Rural Health Transformation Grant Guide — Delaware

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Delaware can use the CMS Rural Health Transformation (RHT) Program to expand rural access and stabilize provider finances while accelerating data, workforce, and technology modernization. The RHT Program provides $50B across FY26–FY30 via cooperative agreements to States, with half of each year's funding distributed equally and half allocated by points tied to rural factors and technical performance. Applications are due November 5, 2025 at 11:59 p.m. ET; optional LOIs are due September 30, 2025 to MAHARural@cms.hhs.gov. Only States are eligible; the Governor designates a lead agency. These requirements and timelines are confirmed in CMS's NOFO and program page. (files.simpler.grants.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Delaware with modular capabilities that map directly to RHT uses of funds: virtual specialty and emergency support for rural hospitals (Avel eCare); remote patient monitoring and AI-driven exception management (BioIntelliSense); consumer-facing triage, multilingual intake, and PHR tools (Humetrix); pharmacy-enabled chronic care and adherence programs (CVS Health, Walgreens); analytics and value-based payment design (Accenture, KPMG, PwC); and secure, interoperable cloud, analytics, and cybersecurity (Microsoft). These offerings align with RHT priorities spanning prevention, workforce, innovative care, and tech innovation.

High-leverage opportunities for Delaware include: Sussex/Kent-focused primary care and chronic disease management (RPM + retail pharmacy + FQHCs), 24/7 tele-emergency and tele-behavioral support for rural sites, pharmacy-enabled hypertension/diabetes pathways, and a shared data/cyber foundation integrating EHR, HIE, and claims. Each is compatible with RHT rules on allowable uses and caps (e.g., provider payments ≤15%; Category J capital/infrastructure ≤20%; EMR replacement ≤5%; "Rural Tech Catalyst"-like initiatives ≤10% or $20M). (files.simpler.grants.gov) The Collaborative can also help organize rural providers into High Value Networks (HVNs) for shared services and accountable investment tracking.

1.1 One-page printable summary

- What RHT funds: States only; five budget periods (FY26–FY30); half baseline, half points-based workload; cooperative agreement with substantial CMS involvement. Due 11/5/2025; optional LOI to MAHARural@cms.hhs.gov by 9/30/2025. (files.simpler.grants.gov)
- Key NOFO caps: Admin ≤10%; provider payments ≤15%; Category J (capital/infrastructure) ≤20%; EMR replacement ≤5% (if HITECH-certified EMR existed 9/1/2025); "Rural Tech Catalyst" ≤ the lesser of 10% or $20M per period. (files.simpler.grants.gov)
- Delaware context (illustrative 2020–2025): Rural population share 17.4% (172k people); Sussex has ~89k rural residents; 0 CAHs; 0 RHCs (historically); 3 FQHC awardees reported in 2024 UDS; three Medicaid MCOs since 1/1/2023 (AmeriHealth Caritas, Highmark Health Options, Delaware First Health); DSHP 1115 extension through 12/31/2028 includes contingency management and enhanced postpartum supports; primary care HPSA coverage includes ~231k residents with a need for ~71 additional PCPs (as of 3/31/2025). (ncsl.org)
- Collaborative fit:
    - Virtual care + tele-specialty for rural hospitals/clinics (Avel eCare) and stroke AI (Viz.ai).
    - RPM + exception management for chronic disease (BioIntelliSense).
    - Consumer tech for triage and navigation (Humetrix), retail pharmacy chronic-care engagement (CVS Health, Walgreens).
    - Data, analytics, payment integrity, and VBP design (Accenture, KPMG, PwC); cloud/cyber (Microsoft).
    - Governance via rural provider HVNs (Cibolo Health).

