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

1. Executive Summary The Rural Health Transformation (RHT) Program offers Virginia a five-year cooperative agreement to improve rural access, quality, and outcomes through system-level change. Applications are due November 5, 2025 at 11:59 p.m. ET; an optional LOI is due September 30, 2025; CMS expects to issue awards by December 31, 2025. Only states may apply, and the Governor must designate the lead agency; one application per state will be reviewed (latest on-time submission) and SF-424 Box 19c must be marked "No" (E.O. 12372 does not apply). (files.simpler.grants.gov)

Virginia can pair the RHT Collaborative's capabilities—virtual hospital and tele-specialty coverage (Avel eCare), continuous remote monitoring (BioIntelliSense), cyber-secure cloud data/AI infrastructure (Microsoft), population analytics and consumer tools (Humetrix; Pangaea Data), and rural provider High Value Network (HVN) enablement (Cibolo Health)—with state Medicaid levers and COPN oversight to address access, workforce, financial stability, behavioral health, perinatal outcomes, and data infrastructure gaps. These offerings are configurable, standards-based (HIPAA/FHIR), and have been used in rural settings; implementation remains subject to State procurement, contracting, and integration.

High-leverage areas for early impact include:

- Tele-ER/ICU and on-demand specialty support for CAHs/PPS rural hospitals, anchored by statewide EMS linkages and transfer protocols (Avel eCare), which can support 24/7 coverage and reduce avoidable transfers.
- Cardiometabolic and maternal remote physiologic monitoring with exception-based clinical dashboards (BioIntelliSense), aligned with Virginia Medicaid's 2025 telehealth bulletin clarifying RPM coverage (including for high-risk pregnancy). (vamedicaid.dmas.virginia.gov)
- A rural provider HVN model to coordinate investments, track funds and outcomes, and negotiate value arrangements at scale while preserving local control (Cibolo Health).

The RHT funding formula splits awards into an equal "baseline" and a scored "workload" portion. CMS assigns points for rural facility/population factors and for technical factors that include state policies (e.g., licensure compacts, scope of practice, EMS, SNAP waivers, payment incentives, remote care, data infrastructure). States may earn conditional credit initially for proposed policy changes but must finalize by set deadlines or funds tied to those points are at risk of recovery. (files.simpler.grants.gov)

One-page printable summary (for distribution)

- What the RHT Program funds (selected): prevention/chronic disease; limited provider payments (≤15% of award); consumer tech; training/TA for telehealth/AI/robotics; workforce recruitment/retention with ≥5-year rural commitments; IT/cybersecurity; right-sizing service lines; behavioral health (OUD/SUD, MH); innovative/value models; minor renovations/equipment; regional partnerships. Caps: Category J capital ≤20%; EMR replacement ≤5% if a HITECH-certified system already existed by 9/1/2025; "rural tech catalyst"-type initiatives ≤ the lesser of 10% or $20M. Administrative expenses ≤10%. (files.simpler.grants.gov)
- Required application components (selected): project summary; project narrative; budget narrative; forms (SF-424, SF-424A, SF-LLL, Project/Performance Site); Governor's letter; business assessment; program duplication assessment; other attachments. (files.simpler.grants.gov)
- Virginia fit signals (2024–2025): 8 CAHs; broad EMS system (≈548 agencies in 2025); rural health clinics and FQHC presence; ongoing 1115 waiver (ARTS, FFCY; pending SMI amendment); D-SNP exclusively aligned enrollment effective 1/1/2025; STLDI restricted to 3 months (≤6 months/year); telehealth/RPM updates in 2025; ~392k unserved broadband locations as of Dec 2023. (vdh.virginia.gov)
- Collaborative anchors: tele-specialty (Avel eCare); continuous RPM (BioIntelliSense); cloud/AI/cybersecurity (Microsoft); consumer/mobile and claims analytics (Humetrix/Pangaea); HVN design/governance (Cibolo).

