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

1. Executive Summary Ohio can leverage the Rural Health Transformation (RHT) Program to stabilize rural access, advance population health, and modernize data and payment infrastructure. CMS will award cooperative agreements to States only, with a one-time application due November 5, 2025, awards by December 31, 2025, and five budget periods FY26–FY30. Half of funds are distributed equally; half are tied to a points system that combines rural facility/population factors and technical factors. Caps apply to selected uses (for example, provider payments ≤15% and capital/infrastructure ≤20% per budget period). These elements define success conditions and compliance boundaries for Ohio's proposal. (files.simpler.grants.gov)

The Rural Health Transformation Collaborative (the Collaborative) offers interoperable health IT, telehealth/virtual hospital services, remote patient monitoring (RPM), pharmacy-enabled chronic care, analytics, and program management support that can be contracted by the State or subrecipients. These capabilities can underpin Ohio's initiatives across prevention, workforce, innovative care, data infrastructure, and partnerships while aligning to scoring factors (e.g., remote care services, data infrastructure, rural provider partnerships).

Ohio's rural context—about 2.80 million residents (23.7%) live in rural areas by 2020 Census criteria; the State has roughly 33 Critical Access Hospitals (CAHs), 70 Rural Health Clinics (RHCs), and 206 FQHC sites located outside urbanized areas—indicates scale and distribution for impact. Medicaid covers about 3.21 million Ohioans in FY2024 (~27.1% of residents), and Ohio's "Next Generation" managed care program launched February 1, 2023, offers a foundation for payment and data integration. Ohio recorded 4,452 unintentional drug overdose deaths in 2023 (down from 4,915 in 2022), with provisional CDC data indicating a further ≥35% decline in 2024. These trends reinforce the need for targeted rural behavioral health/SUD, maternal health, and chronic disease strategies supported by technology and workforce solutions. (ncsl.org)

The guide outlines compliant, Ohio-specific program options, governance and RACI, payment/funding approaches, evaluation, and a 24-month implementation plan. All implementation statements are conditional upon contracting, data-sharing agreements, and alignment with CMS and State requirements.

One-page printable summary (for distribution)

- What CMS is offering
  - Cooperative agreements to States only; total $50B FY26–FY30; 50% equal baseline, 50% points-based workload; single application due 11/5/2025; awards 12/31/2025. (files.simpler.grants.gov)
- What Ohio must file
  - Project narrative (≤60 pp), budget narrative (≤20 pp), governor's endorsement (≤4 pp), business assessment, duplication assessment, required forms (SF-424/424A, SF-LLL, site form). Check "No" on SF-424 19c (EO 12372 not applicable). Admin costs ≤10%. (files.simpler.grants.gov)
- High-leverage initiatives (examples; see Section 5)
  - Tele-enabled emergency/ICU support and rural EMS integration; statewide RPM for high-risk chronic conditions; pharmacist-enabled chronic care and care navigation; maternal/behavioral integration with virtual psychiatry/CBT.
- How the Collaborative can support (subject to procurement)
  - Interoperable data/analytics; secure cloud & cybersecurity; tele-specialty/virtual hospital; AI-supported workflows; retail pharmacy partnerships; HVN governance and program management.

2. Eligibility and RFP Fit 2.1 Snapshot of CMS requirements (selected)

- Eligibility: Only the 50 U.S. States; DC and Territories are ineligible. One official application per State; Governor's endorsement required. (files.simpler.grants.gov)
- Deadlines: Optional LOI by Sep 30, 2025; application due Nov 5, 2025, 11:59 p.m. ET; award/earliest start Dec 31, 2025. (files.simpler.grants.gov)
- Funds distribution: Baseline (equal among approved States) and Workload (points-based). Workload recalculated annually for technical factors; rural facility/population factors fixed off Q4 2025 data. (files.simpler.grants.gov)
- Caps and limits: Provider payments ≤15%; Capital & infrastructure (Category J) ≤20%; EMR replacement ≤5% if a HITECH-certified EMR was in place on 9/1/2025; "Rural Tech Catalyst Fund"-like initiatives ≤10% or $20M per period. Admin expenses ≤10%. (files.simpler.grants.gov)
- Application format: Project summary (1 page), Project narrative (≤60 pages), Budget narrative (≤20 pages), attachments including Governor's letter and business assessment; required forms SF-424/424A, SF-LLL, Project/Performance Site. Check "No" on SF-424 19c (EO 12372 not applicable). (files.simpler.grants.gov)