2. Eligibility and RFP Fit

2.1 Snapshot of NOFO requirements (selected)

- Eligible applicant: only the 50 States; Governor designates lead agency; single official submission per State. (files.simpler.grants.gov)
- Deadlines: optional LOI by 9/30/2025 (email MAHARural@cms.hhs.gov); application due 11/5/2025 11:59 p.m. ET. (files.simpler.grants.gov)
- Distribution: ~$50B total FY26–FY30; half equal baseline; half points-based workload. (cms.gov)
- Scoring framework: Rural facility/population factors (A.1–A.7) and technical factors (B.1–F.3) with fixed weights; points recalculated each period for technical factors; rural baseline set once using Q4 2025 data. (files.simpler.grants.gov)
- Uses of funds: categories A–K (prevention, provider payments, consumer tech, TA/training, workforce, IT/cyber, right-sizing service lines, behavioral health incl. OUD/SUD, innovative care/value-based, capital/infrastructure,

partnerships). (files.simpler.grants.gov)

- Caps and prohibitions: admin ≤10%; provider payments ≤15%; Category J ≤20%; EMR replacement ≤5% (if prior HITECH-certified EMR in place on 9/1/2025); "Rural Tech Catalyst" ≤ the lesser of 10% or $20M; 2 CFR 200.216 telecom prohibition; SF-424 Item 19c "No" (EO 12372 inapplicable). (files.simpler.grants.gov)

2.2 Requirement-to-Collaborative capability mapping (examples)

NOFO requirement	Collaborative capability	Evidence
Prevention/chronic disease (A)	RPM + telehealth + kiosks; pharmacy adherence and screening programs	BioIntelliSense RPM; Humetrix triage/PHR; Walgreens/CVS chronic-care programs.
Consumer-facing tech (C)	Multilingual intake; mobile PHR; AI risk alerts	Humetrix voice-enabled triage and iBlueButton PHR.
Workforce (E)	Tele-mentoring; ambient documentation; pharmacist-enabled care	Avel eCare provider-to-provider support; Microsoft ambient AI; retail pharmacy programs.
IT/cyber/data (F)	HIPAA/FHIR cloud; analytics; cyber hardening	Microsoft cloud/cyber; integrator analytics and program management.
Behavioral health/OUD (H)	24/7 tele-behavioral; opioid risk alerts	Avel eCare; Humetrix analytics.
Innovative care/value-based (I)	VBP/APM design; payment integrity	Accenture/KPMG/PwC toolkits.
Capital/infrastructure (J)	Right-sized renovations and equipment tied to service redesign	Integrator facility/right-sizing experience.

3. Delaware Context Snapshot

- Rural population share: 17.4% (172,131 people) in 2020; Sussex County includes ~89,211 rural residents (2020). (ncsl.org)
- CAHs and RHCs: Delaware has 0 Critical Access Hospitals and historically 0 RHCs; updated counts should be validated prior to application. (definitivehc.com)
- FQHCs: 3 HRSA-funded awardees reported in 2024 UDS (Westside Family Healthcare, La Red Health Center, Southbridge Medical Advisory Council/Henrietta Johnson Medical Center). (data.hrsa.gov)
- Workforce/HPSA indicators: As of 3/31/2025, Delaware's primary care HPSAs encompassed ~231,014 residents with an estimated need for ~71 additional PCPs; HRSA maps confirm active HPSA designations statewide. (commentary.healthguideusa.org)
- Medicaid landscape: Three statewide MCOs since 1/1/2023 (AmeriHealth Caritas Delaware, Highmark Health Options, Delaware First Health). (dhss.delaware.gov)
- 1115 waiver: DSHP extended through 12/31/2028; changes include restoring three months of retroactive eligibility in 2025 and contingency management benefits for SUD; enhancements to postpartum supports. (medicaid.gov)

Table—Delaware metrics and matching capabilities

Metric (year)	Value	Source	Collaborative capability matched
Rural population share (2020)	17.4%	U.S. Census via NCSL. (ncsl.org)	Retail pharmacy access hubs; RPM to extend primary care.
Rural residents in Sussex (2020)	~89,211	Census via CityPopulation. (citypopulation.de)	Targeted RPM/telehealth; pharmacy BP/diabetes programs.