2. Eligibility and RFP Fit 2.1 Program goals and timeline

- Purpose: fund state-led transformation to improve rural access, quality, outcomes via strategic goals: "Make rural America healthy again," Sustainable access, Workforce development, Innovative care, Tech innovation. (files.simpler.grants.gov)
- Key dates and eligibility: optional LOI 9/30/2025; application due 11/5/2025; expected award 12/31/2025; only States eligible; Governor designates lead agency; one official application (latest on-time counts); SF-424 box 19c "No." (files.simpler.grants.gov)
- Funding: cooperative agreement; ~$50B total across FY26–FY30; five budget periods; states may spend each period's funds through the end of the following FY. (files.simpler.grants.gov)

2.2 Scoring and funds distribution

- Workload formula: Total Available Workload Funding × State Points ÷ Sum of Points across approved States; rural facility/population points fixed using Q4 2025; technical factors recalculated each budget period. Table 3 weights (A1–A7, B1–F3) specified at 50%/50%. (files.simpler.grants.gov)
- Conditional points: states may claim partial credit in Year 1 for planned policy changes, with deadlines for finalization (technical factor-specific) or CMS may recover funds tied to unrealized commitments. (files.simpler.grants.gov)

2.3 Compliance checkpoints

- Cost limitations: provider payments ≤15%/period; Category J capital ≤20%; EMR replacement ≤5% where a HITECH-certified EMR existed by 9/1/2025; "rural tech catalyst" initiatives ≤ the lesser of 10% or $20M/period and follow Appendix rules; administrative costs ≤10% (incl. relevant indirects). (files.simpler.grants.gov)
- Prohibitions include lobbying with federal funds; purchase of covered telecom/video surveillance equipment per 2 CFR 200.216; specified sex-trait modification procedures (45 CFR 156.400). Follow 2 CFR Part 200/300 and HHS GPS. (files.simpler.grants.gov)

2.4 Requirement → Collaborative capability → Evidence (examples)

- Demonstrate technology-enabled rural care (telehealth, RPM, AI): Avel eCare 24/7 virtual hospital/tele-specialty; BioIntelliSense continuous RPM with exception-based dashboards; Microsoft cloud, security, analytics. Evidence: collaborative member profiles and capability descriptions.
- Establish governance and partnerships: Cibolo-enabled HVNs to track funds, coordinate investments, and manage outcomes; SI partners (Accenture, KPMG, PwC, AVIA) for PMO, integration, evaluation. Evidence: collaborative governance and SI sections.
- Consumer-facing tools and data exchange: Humetrix patient apps/analytics; outreach via retail health (CVS/Walgreens/Walmart). Evidence: collaborative catalog.

3. Virginia Context Snapshot 3.1 Population, geography, and facilities

- Rural population: In 2020, Virginia had 1.835M rural residents (about 21% of its population, per Fifth District calculations from Decennial Census urban/rural definitions), indicating substantial dispersed need. (richmondfed.org)
- CAHs: 8 designated; listed by VDH (e.g., Bath, Giles, Dickenson, Lee County Community, Page, Shenandoah, Rockbridge, Rappahannock General), updated Oct 11, 2024. Collaborative support: tele-ER/ICU, RPM, cyber. (vdh.virginia.gov)
- RHCs/FQHCs: RHI Hub (HRSA-sourced, July 2025) shows 87 RHCs and 106 FQHC sites in rural areas; 8 CAHs; 0 Rural Emergency Hospitals. (ruralhealthinfo.org)
- EMS: ≈548 volunteer and career EMS agencies in 2025; ≈40k certified providers; ~1.74M calls in the prior year. Collaborative fit: tele-EMS consults, transfer protocols, tele-triage. (vdh.virginia.gov)

3.2 Workforce and HPSA indicators

- HRSA map gallery shows designated Primary Care, Dental, and Mental Health HPSAs across many rural localities (data as of 10/13/2025). Collaborative fit: recruitment pipelines, compacts, tele-support, AI scribe. (data.hrsa.gov)