2.2 Requirement-to-Capability Mapping (evidence excerpts)

- Requirement: Demonstrate statewide strategy across prevention, access, workforce, innovative care, technology; include measurable outcomes. Capability: Collaborative provides statewide tele-specialty (Avel eCare), RPM (BioIntelliSense), pharmacy-enabled chronic care (Walgreens/CVS), analytics and program management (Accenture/KPMG/PwC/AVIA). Evidence: partner summaries and roles.
- Requirement: Interoperable data infrastructure, privacy/security, remote care services. Capability: Azure-based cloud/security, AI/analytics, TEFCA/FHIR-oriented exchange; consumer-facing apps for triage/navigation; remote monitoring. Evidence: collaborative technology sections.
- Requirement: Rural provider strategic partnerships and governance. Capability: Cibolo-enabled High Value Networks (HVNs) for rural hospitals/clinics; shared services, compliance tracking. Evidence: Cibolo HVN model.
- Requirement: Behavioral health/OUD access. Capability: Tele-behavioral services via Avel/Teladoc; risk triage and medication safety alerts (Humetrix). Evidence: behavioral access and analytics descriptions.

3. Ohio Context Snapshot 3.1 Population, rurality, facilities, coverage (selected metrics)

- Rural population: 2,798,349 (23.7%) in 2020. (ncsl.org)
- Rural facilities: 33 CAHs, 70 RHCs, 206 FQHC sites outside urbanized areas (HRSA data reflected by RHIhub, July 2025). (ruralhealthinfo.org)
- Medicaid coverage: FY2024 average enrollment ~3.21M (27.1% of residents). (usafacts.org)
- Managed care platform: “Next Generation” Medicaid managed care launched Feb 1, 2023 (staged rollout). (content.govdelivery.com)
- Overdose trend: 4,452 unintentional overdose deaths in 2023 (↓9% vs. 2022), with CDC indicating ≥35% decline in 2024 (provisional). (timesleaderonline.com)

3.2 Metric-to-Capability Table (illustrative)

- Rural share and dispersion (2020) → Tele-specialty coverage to reduce transfers; statewide RPM for chronic disease; consumer triage and navigation. (ncsl.org)
- CAHs/RHCs/FQHCs inventory (2025) → Virtual hospital support (tele-ER/ICU/hospitalist), pharmacy-enabled chronic care, remote diagnostics. (ruralhealthinfo.org)
- Medicaid enrollment and managed care platform → Analytics for attribution, quality, and incentive design; claims modernization and prior auth support. (usafacts.org)
- Overdose burden (2023–2024 trend) → Tele-behavioral crisis support, OUD treatment access, medication safety alerts, community screening and linkage. (timesleaderonline.com)

Assumptions and Open Questions (to be confirmed during application drafting)

- CCBHC sites as of Sep 1, 2025: Confirm list and locations from SAMHSA/OhioMHAS.
- Count of hospitals receiving Medicaid DSH in most recent State Plan Rate Year: ODM confirmation needed (NOFO requires reporting). (files.simpler.grants.gov)
- Broadband baselines by county: Source alignment (FCC/NTIA/BroadbandOhio) to be finalized for targeting remote care infrastructure.
- Alignment with State legislative priorities (e.g., scope of practice adjustments, licensure compacts) to maximize technical scoring.