Metric (year)	Value	Source	Collaborative capability matched
CAHs (2025)	0	Definitive Healthcare summary. (definitivehc.com)	Tele-hospitalist/tele-ER/tele-ICU to offset lack of CAHs.
RHCs (2022 list)	0	HRSA RHC testing allocations. (hrsa.gov)	FQHC + pharmacy + mobile models to fill access gaps.
FQHC awardees (2024)	3	HRSA UDS State Report. (data.hrsa.gov)	FQHC integration with RPM, tele-specialty, consumer tech.
Primary Care HPSA pop (3/31/2025)	~231,014; need ~71 PCPs	HRSA-derived summary. (commentary.healthguideusa.org)	Tele-mentoring; ambient AI; pharmacist-enabled care.
MCOs (2023–2025)	3 MCOs	DMMA. (dhss.delaware.gov)	Claims feeds, payment integrity, and VBP modeling.
DSHP 1115 (through 2028)	Approved; retroactive eligibility restored 1/1/2025; CM for SUD	CMS. (medicaid.gov)	

4. Strategy Aligned to RFP

4.1 Transformation model (conditional construct)

- Access and right-sizing: Deploy tele-hospitalist/tele-ER and tele-behavioral bench strength at rural sites; extend pharmacist-enabled chronic disease workflows and FQHC-linked screening/RPM in Sussex and Kent; right-size service lines using data on demand, transfers, and outcomes.
- Outcomes and technology: Implement RPM+analytics for CKD, CHF, COPD, diabetes; multilingual intake/PHR; AI-supported stroke detection and population risk stratification.
- Workforce: Tele-mentoring, ambient documentation, pharmacist and tech-enabled models to reduce admin load and expand capacity.
- Data/cyber: HIPAA/FHIR cloud, identity/data governance, dashboards, and payment integrity tooling to meet RHT reporting.

4.2 Mapping to RHT scoring and pillars

- Pillars Make Rural America Healthy Again and Tech Innovation: RPM + consumer screening + AI; cloud/cyber.
- Technical factors: partnerships (C.1), EMS (C.2), data infrastructure and remote services (F.1–F.2), consumer tech (F.3), payment incentives (E.1). (files.simpler.grants.gov)

4.3 Equity strategy

- Focus geographies: Sussex rural tracts and agricultural communities; integrate community health workers; multilingual digital front doors; align with FQHC service areas.

4.4 Data use and privacy

- Architecture: Role-based access, audit trails, de-identification for population analytics; state data-sharing MOUs; alignment to ONC/FHIR and HHS cyber practices.

5. Program Design Options (Delaware-tuned; all conditional)

Option A: Rural chronic disease and primary care capacity (Sussex/Kent)

- Target: Adults with hypertension/diabetes/CVD risk in rural tracts, anchored at FQHCs and pharmacies. (citypopulation.de)
- Problem: 17.4% rural population with limited specialty access; workforce shortages in HPSAs. (ncsl.org)
- Collaborative stack: RPM (BioIntelliSense), pharmacy adherence and BP workflows (Walgreens/CVS), consumer triage (Humetrix), tele-specialty (Avel eCare), analytics (Accenture), cloud/cyber (Microsoft).

- Payment logic: Care management bundles + P4P via MCOs; provider payment usage ≤15% of annual award. (files.simpler.grants.gov)
- Policy enablers: Leverage MCO contracts and DSHP authorities for CM; document any conditional State policy changes per NOFO technical factors and deadlines. (files.simpler.grants.gov)
- Pros/risks: Rapid impact on BP/diabetes; relies on consistent device/telehealth adoption and pharmacy engagement.

Option B: Rural hospital support and transfer avoidance

- Target: Rural ED/inpatient units in Sussex/Kent; EMS partners.
- Problem: No CAHs; intermittent specialty coverage; EMS strain. (definitivehc.com)
- Capabilities: 24/7 tele-ER/tele-ICU/hospitalist (Avel eCare); stroke AI alerts (Viz.ai); EMS tele-support; sepsis pathways.
- Payment logic: Facility support under right-sized services; capital ≤20% for minor renovations/equipment. (files.simpler.grants.gov)
- Pros/risks: Keeps care local; requires governance and credentialing alignment.

