; SF-424 Box 19c "No" (EO 12372 not applicable). (ohsu.edu)
- Funds and distribution: $50B across FY26–FY30, five budget periods; 50% baseline equal split; 50% workload via points; rural facility/population score fixed at Q4 2025; technical score recalculated annually via state reporting. (ohsu.edu)

- Allowable uses (select): prevention & chronic disease (A); provider payments (B, ≤15%/period); consumer tech (C); training/TA (D); workforce recruitment with ≥5-year service commitments (E); IT/cyber (F); right-sizing services (G); behavioral health (H); innovative care/value-based models (I); minor capital/equipment (J, ≤20%/period). EMR replacement cap 5% if a HITECH-certified system existed 9/1/2025. "Rural Tech Catalyst"-like initiatives ≤ lesser of 10% or $20M/period. (ohsu.edu)
- Admin cap: ≤10% of each budget period. (ohsu.edu)
- Conditional technical points for policy actions: available in Year 1; must be finalized by Dec 31, 2027 (by Dec 31, 2028 for B.2, B.4) or points fall to zero and related funds are subject to recovery. (ohsu.edu)
- Application content: project summary; ≤60-page narrative; ≤20-page budget narrative; attachments including governor's endorsement, business assessment, program duplication assessment; required forms (SF-424/SF-424A/SF-LLL/Site Locations). Grants.gov submission only. (ohsu.edu)

2.2 Requirement-to-capability map (examples)

Requirement → Collaborative capability → Evidence

- Telehealth/remote care enablement (A,C,F,H) → Avel eCare virtual hospital (ER/ICU/hospitalist) and tele-behavioral backstop; Teladoc network; pharmacy tele-services; RPM via BioIntelliSense. →
- Consumer screening, triage, multilingual intake (A,C) → Humetrix voice-enabled intake/triage; retail-based screening (Higi/Topcon noted in catalog), referral to primary care. →
- Cybersecurity, data & analytics backbone (F) → Microsoft secure cloud/AI; system integrator program management and value tracking; HIE/CDR integration. →
- Workforce: recruitment/retention & training (D,E) → Ambient documentation and tele-mentoring to reduce burnout; pharmacist workforce pipelines; CHW training with NACHC. →
- Governance/partnerships (K) → Cibolo Health facilitation of provider-owned High Value Networks (HVNs) for shared investments and accountability. →

3. Washington Context Snapshot

3.1 Population and rural distribution

- Washington's rural population share is 16.6% (2020 Census county-level urban/rural classification). (ncsl.org)
- State broadband: Washington has been allocated about $1.228B in BEAD funding; three BEAD rounds underway in 2025 to expand high-speed internet in unserved/underserved areas—critical to telehealth/RPM reliability. (ntia.gov)

3.2 Facility mix and networks

- 39 Critical Access Hospitals (CAHs); 127 Rural Health Clinics; 88 FQHC sites in rural areas (July 2025). (ruralhealthinfo.org)
- State-designated HIE (OneHealthPort) and HCA Clinical Data Repository (CDR) provide transport and storage for statewide clinical data exchange, with >300 contracted orgs and multi-program feeds (ELR, IIS, syndromic surveillance, eCR, PMP). (doh.wa.gov)

3.3 Workforce shortage indicators

- Mental health HPSAs: 208 designations affecting ~3.31M residents; ~156 additional practitioners needed (HRSA 3/31/2025, as compiled). (commentary.healthguideusa.org)
- Primary care HPSAs: 214 designations; ~2.61M residents in shortage areas; ~499 practitioners needed (HRSA 3/31/2025, as compiled). (commentary.healthguideusa.org)
- Policy enablers: Washington participates in NLC (MSL issuance began Jan 31, 2024), IMLC (expedited MD licensure), PA Compact (enacted; activation underway), and PSYPACT (enacted; rules/fees implemented). These ease multi-site staffing and tele-practice (subject to payer and facility credentialing). (nursing.wa.gov)