4. Strategy Aligned to RFP Ohio’s Rural Transformation Model (conditional)

- Core: A rural High Value Network (HVN) framework linking CAHs, RHCs, FQHCs, EMS, and retail pharmacy access points; virtual hospital services; statewide RPM for high-risk chronic conditions; maternal/behavioral integration; and a data platform with privacy/security controls aligned to FHIR/TEFCA.
- Scoring alignment:
  - C.1 Rural provider strategic partnerships: HVN construct for shared services.
  - F.1 Remote care services: RPM + tele-specialty bundles.
  - F.2 Data infrastructure: Cloud, analytics, cyber hardening.
  - B.1 Population health clinical infrastructure/B.2 Health & lifestyle: Consumer triage/engagement and pharmacist-enabled disease management.
- Equity for rural and Tribal communities: Targeting by HPSA status and social risk using claims/EHR/population data; multi-language triage and navigation; community partners (AHA/ASA) for screenings.
- Data use and privacy: HIPAA-compliant platforms; consent management; de-identified analytics for evaluation; security practices aligned with HHS/CMS requirements.

5. Program Design Options (Ohio-tuned; all subject to procurement and SPA/waiver review as applicable) Option A: Virtual Hospital and EMS-First Rural Access

- Target: CAHs and EMS in high-transfer corridors; rural ED throughput and time-critical conditions.
- Problem: Transfer delays and limited specialist access; pressure on rural ERs.
- Components: Avel eCare tele-ER/ICU/hospitalist; Viz.ai stroke/large-vessel occlusion alerts; EMS

tele-consult; pharmacy-based BP/diabetes management to offload ED revisits.
- Payment logic: Facility support through Category B (≤15%) for defined non-reimbursable services; RPM/device services via existing payers when billable; value-oriented add-ons via Medicaid incentives/quality pools. (files.simpler.grants.gov)
- Policy enablers: EMS protocols, telehealth parity (administrative), data-sharing agreements.
- Risks: Cybersecurity, referral leakage, workforce adoption; mitigations via security hardening, HVN governance, training.

Option B: Statewide Remote Patient Monitoring for Cardio-Metabolic High-Risk Cohorts

- Target: Medicaid members with uncontrolled HTN/CHF/diabetes; high-risk post-discharge.
- Components: BioIntelliSense BioButton with exception-based dashboards; pharmacist-led titration protocols; virtual visits (Teladoc/Avel); multi-language triage.
- Payment logic: Blend of reimbursable RPM codes (where applicable) and gap-filling support under Category A/B; incentives under E.1 technical factor via Medicaid plan quality measures. (files.simpler.grants.gov)
- Risks: Device logistics and digital literacy; mitigations through digital navigators and CHWs.

Option C: Maternal and Behavioral Health Integration for Rural Counties

- Target: Rural maternal health deserts; SUD/OUD with perinatal focus.
- Components: Tele-OB consults; remote BP monitoring postpartum; virtual psychiatric care; medication safety alerts (Humetrix) for polypharmacy and OUD risk; community screening via AHA/ASA partners.
- Payment logic: Focus Category A/H; coordinate with Medicaid managed care incentives; align with CCBHC partners where designated.
- Risks: Care coordination across multiple entities; mitigated by HVN governance and shared care pathways.

Option D: Data, Cybersecurity, and Analytics Backbone

- Target: All participating rural facilities.
- Components: Azure cloud, cybersecurity, analytics; claims modernization and prior authorization workflow support; consumer apps for navigation; FHIR/TEFCA integration.
- Payment logic: Category F (IT advances), with adherence to capital/EMR caps. (files.simpler.grants.gov)
- Risks: Integration complexity; mitigations via systems integrators and PMO support.

6. Governance and Collaborative Roles 6.1 Structure (described)

- State leads: Governor-designated agency (e.g., ODH or ODM) as prime recipient; statewide Steering Committee; HVN board(s) for rural providers.
- Data governance: State-owned environment, role-based access, BAAs/DUAs, TEFCA/FHIR exchange.

6.2 RACI (illustrative)

- Strategy/Plan: State (A/R); Collaborative SI partners (C); Provider/HVN (C/I).
- Data platform/cyber: State CIO/ODH-IT (A/R); Microsoft + SI (R); providers (C).
- Tele-specialty & RPM operations: Providers/HVN (A/R); Avel/BioIntelliSense (R); payers (C).
- Retail pharmacy chronic care: Walgreens/CVS (R); FQHCs/PCPs (A); State (C).
- Program management and evaluation: State PMO (A/R); Accenture/KPMG/PwC/AVIA (R).

