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

1. Executive Summary Nebraska's rural profile—34.4% of residents living in nonmetro areas in 2023, with 62 Critical Access Hospitals (CAHs), 128 Rural Health Clinics (RHCs), 25 FQHC sites outside urban areas, and one Rural Emergency Hospital—positions the state to leverage the CMS Rural Health Transformation Program (RHT) to accelerate access, quality, and sustainability of care in frontier and rural communities. [1] (ruralhealthinfo.org)

The RHT Program offers $50B over FY26–FY30 via cooperative agreements to states; half of each year's funds are distributed evenly and half by a points-based workload methodology. Applications are due November 5, 2025, with awards targeted by December 31, 2025. [2][3] (cms.gov) Nebraska can align its plan with the program's five strategic goals—prevention, sustainable access, workforce, innovative care, and tech innovation—while staying within program caps (e.g., provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5%; admin ≤10%). [3] (cms.gov)

The Rural Health Transformation (RHT) Collaborative can support Nebraska by combining: (a) statewide tele-hospital, tele-emergency, and tele-behavioral coverage through experienced virtual hospital partners; (b) chronic disease programs that integrate remote patient monitoring and pharmacy-enabled primary care; (c) secure cloud data and analytics for outcomes tracking, payment integrity, and evaluation; (d) cybersecurity uplift for rural facilities using nationally scaled programs; and (e) accountable provider networks for rural sustainability. These capabilities map directly to allowable uses, technical scoring factors, and initiative scoring in the NOFO and webinar. [4][5][6] (cms.gov)

Nebraska's policy and infrastructure context strengthens this fit. The state administers Medicaid mainly through Heritage Health managed care (Molina, Nebraska Total Care, UnitedHealthcare) and has an extended SUD 1115 demonstration through June 2030—a platform for integrated behavioral health initiatives. Nebraska is also deploying BEAD and state broadband investments to close rural connectivity gaps, a prerequisite for telehealth and data exchange. [7][8][9][10] (mltcfindprovider-dhhs.nebraska.gov)

One-page printable summary

- What RHT brings: $50B total (FY26–FY30); 50% even + 50% points-based; state-led portfolio spanning prevention, access, workforce, innovation, tech; one application window (Nov 5, 2025). [2][3] (cms.gov)
- Nebraska need snapshot (latest available): 34.4% nonmetro population (2023); 62 CAHs, 128 RHCs, 25 FQHC sites outside urban, 1 REH (July 2025); maternal care deserts among the highest-percentage states (2024). [1][11] (ruralhealthinfo.org)
- High-leverage initiatives the Collaborative can support (subject to procurement/integration): • Rural Tele-Hospital Grid (tele-ER/ICU, hospitalist, pharmacy, and psychiatry) integrated with EMS. • Primary care + pharmacy chronic disease model with remote monitoring and AI-enabled workflows. • Behavioral health/SUD integration aligned to Nebraska's 1115 SUD demo. • Cybersecurity uplift and data platform for outcomes/evaluation. [4][12] (aha.org)
- Funding guardrails: provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% (if HITECH-certified system in place 9/1/2025); admin ≤10%. [3] (cms.gov)
- Scoring: Rural facility/population (50%) + Technical factors (50%); factor weights and initiative-level scoring drive workload points. [5] (cms.gov)

2. Eligibility and RFP Fit 2.1 Program summary and deadlines (extract)

- Applicant: U.S. states only (DC and territories ineligible). One application per state; Governor's endorsement required. [2][3] (cms.gov)
- Timeline (2025): Optional LOI Sep 30; application due Nov 5, 11:59 p.m. ET; awards by Dec 31. [3] (cms.gov)
- Funds: $10B each FY26–FY30; 50% baseline; 50% workload based on data factors, technical factors, and initiative scoring. [2][5] (cms.gov)
- Key allowable uses: prevention/chronic disease; provider payments (capped); consumer tech for chronic disease; training/TA for advanced tech; workforce (≥5-year rural service); IT/cyber; right-sizing services; behavioral health/SUD; innovative care/payment models; additional Administrator-approved uses. [2][3] (cms.gov)
- Caps: provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% (if HITECH-certified system pre-9/1/2025); admin ≤10%; "tech catalyst"-type initiatives ≤10% or $20M per period. [3] (cms.gov)
- Required contents: project summary; project narrative; budget narrative; attachments (Governor letter, indirect cost rate, business assessment, duplication assessment, others); forms (SF-424, SF-424A, SF-LLL, performance sites). [3] (cms.gov)