3.4 Medicaid and coverage context

- Apple Health managed care statewide; five MCOs (CHPW, Coordinated Care, Molina, UnitedHealthcare, Wellpoint) under NCQA-accredited contracts; aligned enrollment for duals (Apple Health Medicare Connect). (hca.wa.gov)
- Section 1115 "Medicaid Transformation Project 2.0" approved through June 30, 2028; 2025 amendment extended continuous eligibility for CHIP up to age six and other flexibilities—creating a foundation for value-based and community supports synergies. (hca.wa.gov)

3.5 Telehealth, EMS, and policy highlights

- Audio-only telemedicine reimbursement (commercial and Medicaid) with established relationship

requirement; RHCs reimbursed at encounter rate under Apple Health; consent rules in effect. (codes.findlaw.com)
- EMS minimum response standards include a 45-minute 80th percentile target in rural response areas—relevant to community paramedicine and tele-consult design. (lawfilesext.leg.wa.gov)
- Certificate of Need program active for hospitals and related services. (doh.wa.gov)
- Short-term, limited-duration insurance is not available for purchase in Washington (2025), and state rules limit duration to three months with no renewals—relevant to factor E.3 in NOFO technical scoring. (healthinsurance.org)

3.6 Behavioral health and maternal health

- Drug overdose deaths: 3,431 in 2023 (Results Washington, state dashboard), with DOH indicating a rise in late-2024 opioid overdoses and ongoing fentanyl impact—underscoring H and I use-of-funds opportunities. (results.wa.gov)
- Maternal mortality: DOH's 2023 Maternal Mortality Review identified 15.9 pregnancy-related deaths per 100,000 live births (2014-2020); behavioral health conditions were the leading underlying cause (32%); 80% of pregnancy-related deaths were preventable—supporting integrated maternal-behavioral initiatives. (doh.wa.gov)

3.7 Washington metrics to capability match (illustrative)

Metric (year, source) → Gap/opportunity → Collaborative capability

- 39 CAHs; 127 RHCs; 88 rural FQHC sites (2025, RHIhub) → Fragmented specialty access, transfer burden → Tele-ER/ICU/backstop; RPM; virtual specialty clinics; retail-pharmacy integration. (ruralhealthinfo.org)
- Mental health HPSAs (208; 3/31/2025) → Psychiatric access and crisis support gaps → Tele-behavioral consults; 24/7 crisis support; CCBHC adoption planning. (commentary.healthguideusa.org) (hca.wa.gov)
- Broadband BEAD allocation ~$1.228B (NTIA 2024) → Rural last-mile constraints for telehealth/RPM → Cloud architectures tolerant to limited bandwidth; offline-capable intake; asynchronous analytics; HIE/CDR integration. (ntia.gov)
- Audio-only parity (RCW 48.43.735; RCW 74.09.327) → Sustain tele-access in low-bandwidth areas → Clinic/retail tele-workflows, modifiers, and billing TA. (codes.findlaw.com)

4. Strategy Aligned to RFP

4.1 Model concept for Washington

- A connected rural system-of-systems built on:
  - Statewide tele-emergency/ICU/hospitalist coverage to CAHs and rural EDs; EMS tele-consults with treat-and-refer protocols (Avel eCare).
  - Tiered RPM (BioIntelliSense) for high-risk chronic and post-acute patients; programmatic integration into FQHCs/RHCs/CAHs with multilingual patient engagement (Humetrix).
  - Pharmacy-enabled chronic disease and immunization access (CVS, Walgreens, Walmart) aligned with local primary care and value-based arrangements.
  - A secure data and cyber platform (Microsoft) tied to OneHealthPort HIE and HCA CDR, enabling required RHT reporting and outcome analytics. (doh.wa.gov)
  - Provider-owned rural High Value Networks (Cibolo Health) for joint procurement, shared services, and accountability.