3.3 Medicaid and coverage context

- 1115 demonstration ("Building and Transforming Coverage, Services, and Supports for a Healthier Virginia") includes ARTS SUD, Former Foster Care Youth, with a pending SMI IMD coverage amendment (submitted 12/31/2024; federal public comment Jan–Feb 2025). Collaborative fit: behavioral health access, tele-psychiatry. (medicaid.gov)
- Duals alignment: Beginning Jan 1, 2025, full-benefit dual eligibles choosing a D-SNP are placed in the Medicaid plan that matches their D-SNP (exclusively aligned enrollment), improving integration. Collaborative fit: integrated analytics, care coordination. (vamedicaid.dmas.virginia.gov)
- Telehealth policy: 9/30/2025 DMAS bulletin updates coverage, including RPM for high-risk pregnancy and chronic conditions; supports out-of-state telemedicine enrollment without in-state physical presence. Collaborative fit: RPM programs and maternal health. (vamedicaid.dmas.virginia.gov)
- Short-term limited-duration insurance (STLDI): Virginia limits STLDI contract terms to ≤3 months, with ≤6 months total in any 12-month period; federal 2024 rule caps to 3 months initial and 4 months maximum for new policies starting on/after 9/1/2024. Collaborative fit: consumer navigation tools. (law.lis.virginia.gov)

3.4 Broadband and digital readiness

- Broadband availability: JLARC (Dec 2023) estimated 87% of Virginia locations had broadband; ~392,020 locations remained unserved (concentrated in Southside and Shenandoah Valley). Collaborative fit: satellite/fixed-wireless-aware care pathways, offline-tolerant tools, and cyber-hardening.

(jlarc.virginia.gov)

3.5 Maternal health and behavioral health signals

- Maternal and child health: VDH dashboards report 34.5 maternal deaths per 100,000 live births (2019–2023 combined), with leading contributors including indirect cardiovascular causes; 2022 pregnancy-associated death rate estimated 70.1 per 100,000 live births. Collaborative fit: maternal RPM, tele-OB, perinatal mental health. (vdh.virginia.gov)
- Overdose trends: In 2023 Virginia recorded 2,463 drug overdose deaths; preliminary 2024 data (as of June 2025) show 1,403 deaths (subject to revision). Collaborative fit: SUD tele-care, pharmacy-based engagement, analytics alerts. (vdh.virginia.gov)

3.6 Certificate of Public Need (COPN)

- Virginia's COPN requires State Health Commissioner approval before initiating specified facility/service projects; aims at cost containment and access. Collaborative fit: right-sizing service lines and facility modifications within Category J limits. (vdh.virginia.gov)

Table: Virginia snapshot and Collaborative alignment (selected)

- CAHs (2024; VDH): 8 → Tele-ER/ICU (Avel), RPM (BioIntelliSense), cyber (Microsoft). (vdh.virginia.gov)
- EMS agencies (2025; VDH): ≈548 → Tele-EMS/transfer playbooks, 988 integration. (vdh.virginia.gov)
- RHCs/FQHC rural sites (July 2025; HRSA/RHI Hub): 87/106 → Tele-primary care, consumer screening kiosks/applications. (ruralhealthinfo.org)
- 1115 (pending SMI amendment; 2025): "ARTS/FFCY + SMI amendment" → BH tele-consults, remote care and care management. (medicaid.gov)
- D-SNP alignment (2025): exclusively aligned enrollment → Data exchange, cross-payer care plans. (vamedicaid.dmas.virginia.gov)
- STLDI (2021 regs; 2024 federal rule): ≤3 months (≤6/yr VA); ≤4 months fed cap for new STLDI → Consumer decision support. (law.lis.virginia.gov)
- Broadband (Dec 2023): 87% served; ~392k unserved → Hybrid connectivity and offline-tolerant tools. (jlarc.virginia.gov)

4. Strategy Aligned to RFP Virginia can frame an integrated rural transformation anchored in: (a) a member-owned rural provider HVN for governance, shared services, and value arrangements; (b) a virtual hospital framework linking CAHs/RHCs/FQHCs/EMS; (c) targeted chronic disease, maternal, and behavioral health programs with consumer tools; and (d) a cyber-secure cloud data/AI platform supporting evaluation and payment integrity. These elements map to RHT strategic goals and allowable uses (A, C, D, E, F, G, H, I, J, K) and the technical scoring factors (B1–F3). (files.simpler.grants.gov)

Evidence/examples (from Collaborative catalog; implementation in Virginia subject to procurement and integration):

- Virtual hospital/tele-specialty coverage (Avel eCare) across ER, ICU, hospitalist, pharmacy, senior care; supports local care capacity.
- Continuous RPM (BioIntelliSense BioButton) for high-risk chronic and perinatal populations with exception dashboards; ties to Medicaid RPM policy update. (vamedicaid.dmas.virginia.gov)
- Cloud/AI/cybersecurity (Microsoft) to improve data exchange, analytics, and resilience.
- Consumer analytics and multilingual triage/PHR tools (Humetrix) to route patients to appropriate care and detect risks (e.g., polypharmacy).