7. Payment and Funding 7.1 Funding policies (guardrails)

- Category B provider payments ≤15%; Category J capital/infrastructure ≤20%; EMR replacement ≤5% (if HITECH EMR in place on 9/1/2025); “Rural Tech Catalyst Fund”-like initiatives ≤ the lesser of 10% or $20M/budget period. Admin expenses ≤10%. (files.simpler.grants.gov)

7.2 Medicaid alignment (opportunities)

- Use managed care incentives/quality pools for RPM/behavioral integration; evaluate SPA or APM constructs for HVN-based primary care incentives; actuarial modeling via analytics partners.

7.3 Costing table (rough order of magnitude; planning)

- Data/cyber platform; tele-specialty coverage; RPM kits & monitoring; pharmacy-enabled chronic care; evaluation. Funding: RHT categories A/D/F/J; timing aligned to five budget periods; deliverables: live services, dashboards, KPI reports. (Ensure admin total ≤10% and Category caps observed.) (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Core measures: Access (tele-specialty response; ED transfer rate), quality (BP control; A1c; postpartum BP; antidepressant adherence), utilization (avoidable ED; readmissions), financial (CAH margin trend; cost per beneficiary), workforce (vacancy, retention), technology (downtime, MFA adoption).
- Sources: Medicaid claims/encounters; EHRs; HIE; EMS data; pharmacy data; consumer app telemetry (de-identified); public health registries; HRSA shortage indicators.
- Frequency: Monthly ops dashboards; quarterly KPI reviews; annual CMS reporting per NOFO. (files.simpler.grants.gov)
- Evaluation: State-led with SI analytic support; quasi-experimental designs where feasible; continuous learning loops to adjust programs.

9. Implementation Plan (12–24 months; conditional; Gantt-style) | Workstream | Start | End | Primary owner | Key outputs | |—|—|—|—|—| | Program governance + PMO | Jan 2026 | Mar 2026 | State PMO | Charter, RACI, reporting calendar | | Data platform + cyber hardening | Jan 2026 | Aug 2026 | State IT + SI | Secure cloud tenant, identity/MFA, data pipelines, KPI dashboards | | HVN formation + contracts | Feb 2026 | Jun 2026 | Cibolo + Providers | HVN bylaws, participation agreements, shared services plan | | Tele-ER/ICU/hospitalist pilots | Apr 2026 | Dec 2026 | Avel + CAHs | Go-lives, protocols, transfer metrics baseline | | RPM cohort rollout (HTN/CHF/DM) | May 2026 | Mar 2027 | BioIntelliSense + PCPs | Enrollment, device logistics, alert thresholds | | Pharmacy-enabled chronic care | May 2026 | Mar 2027 | Walgreens/CVS + FQHCs | BP checks, med reconciliation, MTM documentation | | Behavioral/maternal integration | Jun 2026 | Mar 2027 | Teladoc/Avel + OB providers | Tele-OB consults, tele-psychiatry slots, postpartum RPM | | Evaluation & sustainability plan | Jul 2026 | Mar 2027 | State + SI | Year-1 evaluation, sustainability scenarios |

10. Risk Register (selected)

- Data privacy/security incidents; mitigation: zero-trust, MFA, logging; Owner: State CIO/SI.
- Workforce adoption shortfalls; mitigation: training/tele-mentoring/ambient documentation; Owner: HVN Clinical Leads.
- Integration delays; mitigation: phased interfaces, vendor SLAs; Owner: SI Lead.
- RPM non-use; mitigation: CHW/digital navigators; Owner: Provider PMO.
- Payment misalignment; mitigation: payer engagement and quality incentives; Owner: ODM/Payers.
- Tele-behavioral capacity constraints; mitigation: pooled virtual network; Owner: Provider/HVN.
- Capital cap overrun; mitigation: cap tracking and portfolio steering; Owner: State Finance. (files.simpler.grants.gov)
- Provider payment cap breach; mitigation: guardrails in subaward budgets; Owner: Grants Mgmt. (files.simpler.grants.gov)
- Admin cap breach; mitigation: chart of accounts and monthly variance checks; Owner: Grants Mgmt. (files.simpler.grants.gov)
- Performance noncompliance; mitigation: corrective action cycles per 2 CFR; Owner: State PMO. (files.simpler.grants.gov)