4.2 NOFO pillar and technical scoring alignment (examples)

- Prevention/chronic disease (A) and consumer tech (C): screening kiosks/retail activation; RPM; multilingual intake and navigation; analytics to close care gaps.
- Workforce (D,E): ambient documentation to reduce burden; tele-mentoring; pharmacist pipelines and CHW training via NACHC.
- Payment innovation (I): analytical support for shared savings/global budget pilots within rural networks; payer engagement; claims modernization.
- IT/cyber/data (F): zero-trust cloud services; HIE/CDR interfaces; TEFCA-ready exchange; dashboards for RHT metrics.

4.3 Equity strategy (rural and Tribal)

- Embed multilingual intake, culturally-relevant outreach, and pharmacy-adjacent access points in rural counties with high HPSA scores and overdose burden; support Tribal and IHS connectivity via HIE/CDR rails and tele-specialty linkages (subject to Tribal consent and data agreements). (doh.wa.gov)

4.4 Data use and privacy

- Use OneHealthPort HIE as preferred transport; maintain data minimization and HIPAA alignment; leverage HCA CDR for Medicaid clinical analytics and RHT reporting, governed by state privacy and participation agreements. (doh.wa.gov)

5. Program Design Options (Washington-tuned)

Option A: Rural acute stabilization and chronic management bundle

- Target: CAH ED/ICU patients; CHF/COPD/diabetes/high-risk post-discharge.
- Problem/need (2023–2025 data): Rural access gaps, EMS transport times (rural 45-minute standard), readmissions risk, fentanyl-driven ED load. (lawfilesext.leg.wa.gov)
- Collaborative components: Tele-ER/ICU/hospitalist; EMS tele-consults; RPM with BioButton; multilingual intake; pharmacy follow-up for meds/screenings.
- Payment logic: Care management fees + shared savings with MCOs for readmission/ED reduction; limited provider payments under RHT (≤15%) to address true gaps not otherwise reimbursable. (ohsu.edu)
- Policy enablers: Audio-only parity; NLC/IMLC for staffing flexibility. (codes.findlaw.com)
- Pros/risks: Rapid ED stabilization benefits vs. credentialing/onboarding complexity; mitigate via HVN contracting and standard playbooks.

Option B: Retail-linked chronic disease and maternal-behavioral integration

- Target: Adults with hypertension/diabetes; perinatal persons with behavioral health risks identified by DOH MMRP findings. (doh.wa.gov)
- Components: Pharmacy-based screening/education; connected devices; behavioral tele-consults; referral to CCBHCs where present; CHW outreach. (hca.wa.gov)
- Payment: Value-based incentives with MCOs; limited RHT provider payments (≤15%) for non-reimbursable services (e.g., pathway activation). (ohsu.edu)
- Pros/risks: Broad reach; data-sharing MOUs needed; mitigate through HIE-enabled workflows. (doh.wa.gov)

Option C: Community Paramedicine + Tele-navigation

- Target: Rural counties with long EMS times and limited clinics.
- Components: Treat-and-refer protocols; tele-triage; multilingual tele-navigation; post-overdose follow-up with naloxone linkage. (doh.wa.gov)
- Payment: MCO care coordination PMPM; RHT training/IT costs; EMS integration investments (capital J ≤20%). (ohsu.edu)
- Pros/risks: Avoidable transports reduced; scope and medical direction must be standardized.

Option D: Rural provider High Value Networks (HVNs) for value-based payment

- Target: Independent CAHs/RHCs.
- Components: Network governance, shared analytics, cyber uplift, common tele-specialty contracts; payer negotiation for shared savings or global budgets (subject to CMS/State policy).
- Payment: RHT supports governance/data/cyber (F,K,J); payer contracts align incentives.
- Pros/risks: Durable scale vs. multi-party governance timelines; mitigated by standard bylaws and facilitation.