Equity strategy

- Deploy services to rural HPSAs, high-overdose counties, and maternal care deserts first; use EMS and pharmacy footprints for outreach. Use multilingual mobile intake, low-bandwidth modalities, and community screening with local partners (AHA/ASA; retail health). (data.hrsa.gov)

Data use and privacy

- Use a HIPAA/FHIR-aligned cloud platform with role-based access, audit logs, and TEFCA-compatible exchange through participating QHINs; integrate claims (Medicaid/D-SNP), HIE, EMS, and EHR feeds; align with HHS Cybersecurity Performance Goals.

5. Program Design Options (Virginia-tuned; not prescriptive) Option A: Rural Tele-ER/ICU and Stabilization Network

- Target: CAHs and small PPS rural hospitals in SW/Southside; EMS agencies.
- Problem: Off-hours specialist gaps, high transfer rates, staffing strain (EMS and hospitals). Evidence:

large multi-agency EMS footprint; rural hospital mix. (vdh.virginia.gov)
- Components: Avel eCare tele-ER/ICU/pharmacy; EMS tele-consults; standardized transfer/tele-stroke workflows (Viz.ai for stroke activation); cyber-hardening.
- Payment: Medicaid MCO directed payments tied to rural access/quality; facility infrastructure via Category J (≤20%). Policy: COPN coordination; E.D. care quality metrics. (files.simpler.grants.gov)
- Pros/risks: Fast coverage uplift; dependency on clinical staffing/onboarding and bandwidth; mitigations via training and staged go-lives (SIs).

Option B: Cardiometabolic and Maternal RPM + Community Pharmacy Integration

- Target: Rural adults with HTN/diabetes; high-risk pregnancy (maternal HTN/diabetes).
- Problem: Chronic disease and maternal complications; telehealth RPM now supported/clarified by DMAS (2025). (vamedicaid.dmas.virginia.gov)
- Components: BioIntelliSense RPM; pharmacy BP checks/adherence programs (retail partners), multilingual intake (Humetrix), tele-MFM consults.
- Payment: RPM codes; MCO pay-for-outcomes; directed payments for rural chronic care management.
- Pros/risks: Reduced ED visits/readmissions; require device logistics/education; mitigations via digital health navigators.

Option C: Behavioral Health and SUD Access Expansion

- Target: Rural high-overdose counties; duals in aligned D-SNPs; perinatal SUD.
- Problem: High overdose burden; access gaps for psychiatry/therapy. (vdh.virginia.gov)
- Components: Tele-psychiatry (Avel; health system partners), 988 integration, Humetrix safety alerts, pharmacy-based engagement, peer supports; leverage 1115 ARTS/SMI. (medicaid.gov)
- Payment: 1115 waiver authorities; MCO behavioral health incentives.
- Pros/risks: Rapid access; care coordination complexity; mitigations via care navigators and unified analytics.

Option D: Rural Provider High Value Network (HVN) for Shared Services and Value

- Target: Independent rural hospitals/clinics; FQHCs; RHCs.
- Problem: Fragmented investments and limited payer leverage.
- Components: Cibolo-enabled HVN; PMO; shared analytics; contract support for value arrangements; consistent cyber and EHR upgrades.
- Payment: Management costs (admin ≤10%); tech via Category F/J limits; value arrangements with MCOs/D-SNPs.
- Pros/risks: Scale and accountability; requires governance agreements; mitigations via charter and transparent reporting.

6. Governance and Collaborative Roles 6.1 Structure

- State lead agency (Governor-designated) retains decision rights and accountability to CMS; Cooperative Agreement terms apply. (files.simpler.grants.gov)
- Proposed coordination body: a Virginia Rural Transformation Steering Committee (VDH, DMAS, Office of Broadband, hospital association, FQHC PCA, EMS councils, HIE) with a PMO (SI partner) for day-to-day program management.