Option C: Behavioral health and SUD integration (primary care + crisis)

- Target: Rural primary care and EDs; linkage to 988 and community partners.
- Problem: Persistent SUD/maternal behavioral needs; DSHP authorizes contingency management. (cms.gov)
- Capabilities: Tele-psychiatry; virtual behavioral crisis support (Avel eCare); opioid risk analytics and consumer alerts (Humetrix).
- Payment logic: Use H and I categories; coordinate with MCO quality incentives.

Option D: Delaware Rural Health Data & Cyber Core

- Target: State lead agency + Medicaid + HIE + provider networks.
- Problem: Fragmented data and cyber risk; RHT data-driven points require progress and reporting. (files.simpler.grants.gov)
- Capabilities: State data platform (Azure), identity and consent, real-time dashboards, payment integrity, and cyber hardening.

6. Governance and Collaborative Roles

6.1 Partner/decision-rights diagram (conceptual)

- State lead agency (prime recipient): strategy, policy, funds flow, reporting to CMS.
- Medicaid/DHSS (DMMA): payer alignment, data feeds, VBP.
- Provider coalitions/HVNs (Cibolo Health): local governance, shared services, compliance.
- FQHCs/hospitals/EMS: delivery, data sharing, quality.
- Collaborative members (technology/advisory): build/operate platforms, training, analytics.

6.2 RACI (illustrative)

Task	State lead	Medicaid	FQHCs/Hospitals	Collaborative
Strategy & NOFO alignment	R	C	C	A (advisory)
Funds flow & compliance	A	R	C	C
Data/cyber platform	C	C	C	A
Tele-specialty operations	C	C	A	R (Avel eCare)
RPM & consumer tech	C	C	A	R (BioIntelliSense, Humetrix)
Pharmacy-enabled care	C	C	A	R (CVS/Walgreens)
Program analytics & VBP	C	A	C	R (Accenture/KPMG/PwC)

7. Payment and Funding

- Funding flow: combine baseline + workload allocations; workload points updated annually; rural facility/population factors fixed from Q4 2025. (files.simpler.grants.gov)
- Budget boundaries: admin ≤10% (direct + indirect); provider payments ≤15%; Category J ≤20%; EMR replacement ≤5%; "Rural Tech Catalyst" ≤ the lesser of 10% or $20M; telecom/video surveillance bans under 2 CFR 200.216. (files.simpler.grants.gov)
- Medicaid alignment: model P4P/APMs with MCOs; analytics support for rate/logic; ensure no supplanting of reimbursable services; document SPA/contractual levers if any. (files.simpler.grants.gov)

Table—Illustrative cost categories (ROM), funding source, timing, deliverables

Category	ROM %	RHT category	Timing	Collaborative deliverables
Tele-ER/ICU/hospitalist	10–15	G/I	6–18 mo	Clinical protocols, 24/7 coverage (Avel eCare).
RPM & devices	8–12	A/F	6–24 mo	RPM kits, dashboards, training (BioIntelliSense).
Consumer tech & triage	3–6	C/F	6–18 mo	Multilingual intake/PHR (Humetrix).
Pharmacy chronic care	4–8	A/I	6–24 mo	BP/DM programs, adherence supports (CVS/Walgreens).
Data/cyber platform	10–15	F	6–24 mo	Cloud, IAM, dashboards (Microsoft + integrators).
Capital/minor renovations	≤20 (cap)	J	9–24 mo	Tele rooms, network, equipment (integrators). (files.simpler.grants.gov)
Program mgmt/TA	5–8	K	0–24 mo	PMO, economic modeling (Accenture/KPMG/PwC).
Admin/indirect	≤10 (cap)	—	—	Budget/admin controls. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Measures: access (ED transfer rates, time-to-specialist), outcomes (BP control, A1c), utilization (avoidable admissions), financial (operating margins), workforce (vacancy/retention), technology (uptime, cyber incidents), implementation (fidelity, adoption).
- Data sources: claims (MCOs/Medicaid), EHRs, HIE, EMS CAD; consumer tools; HRSA UDS; HPSA and shortage data for workforce targeting. (data.hrsa.gov)
- Points linkage: track technical-factor improvements (remote services, data infrastructure, consumer tech) against Table 3 weights. (files.simpler.grants.gov)
- Evaluation approach: learning system with quarterly reviews; support for CMS/third-party evaluations per NOFO. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; conditional pacing)