6. Governance and Collaborative Roles

6.1 Structure (conceptual)

- Lead agency (Governor-designated): accountable for CMS cooperative agreement, compliance, reporting.
- Program Management Office (PMO): staffed by state + SI partner(s) for schedule, risk, reporting.
- Technical/Data Council: state CIO/HIE/CDR + vendors.
- Clinical Council: WSHA/WSMA/FQHCs/RHCs/EMS + behavioral health/CCBHCs.
- Community & Equity Council: Tribal/IHS (as applicable), local health jurisdictions, community organizations.

6.2 RACI (selected deliverables)

Deliverable → Accountable / Responsible / Consulted / Informed

- RHT Application & annual NCC: Lead agency (A)/PMO, Collaborative SI (R)/HCA DOH WSHA (C)/Stakeholders (I). (ohsu.edu)
- Tele-ER/ICU deployment to CAHs: PMO & CAHs (A)/Avel eCare (R)/WSHA EMS (C)/MCOs (I).

- RPM program: PMO & FQHCs/RHCs/CAHs (A)/BioIntelliSense (R)/MCOs DOH (C)/Consumers (I).
- Data platform & cyber uplift: State CIO/HIE/CDR (A)/Microsoft + SI (R)/HIE participants (C)/All (I). (doh.wa.gov)
- HVN setup: Lead agency + Cibolo (A/R)/Providers Payers (C)/Communities (I).

7. Payment and Funding

7.1 Pathways consistent with NOFO

- Use RHT funds for category A/C/D/F/H/I/J activities, with explicit adherence to caps (B ≤15%; J ≤20%; EMR replacement ≤5% if prior HITECH-certified; "tech catalyst" ≤10% or $20M). (ohsu.edu)
- Align Medicaid (Apple Health) incentives: MCO care management fees, shared savings arrangements, potentially actuarial support for rural network models (outside NOFO funding). (hca.wa.gov)

7.2 Illustrative cost framework (rough order of magnitude; subject to detailed budgeting)

- Workstream → Cost category → Funding source → Timing → Deliverable
  - Tele-ER/ICU: services, equipment (minor capital) → RHT J + provider ops → FY26–27 → 24/7 virtual coverage, transfer reduction dashboard. (ohsu.edu)
  - RPM kits and monitoring: devices/services → RHT A/C + MCO PMPM → FY26–28 → Risk-stratified RPM cohorts. (ohsu.edu)
  - Data/cyber platform: software, integration, security services → RHT F + state/HIE fees → FY26–29 → Unified data model, CMS metric extracts. (ohsu.edu)
  - Workforce/TA: training, tele-mentoring → RHT D/E → FY26–30 → Course completions, retention metrics. (ohsu.edu)

8. Data, Measurement, and Evaluation

8.1 Core measures and cadence

- Access: ED transfer rates from CAHs; tele-consult response times; audio-only utilization in low-bandwidth areas. (lawfilesext.leg.wa.gov)
- Quality/outcomes: 30-day readmissions (CHF/COPD); HbA1c control; maternal BH screening and follow-up. (doh.wa.gov)
- Behavioral health: overdose ED visits and deaths per 100k; naloxone distribution/linkage. (doh.wa.gov)
- Financial sustainability: total cost of care trends for MCO contracts; avoidable transfers.
- Reporting: quarterly internal dashboards; annual RHT technical score updates per NOFO Table 4. (ohsu.edu)

8.2 Data sources and integrations

- HIE (OneHealthPort), HCA CDR, WA-APCD (as available), MCO claims, EHRs, EMS (WEMSIS), public health registries; TEFCA-capable exchange as feasible. (doh.wa.gov)
- Privacy and security aligned to HIPAA/HITRUST where applicable; data sharing governed by state agreements and Tribal data sovereignty where applicable.