6.2 RACI (illustrative)

- Accountable: State lead agency (program objectives, compliance). Responsible: PMO (planning, integration, reporting). Consulted: Hospital association, FQHC PCA, EMS councils, HIE, universities, payers. Informed: Community orgs, retail pharmacies.
- Collaborative member roles (capability-aligned):
  - Avel eCare: tele-ER/ICU/hospitalist services, training.
  - BioIntelliSense: RPM devices/analytics and clinical dashboards.
  - Microsoft: cloud/AI platform, cyber program.
  - Humetrix: consumer PHR/triage apps, population analytics.
  - Cibolo Health: HVN design/operations, fund tracking.
  - SI partners (Accenture, KPMG, PwC, AVIA): PMO, procurement support, outcome evaluation.

7. Payment and Funding 7.1 Payment paths consistent with the NOFO

- Use Medicaid managed care directed payments and APM pilots for rural access/quality; value arrangements for HVN participants; limited direct provider payments within the 15% cap; Category J for minor renovations/equipment within 20% cap; EMR replacement (≤5%) only for systems with a pre-9/1/2025 HITECH-certified baseline; administrative ≤10%. (files.simpler.grants.gov)
- Align duals with D-SNP exclusively aligned enrollment to streamline care management and analytics.

(vamedicaid.dmas.virginia.gov)

7.2 Illustrative budget categories, funding sources, and deliverables (ROM proportions; actuals to be finalized in SF-424A)

- Tele-ER/ICU services and training (E), RPM devices/services (A/F), consumer engagement tools (C), HVN and PMO (K/admin), cyber/IT (F), minor renovations/equipment (J); map each line to initiatives and to NOFO caps (and to A–K use-of-funds categories). (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Measures: access (time-to-consult, tele-ER response), quality/safety (stroke door-to-needle, OB hypertension control), chronic disease control (BP, A1c), behavioral health engagement, utilization (avoid transfers/ED revisits), financial metrics (rural margin), technology metrics (uptime, cyber posture), implementation milestones. NOFO requires cooperation with CMS evaluations. (files.simpler.grants.gov)
- Data sources/integration: Medicaid/D-SNP claims; HIE feeds; EHRs; EMS ePCR; social services; consumer app data—ingested to a HIPAA/FHIR cloud with governance and audit; alignment with HHS Cybersecurity Performance Goals.

9. Implementation Plan (12–24 months; initial tranche) Gantt-style table (illustrative)

- Workstream; Start; End; Owner; Outputs
- PMO mobilization; Jan 2026; Mar 2026; SI PMO; Charter, risk plan, reporting templates.
- Tele-ER/ICU pilot (3 hospitals); Feb 2026; Aug 2026; Avel + hospitals; SOPs, coverage, metrics baseline.
- RPM cohort (HTN/diabetes, perinatal); Mar 2026; Sep 2026; BioIntelliSense + FQHCs; enrolled patients, dashboards.
- Consumer engagement and triage; Apr 2026; Oct 2026; Humetrix + pharmacies; multi-language intake, routing.
- HVN stand-up; Feb 2026; Jun 2026; Cibolo; bylaws, funds tracking, common metrics.
- Cyber/IT baseline and gap remediation; Feb 2026; Nov 2026; Microsoft + sites; cyber assessments, action plans.
- Evaluation design and dashboards; Mar 2026; Jul 2026; SI + State + CMS; measure library, scorecards.

Key gating decisions

- Site readiness and broadband adequacy; COPN alignment for any service changes; compliance with NOFO caps; data-sharing and BAAs; procurement timing. (jlarc.virginia.gov)

10. Risk Register (selected)

- Staffing/coverage gaps for tele-ER/ICU (Owner: hospital/Cibolo/Avel). Mitigation: staged activation, cross-coverage pools.
- RPM adherence/device logistics (Owner: BioIntelliSense/FQHCs). Mitigation: digital navigators, device swap stock.
- Data-sharing delays (Owner: State PMO/SI). Mitigation: standardized DUAs, phased interfaces.
- Cyber vulnerabilities (Owner: sites/Microsoft). Mitigation: baseline assessment and managed response.
- Policy dependencies (e.g., compacts, scope, SNAP waiver status) (Owner: State). Mitigation: legislative/regulatory plan; use conditional points framework. (files.simpler.grants.gov)
- Broadband constraints (Owner: sites/Office of Broadband). Mitigation: offline-tolerant workflows; phased deployment in served areas first. (jlarc.virginia.gov)
- Caps compliance (Owner: PMO/Budget). Mitigation: fund tracking against caps (B 15%, J 20%, admin 10%, EMR 5%). (files.simpler.grants.gov)
- HPSA recruitment challenges (Owner: HVN/DMAS). Mitigation: compact participation where applicable (PT, PSYPACT, PA, EMS), loan repayment and NHSC placements. (dhp.virginia.gov)
- Duals integration change management (Owner: DMAS/MCOs). Mitigation: aligned enrollment communications, integrated call centers. (vamedicaid.dmas.virginia.gov)
- COPN timing (Owner: VDH COPN Office/sites). Mitigation: batch planning. (vdh.virginia.gov)