11. Draft RFP Response Language (Ohio-tailored; paste-ready; conditional) 11.1 Rural Health Needs and Target Population Ohio’s rural population totals approximately 2.80 million (23.7%, 2020), with significant concentrations of CAHs, RHCs, and FQHC sites outside urbanized areas (33, 70, and 206, respectively). Medicaid covers ~3.21 million Ohioans (FY2024). Ohio experienced 4,452 unintentional overdose deaths in 2023 (↓9% vs. 2022), with provisional federal data indicating ≥35% decline in 2024. These factors inform our priorities in emergency access, chronic disease, behavioral health, maternal health, and data infrastructure. (ncsl.org)

11.2 Goals, Strategies, and State Policy Actions We propose a statewide model anchored by rural High Value Networks, tele-specialty/virtual hospital services, and RPM-enabled chronic care, supported by secure, interoperable data infrastructure and pharmacy-enabled primary care. We will evaluate policy options that may improve our technical score (e.g., workforce recruitment incentives, licensure compacts, and defined remote care standards), subject to State legislative and regulatory processes.

11.3 Proposed Initiatives and Use of Funds We will fund a portfolio that addresses at least three allowed categories: prevention/chronic disease; workforce recruitment/retention; innovative care models; IT advances; behavioral health; and right-sizing service lines. Program budgets will comply with NOFO caps (provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5%; any tech-catalyst-like initiative ≤10% or $20M per period) and administrative expenses ≤10%. (files.simpler.grants.gov)

11.4 Implementation and Timeline Our 24-month plan sequences governance/PMO, data/cyber buildout, HVN formation, tele-specialty and RPM rollouts, and evaluation, with quarterly milestones and KPIs.

11.5 Stakeholder Engagement We will convene rural hospitals, CAHs, FQHCs, RHCs, EMS, retail pharmacies, payers, universities, and community organizations, documenting support and roles.

11.6 Metrics and Evaluation We will report access, quality, utilization, workforce, technology, and financial metrics using Medicaid claims, EHR/HIE, EMS, and public health data, and cooperate with CMS/third-party evaluation.

Compliance cross-references: application format, forms, EO 12372, reporting

- Formats/page limits and attachments; required forms SF-424/424A, SF-LLL; “No” on 19c (EO 12372 does not apply); post-award reporting per 2 CFR/HHS GPS. (files.simpler.grants.gov)

12. References

1. Rural Health Transformation Program — NOFO CMS-RHT-26-001, CMS, https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf, accessed 2025-10-14. (files.simpler.grants.gov)
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4. Rural health for Ohio — facilities and nonmetro shares, Rural Health Information Hub, https://www.ruralhealthinfo.org/states/ohio, accessed 2025-10-14. (ruralhealthinfo.org)
5. Medicaid enrollment in Ohio FY2024 (~3.21M; 27.1%), USAFacts (CMS source), https://usafacts.org/..., accessed 2025-10-14. (usafacts.org)
6. Ohio Next Generation Medicaid managed care launch (Feb 1, 2023) — ODM bulletin, https://content.govdelivery.com/.../3380164, accessed 2025-10-14. (content.govdelivery.com)
7. Ohio unintentional overdose deaths 2023 (4,452) — press coverage citing State report, The Times Leader, https://www.timesleaderonline.com/..., accessed 2025-10-14. (timesleaderonline.com)
8. U.S./Ohio 2024 provisional overdose declines (≥35% Ohio), CDC NCHS press release, https://www.cdc.gov/nchs/pressroom/..., accessed 2025-10-14. (cdc.gov)
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10. Rural-Urban Continuum Codes (documentation), USDA ERS, https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/, accessed 2025-10-14. (ers.usda.gov)
11. Rural Health Transformation Collaborative consensus document (capabilities, partners, roles), RHT Collaborative R1 (10-11-25).

13. AI Generation Notice This guide was generated with the gpt-5 model on 2025-10-14. The content is AI-generated and provided for planning support. All facts, figures, and citations must be independently validated against primary sources (e.g., CMS NOFO, State data) before use in any official submission or public communication.