Gantt-style plan (illustrative)

Workstream	Start	End	Owner	Outputs
Program mobilization & PMO	Jan 2026	Mar 2026	State + integrators	Governance, risk plan, reporting templates.

Workstream	Start	End	Owner	Outputs
Data/cyber platform foundation	Jan 2026	Sep 2026	State IT + Microsoft	Landing zones, IAM, initial dashboards.
Tele-ER/ICU pilot (rural site set 1)	Mar 2026	Dec 2026	Avel eCare + hospitals	Go-lives; transfer rate baseline/targets.
RPM cohort 1 (HTN/DM)	Apr 2026	Mar 2027	BioIntelliSense + FQHCs	Enrolled patients; exception alerts; outcomes.
Pharmacy chronic care activation	Apr 2026	Dec 2026	CVS/Walgreens + FQHCs	Adherence/BP pathways; referrals.
Consumer intake/triage	May 2026	Nov 2026	Humetrix + sites	Multilingual intake live; PHR enrollments.
VBP and payment integrity	May 2026	Mar 2027	Medicaid + integrators	Incentive design; integrity analytics.
Capital/minor renovations	Jun 2026	Jun 2027	Integrators	Tele rooms/equipment; ≤20% cap. (files.simpler.grants.gov)
Evaluation & points tracking	Ongoing	—	State + integrators	Quarterly dashboards vs. Table 3 factors. (files.simpler.grants.gov)

10. Risk Register (top items)

Risk	Likelihood/Impact	Mitigation	Owner
Device/telehealth adoption lags	Med/High	CHW onboarding; pharmacy-based coaching; simplify UX.	FQHCs/Collaborative
Workforce burnout persists	Med/High	Ambient documentation; tele-mentoring; flexible scope.	Providers
Cyber incidents	Med/High	Microsoft cyber program; MFA/zero trust; drills.	State IT/Providers
Data-sharing barriers	Med/Med	Legal templates, governance, consent tools.	State + HIE
Capital overrun risk	Low/Med	Minor renovations only; strict cap ≤20% and change control. (files.simpler.grants.gov)	State PMO
Provider payment misuse	Low/High	≤15% cap; clear criteria; audit/payment integrity tools. (files.simpler.grants.gov)	Medicaid + PMO
Supplanting reimbursable services	Low/Med	Gap analyses; payer checks; NIAs. (files.simpler.grants.gov)	PMO
MCO integration delays	Med/Med	Joint workplan with 3 MCOs; data SLAs. (dhss.delaware.gov)	Medicaid/MCOs
HPSA targeting misaligned	Med/Med	Use HRSA maps + local input for site selection. (data.hrsa.gov)	State PCO
Points underperformance	Med/High	Quarterly points review vs. Table 3 metrics; adjust initiatives. (files.simpler.grants.gov)	State + PMO

11. Draft RFP Response Language (Delaware-ready boilerplate; adapt as needed)

11.1 Rural health needs and target populations “Delaware’s rural share was 17.4% in 2020 (172,131 residents), concentrated in Sussex and Kent Counties; approximately 89,211 residents in Sussex live in rural areas. Providers in designated HPSAs serve about 231,000 residents with a modeled need of ~71 additional primary care physicians. Our plan targets these communities with integrated FQHC–pharmacy–telehealth pathways, remote monitoring, and tele-specialty support.” (ncsl.org)