11. Draft RFP Response Language (Virginia-tailored; paste-ready excerpts) 11.1 Project Summary (abstract) “Virginia proposes to improve rural access, outcomes, and sustainability by deploying a coordinated tele-specialty and remote monitoring network, establishing a rural provider High Value Network for shared services and value-based arrangements, strengthening behavioral health and maternal care access via telehealth and community partnerships, and modernizing cyber-secure data infrastructure to support evaluation and payment integrity. Initiatives align with the RHT goals (prevention, sustainable access, workforce, innovative care, technology) and adhere to program caps and requirements.” (files.simpler.grants.gov)

11.2 Rural Health Needs and Target Population “Virginia’s rural system includes 8 CAHs, ≈548 EMS agencies,

and a network of RHCs/FQHCs serving ~1.8M rural residents (2020). Recent indicators include 2,463 overdose deaths in 2023 (preliminary 2024 = 1,403 as of June 2025) and a maternal mortality rate of 34.5 per 100,000 live births (2019–2023). Connectivity gaps persist (~392k unserved locations as of Dec 2023). Priority geographies include Southside and Shenandoah Valley and HPSA-designated counties." (vdh.virginia.gov)

11.3 Goals and Strategies "Virginia will pursue five program-level objectives (FY26–FY31): (1) reduce avoidable transfers from rural hospitals by ≥15%; (2) improve blood pressure control to ≥70% among RPM-enrolled patients; (3) reduce 30-day all-cause readmissions from CAHs by ≥10%; (4) increase perinatal follow-up within 7 days postpartum by ≥20% in targeted regions; and (5) achieve a statewide cyber minimum per HHS Cybersecurity Performance Goals across rural sites. Strategies map to allowable uses A, C, D, E, F, G, H, I, J, K." (files.simpler.grants.gov)

11.4 Proposed Initiatives and Use of Funds "Virginia proposes: (i) Rural Tele-ER/ICU Network (Avel eCare); (ii) Cardiometabolic & Maternal RPM (BioIntelliSense); (iii) Behavioral Health Access Expansion (tele-psychiatry; 1115 ARTS/SMI); (iv) HVN Formation & Shared Services (Cibolo); (v) Cyber & Data Infrastructure modernization (Microsoft). Each initiative includes ≥4 measurable outcomes, county lists (FIPS), and budget lines mapped to the categorical caps (B≤15%, J≤20%, admin≤10%, EMR≤5%)." (files.simpler.grants.gov)

11.5 Implementation Plan & Timeline "Phased 24-month plan with PMO activation, pilot sites, statewide scale-up, evaluation, and NCC submissions; includes contracting milestones with partners and gating decisions tied to COPN and broadband readiness." (files.simpler.grants.gov)

11.6 Stakeholder Engagement "Formal roles for VDH, DMAS, Office of Broadband, EMS councils, VHHA, the PCA, HIE, tribal/IHS (as applicable), universities, and community organizations; steering committee with monthly cadence and consumer input."