2.2 Scoring and distribution highlights

- Baseline 50% + Workload 50% per period. [5] (cms.gov)
- Rural facility/population factors (50% total): rural population size; % rural facilities; uncompensated care share; % population in rural areas; frontier metric; land area; % hospitals receiving Medicaid DSH—with weights shown in the webinar deck. [5] (cms.gov)
- Technical factors (50% total): population health/clinical infrastructure; health/lifestyle; SNAP waivers; nutrition CME; strategic partnerships; EMS; certificate of need; talent recruitment; licensure compacts; scope of practice; Medicaid payment incentives; duals strategy; short-term limited-duration insurance; remote care; data infrastructure; consumer-facing tech—each with weights as shown. [5] (cms.gov)
- Initiative-level scoring: strategy, workplan/monitoring, outcomes, projected impact, sustainability (reindexed to 100 for workload). [3][5] (cms.gov)

2.3 Compliance checkpoints (examples)

- Annual continuation tied to performance, reporting (workplan, FFR, FFATA, PMS, audit), and cooperation with evaluation. [3] (cms.gov)
- 2 CFR Part 200/Part 300, HHS GPS govern awards. [3] (cms.gov)

2.4 Requirement → Collaborative capability → Evidence (selected)

- Interoperable data stack and cybersecurity → Collaborative cloud/analytics foundation (Microsoft ecosystem), HIE/EHR integration, and rural hospital cybersecurity uplift. Evidence: CMS use-of-funds categories; Microsoft rural hospital cybersecurity program growth (550→700+ hospitals participating by 2025). [2][3][12][13][14] (cms.gov)
- Tele-hospital and EMS support → Avel eCare virtual hospital services (tele-ER/ICU/hospitalist/pharmacy) and 24/7 consults to stabilize staffing and reduce avoidable transfers. Evidence: RHT allowable uses and technical factors for EMS and partnerships; Collaborative member descriptions. [2][5][4] (cms.gov)
- Chronic disease and community access → Pharmacy-enabled hypertension/diabetes programs, RPM with FDA-cleared wearable monitoring, and consumer screening tools. Evidence: allowable uses; Collaborative catalog. [2][4] (cms.gov)
- Behavioral health/SUD integration → Tele-behavioral network, crisis support, and alignment to Nebraska's SUD 1115 extension (coverage of residential services in IMDs). Evidence: state waiver status; Collaborative capabilities. [8][4] (dhhs.ne.gov)

3. Nebraska Context Snapshot 3.1 Population, facilities, and access

- 34.4% nonmetro population (ACS 2023 5-yr). [1] (ruralhealthinfo.org)
- Facility mix outside urban areas (July 2025): 62 CAHs; 1 REH; 128 RHCs; 25 FQHC sites; 9 short-term/PPS hospitals. [1] (ruralhealthinfo.org)
- Maternal access: Nebraska is among states with the highest percentage of counties classified as maternity care deserts (2024 March of Dimes). [11] (marchofdimes.org)
- Title V/HPSA context: As of May 2022, 76 of 93 counties had OB/GYN shortage designation; the majority were designated for psychiatry/mental health. [15] (mchbtvis.hrsa.gov)
- Rural hospital viability: Two CAH closures in the past decade reported; rural financial stress persists. [16] (cfra.org)

3.2 Medicaid, payment, and behavioral health

- Medicaid managed care (Heritage Health): Molina, Nebraska Total Care, UnitedHealthcare (Healthy Blue exited in 2024 per DHHS). [7] (mltcfindprovider-dhhs.nebraska.gov)
- Enrollment: 357,600 average in FY2024 (17.9% of state population). [9] (usafacts.org)
- 1115 SUD demonstration extended through June 2030, covering short-term residential services in IMDs. [8] (dhhs.ne.gov)

3.3 Broadband/telehealth readiness

- BEAD allocation ~$405.3M; initial proposal approved; state Broadband Office deploying funding to un/underserved locations. [10] (ntia.gov)
- Nebraska PSC Broadband Bridge Program awarded $20M in Jan 2025 to expand ≥100/100 Mbps networks in un/underserved areas. [10] (psc.nebraska.gov)
- State broadband mapping indicates remaining unserved/underserved pockets, including high-cost tribal DPAs. [17] (broadband.nebraska.gov)

3.4 Policy levers related to Technical Factors

- Certificate of Need: Nebraska maintains CON focused on long-term care beds; hospitals largely exempt (e.g., rehab and acute beds exempted in 2024). [18] (ncsl.org)
- Licensure compacts: Nebraska participates in multiple compacts (e.g., nursing, EMS, psychology, medicine & surgery, OT, PT, SLP/Audiology), facilitating multistate practice. [19] (dhhs.ne.gov)

3.5 Nebraska metrics-to-capability mapping (illustrative)

- High RHC/CAH footprint (2025) → Tele-hospital coverage, RPM to extend reach, pharmacy-enabled primary care. [1][4] (ruralhealthinfo.org)
- Maternal deserts (2024) → Tele-OB consults, remote BP/diabetes-in-pregnancy monitoring, retail access points for prenatal screening. [11][4] (marchofdimes.org)
- Behavioral health/SUD (1115) → Tele-psychiatry/crisis support and data-driven care navigation aligned to IMD coverage and transitions. [8][4] (dhhs.ne.gov)
- Broadband investments → Prioritize deployable telehealth, secure data exchange, and cybersecurity hardening. [10][12] (ntia.gov) (news.microsoft.com)