11.2 Goals and strategies “Our statewide Rural Health Transformation Plan advances prevention, sustainable access, workforce, innovative care, and tech innovation through initiatives that address at least three allowable uses of funds. We will scale RPM-enabled chronic care, implement 24/7 tele-emergency and tele-hospitalist services, and deploy consumer-facing triage and PHR tools. These activities align to NOFO categories A, C, E, F, G, H, I, and J.” (files.simpler.grants.gov)

11.3 Use of funds and outcomes “Investments stay within NOFO caps (administrative ≤10%; provider payments ≤15%; Category J ≤20%; EMR replacement ≤5%; any ‘Rural Tech Catalyst’-like activity ≤ the lesser of 10% or $20M). For each initiative we define at least four measurable outcomes, including community-level metrics (e.g., ED transfer rate, BP control).” (files.simpler.grants.gov)

11.4 Implementation and governance “The Governor-designated lead agency serves as the prime recipient, with Medicaid and provider/HVN partners executing. Subawards will use transparent selection criteria. The State maintains compliance with 2 CFR Part 200 and HHS GPS; EO 12372 does not apply (SF-424 Item 19c = No).” (files.simpler.grants.gov)

11.5 Data, evaluation, and sustainability “A secure, HIPAA/FHIR-aligned cloud platform will integrate claims, EHR, EMS, and consumer data for dashboards and reporting. We will participate in CMS evaluations and quarterly performance reviews tied to Table 3 technical factors to sustain and improve points and impact.” (files.simpler.grants.gov)

12. Checklists

12.1 Submission checklist (NOFO conformance)

- Grants.gov forms: SF-424 (Item 19c “No”), SF-424A, Project/Performance Site Location(s), SF-LLL. (files.simpler.grants.gov)
- Attachments: Governor’s endorsement; indirect cost agreement (if used); business assessment; program-duplication assessment; supporting docs. (files.simpler.grants.gov)
- LOI (optional) emailed to MAHARural@cms.hhs.gov by Sep 30, 2025 (11:59 p.m. ET). (files.simpler.grants.gov)
- Budget narrative format: single-spaced, ≤20 pages; clearly show admin ≤10% and map costs to initiatives. (files.simpler.grants.gov)
- Uses of funds: include ≥3 categories; respect caps and prohibitions (incl. 2 CFR 200.216). (files.simpler.grants.gov)

12.2 Implementation readiness checklist (programmatic)

- Executed data-sharing and cyber controls for initial sites.
- Tele-specialty staffing rosters and credentialing plans.
- RPM supply, logistics, and CHW coaching workflows.
- Pharmacy collaboration MOUs and referral protocols.
- Points-tracking dashboard aligned to Table 3. (files.simpler.grants.gov)

Assumptions and Open Questions (to be validated by the State)

- Confirm current counts of RHCs and any recent changes since HRSA’s 2022 allocation tables. (hrsa.gov)
- Confirm Delaware’s latest participation status in additional licensure compacts (e.g., Interstate Medical Licensure Compact, PSYPACT) to maximize B/D-factor scoring. (NLC membership and leadership are evident.) (ncsbn.org)
- Confirm Certificate of Public Review details applicable to C.3 and capital planning.
- Provide the CCBHC list as of 9/1/2025 and the count of hospitals receiving Medicaid DSH for the most recent SPRY (per NOFO project narrative requirements). (files.simpler.grants.gov)

13. References

External sources

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3. RHT Program — Frequently Asked Questions, CMS (updated 2025). https://www.cms.gov/files/document/rural-health-transformation-frequently-asked-questions.pdf (accessed 2025-10-14). (cms.gov)

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14. NLC participation (NCSBN notices referencing Delaware Board leadership and NLC). https://www.ncsbn.org/news/the-nlc-celebrates-milestone-anniversary-in-2025 (accessed 2025-10-14). (ncsbn.org)

Internal (Collaborative) sources 15) Rural Health Transformation Collaborative — Summary and Capabilities (R1, 10-11-25). Provided by the Collaborative (members include Avel eCare, BioIntelliSense, Humetrix, Microsoft, Viz.ai, CVS Health, Walgreens, Accenture, KPMG, PwC, Cibolo Health). (Selected pages cited above.)

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