11.7 Metrics & Evaluation "Data platform integrates Medicaid/D-SNP claims, EHR, EMS, and consumer app data; dashboards track access, quality, financial, workforce, technology, and implementation metrics; State will cooperate with CMS/third-party evaluations." (files.simpler.grants.gov)

11.8 Budget Narrative (caps and compliance) "Budgets adhere to administrative ≤10%, Category J ≤20%, provider payments ≤15%, and EMR replacement ≤5% (as applicable); each line is mapped to an initiative and A–K use-of-funds categories; sub-awards include Federal flow-down terms." (files.simpler.grants.gov)

Assumptions and Open Questions (for internal planning)

- We rely on CMS's posted NOFO PDF for deadlines, caps, scoring, and content; if CMS issues any amendments, figures will be updated. (files.simpler.grants.gov)
- Frontier metric (A.5): Virginia likely has minimal "frontier" areas under standard definitions; confirm with CMS's Table 4 references when compiling the state's baseline. (files.simpler.grants.gov)
- SNAP waiver status (B.3) and nutrition CME (B.4): verify current Virginia policies and timelines to determine eligibility for conditional points. (files.simpler.grants.gov)
- Medicaid provider incentive programs (E.1): align with current DMAS directed payment/APM opportunities; specify in SPA/NCC as needed. (files.simpler.grants.gov)
- CCBHC list (as of 9/1/2025) and count of Medicaid DSH hospitals (latest SPRY): to be appended per NOFO. (files.simpler.grants.gov)

12. References

1. Rural Health Transformation Program — Notice of Funding Opportunity (CMS-RHT-26-001), Centers for Medicare & Medicaid Services, files.simpler.grants.gov (accessed 2025-10-14). https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf (files.simpler.grants.gov)
2. RHT Collaborative — Consensus Catalog (R1, 10-11-25), Rural Health Transformation Collaborative (internal partner capabilities; accessed 2025-10-14).
3. Virginia Department of Health, Critical Access Hospitals (updated 2024-10-11). https://www.vdh.virginia.gov/health-equity/critical-access-hospitals-cah/ (vdh.virginia.gov)
4. Rural Health Information Hub — Virginia State Guide (data.HRSA.gov sources; updated 2025-09-11). https://www.ruralhealthinfo.org/states/virginia (ruralhealthinfo.org)
5. Virginia Office of EMS — EMS Statistics (2023–2025 snapshots; accessed 2025-10-14). https://www.vdh.virginia.gov/emergency-medical-services/ems-statistics/ (vdh.virginia.gov)
6. DMAS — D-SNP exclusively aligned enrollment bulletin (2025-01-01). https://vamedicaid.dmas.virginia.gov/bulletin/change-enrollment-policy-certain-dual-eligible-medicare-medicaid-enrollees (vamedicaid.dmas.virginia.gov)
7. DMAS — Telehealth Services Update (2025-09-30). https://vamedicaid.dmas.virginia.gov/bulletin/telehealth-services-update-3 (vamedicaid.dmas.virginia.gov)
8. Virginia Administrative Code — STLDI (14VAC5-141-140) and Code §38.2-3407.21. https://law.lis.virginia.gov/admincode/title14/agency5/chapter141/section140/; https://law.lis.virginia.gov/vacode/title38.2/chapter34/section38.2-3407.21/ (law.lis.virginia.gov)

9. Federal STLDI final rule (2024-03-28) summary. American Hospital Association/American Society for Health Care Engineering (accessed 2025-10-14). (aha.org)
10. JLARC — Broadband Deployment in Virginia (2024). https://jlarc.virginia.gov/landing-2024-broadband-deployment-in-virgnia.asp (jlarc.virginia.gov)
11. VDH — Drug Overdose Data (dashboard and Fast Facts; accessed 2025-10-14). https://www.vdh.virginia.gov/drug-overdose-data/ (vdh.virginia.gov)
12. VDH — Maternal & Child Health Data (dashboard; updated 2025-10-10). https://www.vdh.virginia.gov/data/maternal-child-health/ (vdh.virginia.gov)
13. Virginia Maternal Mortality Review Team Annual Report 2024 (RD179, published 2025). https://rga.lis.virginia.gov/Published/2025/RD179 (rga.lis.virginia.gov)
14. VDH Licensure & Certification — Certificate of Public Need Program (accessed 2025-10-14). https://www.vdh.virginia.gov/licensure-and-certification/the-certificate-of-public-need-program/ (vdh.virginia.gov)
15. HRSA — Health Professional Shortage Areas Map Gallery (as of 2025-10-13). https://data.hrsa.gov/topics/health-workforce/shortage-areas/map-gallery-hpsa (data.hrsa.gov)
16. CMS RHT Program overview site (timeline/structure). https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview (accessed 2025-10-14). (cms.gov)

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