9. Implementation Plan

9.1 18-month Gantt-style view (illustrative; dates from award start)

Workstream | Start | End | Owner | Outputs

- PMO stand-up, governance | M1 | M3 | Lead agency/PMO | Charter; RACI; risk log.
- HIE/CDR data pipeline design | M2 | M6 | State CIO/HIE/CDR + SI | Data catalog; interfaces.
- Tele-ER/ICU wave 1 (10 CAHs) | M3 | M9 | Avel eCare + CAHs | Go-live; KPIs baseline.
- RPM cohort 1 (CHF) | M4 | M10 | BioIntelliSense + clinics | 1,500 enrollees; protocols.
- Retail-linked screening pilots | M5 | M12 | Pharmacy partners + FQHCs | 30 sites; referral yield.
- Cyber uplift (wave 1) | M4 | M12 | Microsoft + providers | Security controls; audit.
- HVN formation and bylaws | M3 | M9 | Cibolo + providers | Governance docs; payer LOIs.
- Evaluation plan & baseline | M2 | M5 | PMO + SI + HCA | Logic model; KPIs defined.
- Annual RHT report package | M14 | M18 | PMO | CMS submission.

9.2 Procurement/legal checkpoints

- Master services agreements; BAAs; HIE/HCA CDR participation; data use agreements; tribal consultation where applicable; payer addenda for incentives.

10. Risk Register (selected)

Risk → Impact/Probability → Mitigation → Owner

- Policy actions not finalized by Dec 31, 2027 (or 2028 for B.2/B.4) → Funding recovery risk → Early policy roadmap; legal drafting TA; track milestones in PMO. → Lead agency/PMO. (ohsu.edu)
- Cyber incident at rural site → Service disruption → Microsoft security controls; incident response runbooks; tabletop exercises. → Providers/State CIO.
- Data fragmentation → Weak outcome evidence → HIE/CDR interfaces prioritized; data quality sprints. → State CIO/HIE/CDR. (doh.wa.gov)
- Workforce burnout/turnover → Program scaling risk → Ambient documentation + tele-mentoring; flexible staffing via compacts. → Providers/PMO. (nursing.wa.gov)
- Broadband gaps → Telehealth failures → Audio-only pathways; offline workflows; device caching. → Providers/Pharmacies. (codes.findlaw.com)
- EMS integration variability → Uneven outcomes → Standard protocols; training; rural response KPI tracking. → DOH/EMS. (lawfilesext.leg.wa.gov)
- Vendor onboarding lag → Timeline slippage → Wave-based rollout; pre-negotiated SOW templates. → PMO.
- Payer alignment → Financial sustainability risk → Early LOIs; actuarial modeling; evaluation feedback loops. → HCA/PMO. (hca.wa.gov)
- Privacy concerns (Tribal/state) → Data sharing delays → Structured data governance; consent workflows; sovereign data policies. → PMO/HIE.
- STLDI misperceptions → Consumer confusion → OIC/Exchange comms with provider navigation. → HCA/OIC. (healthinsurance.org)

11. Draft RFP Response Language (boilerplate, to tailor)

11.1 Program purpose and alignment (narrative excerpt) “The State proposes a rural health transformation portfolio that addresses prevention and chronic disease, tele-enabled access, workforce support, robust data infrastructure, and sustainable payment models. The portfolio leverages statewide tele-emergency and ICU support, risk-stratified remote monitoring, multilingual consumer engagement, pharmacy-enabled chronic care, and a secure cloud/HIE-integrated data stack. Activities are mapped to the RHT Program’s permissible uses (A,C,D,F,G,H,I,J), adhere to funding caps (B ≤15%; J ≤20%; EMR replacement ≤5%; tech-catalyst ≤10% or $20M), and align with the NOFO’s workload scoring, data-driven metrics, and annual reporting.” (ohsu.edu)

11.2 Technical approach and partnerships (narrative excerpt) “Implementation partners include rural provider networks, FQHCs/RHCs, CAHs, EMS, retail pharmacies, and technology/system-integration organizations. Tele-specialty coverage (Avel eCare), RPM (BioIntelliSense), consumer intake/triage (Humetrix), retail clinical workflows (CVS Health, Walgreens, Walmart), and secure cloud/cyber (Microsoft) are integrated with the State-designated HIE (OneHealthPort) and HCA CDR to support program monitoring and evaluation.” (doh.wa.gov)

11.3 Equity and rural focus (narrative excerpt) “The State targets rural HPSA counties, frontier/remote tracts, and Tribal communities (as applicable) with multilingual tools, pharmacy-adjacent access, and behavioral health integration, consistent with DOH maternal mortality findings and overdose trends.” (doh.wa.gov)

11.4 Budget compliance statement (narrative excerpt) “Administrative costs will not exceed 10% each budget period, inclusive of indirects. Provider payments will be limited to ≤15% per period, focused on documented coverage gaps and transformation aims. Minor capital and equipment will not exceed 20% per period; EMR replacement limited to ≤5% under NOFO conditions.” (ohsu.edu)

12. References

1. Rural Health Transformation Program NOFO (CMS-RHT-26-001), OHSU mirrored copy, 2025. Oregon Office of Rural Health/OHSU. https://www.ohsu.edu/sites/default/files/2025-09/RHTP-instructions%20-%20NOFO.pdf (accessed 2025-10-14). (ohsu.edu)

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13. Assumptions and Open Questions

- Medicaid DSH hospital count and CCBHC site list as of 9/1/2025: The NOFO requires inclusion; counts/sites should be confirmed with HCA/DOH and data.HRSA.gov facility listings before submission. (ohsu.edu)
- SNAP waivers and nutrition CME (NOFO technical factors B.3 and B.4): Washington's current status should be validated with DSHS/DOH and professional boards to support conditional points claims. (ohsu.edu)
- HPSA counts: references cited use HRSA quarterly summaries compiled by a secondary source; final counts should be extracted directly from HRSA's shortage-areas dashboard or data download (as of application lock date) to ensure precision. (data.hrsa.gov)

14. Compliance Checklists

14.1 NOFO compliance checklist (application package)

- Narrative: ≤60 pages; includes rural needs, goals/strategies with FY26–FY31 KPIs; initiatives with ≥4 measurable outcomes each; implementation plan; stakeholder engagement; evaluation/sustainability; required state policy disclosures (technical factors); CCBHC list; DSH count. (ohsu.edu)
- Budget narrative: ≤20 pages; maps to initiatives; shows admin ≤10%; notes provider payments ≤15% and

capital ≤20%; identifies subawards; matches SF-424A. (ohsu.edu)
- Forms/attachments: SF-424/SF-424A/SF-LLL/Site Locations; governor's endorsement; business assessment; duplication assessment; indirect cost agreement (if used). (ohsu.edu)

14.2 Funding caps and restrictions checklist (program-specific)

- [ ] Provider payments (B) ≤15%/period and non-duplicative of reimbursable services. (ohsu.edu)
- [ ] Capital & infrastructure (J) ≤20%/period; no new construction. (ohsu.edu)
- [ ] EMR replacement ≤5% if HITECH-certified EMR existed 9/1/2025. (ohsu.edu)
- [ ] "Tech catalyst" initiatives ≤ lesser of 10% or $20M/period. (ohsu.edu)
- [ ] Prohibited purchases: covered telecom/video surveillance (2 CFR 200.216); lobbying; specified procedures at 45 CFR 156.400; no supplanting; admin ≤10%. (ohsu.edu)

15. AI Generation Notice

This guide was generated with the gpt-5 model on 2025-10-14. It is AI-generated content intended to support planning. All facts, figures, and citations must be independently validated against primary sources (e.g., CMS NOFO, Washington statutes/rules, HRSA/HCA/DOH datasets) before use in any official submission.