4. Strategy Aligned to RFP 4.1 Core model for Nebraska (subject to state procurement and data-sharing agreements)

- Rural Connected Care Grid: • A virtual hospital layer (tele-ER/ICU/hospitalist; tele-pharmacy; tele-behavioral) stabilizes local CAHs and supports EMS. • Primary care network (FQHCs, RHCs, independent practices, Tribal/IHS as appropriate) augmented by pharmacy-based services and RPM to manage chronic disease. • Secure data platform connecting claims, HIE, EHRs, and device telemetry with analytics for outcomes, equity, and payment integrity; plus statewide cybersecurity uplift. [2][4][12] (cms.gov) (news.microsoft.com)

4.2 Alignment to scoring factors (examples)

- EMS and partnerships: 24/7 tele-emergency consults and EMS tele-support address C.2 and C.1 factors. [5][4] (cms.gov)
- Licensure compacts and scope: Multicompact participation facilitates tele-specialty coverage; pharmacy services can advance scope-of-practice goals in rural areas. [5][19][4] (cms.gov)
- Remote care/data infrastructure/consumer tech (F.1–F.3): RPM wearables, virtual visits, secure cloud analytics, and patient-facing apps score across F-factors. [5][4] (cms.gov)
- Medicaid incentives/duals: Analytics and payment integrity tools support E.1/E.2 (e.g., duals integration and quality incentives). [5][4] (cms.gov)

4.3 Equity for rural and Tribal communities

- Use HPSA/MCTA designations, maternal deserts, and Tribal consultation to target initiative sites; ensure culturally responsive tele-behavioral and maternal programs. [11][15] (marchofdimes.org)
- Incorporate retail and community sites (pharmacies, events) for screenings and digital triage, with interpreter/multilingual tools. [4]

4.4 Data use and privacy

- HIPAA-compliant cloud, least-privilege role-based access, Zero Trust cybersecurity, and TEFCA-aligned exchange where available; auditing for 2 CFR/HHS GPS requirements. [3][12] (cms.gov)

5. Program Design Options (Nebraska-tuned; all subject to contracting and state policy decisions) Option A: Rural Tele-Hospital and EMS Stabilization

- Target: CAHs, REH, frontier counties; EMS agencies with long response times. Problem: High transfer rates, staffing gaps, long transport times; maternal OB deserts. Evidence: CAH/REH footprint (2025); maternal deserts (2024). [1][11] (ruralhealthinfo.org)
- Components: Tele-ER/ICU/hospitalist; tele-pharmacy; tele-OB consults; EMS tele-support; hospital-at-home for step-down patients using wearables; cybersecurity hardening. [4][12] (news.microsoft.com)
- Payment logic: Global support through RHT; optional Medicaid SPA to reimburse tele-interprofessional consults and RPM; shared-savings with payers for reduced transfers/readmits. [2][3] (cms.gov)
- Enablers: Licensure compacts; hospital/EMS MOUs. [19] (dhhs.ne.gov)
- Pros/risks: Rapid safety net impact; depends on broadband and local staffing; requires change management.

Option B: Pharmacy-Enabled Chronic Care + RPM

- Target: Rural adults with hypertension/diabetes/CVD; postpartum hypertension. Problem: High chronic burden, access barriers, adherence challenges. Evidence: Maternal deserts and rural access gaps. [11] (marchofdimes.org)
- Components: Community pharmacy enrollment, medication therapy management, BP/glucose RPM (FDA-cleared wearables), tele-primary care follow-up, multilingual patient apps. [4]
- Payment logic: RHT funds under prevention/consumer tech/provider payments (≤15% cap); Medicaid quality incentives for control rates; payer performance-based pharmacy fees. [3] (cms.gov)

- Enablers: Collaborative practice agreements; SPA to cover RPM/RTM codes.
- Pros/risks: Scalable across counties; requires data sharing with primary care and adherence to privacy.

Option C: Behavioral Health and SUD Integration

- Target: Rural adults with OUD/SUD; co-occurring mental health conditions. Problem: Shortage designations; limited local access; ED utilization. Evidence: MH/OB shortage designations; SUD 1115 through 2030. [15][8] (mchbtvis.hrsa.gov)
- Components: Tele-behavioral (24/7); crisis support (988 integration); IMD residential transition using remote monitoring and care navigation; pharmacy naloxone and MAT linkage. [4]
- Payment logic: Align to 1115 SUD demo; Medicaid care management fees; performance measures (retention in treatment).
- Enablers: DSNP/duals data sharing; regional behavioral health authorities.

Option D: Data, Cybersecurity, and Evaluation Backbone

- Target: All RHT initiatives. Problem: Fragmented data; cyber risk. Evidence: BEAD/Bridge investments; national rural hospital cyber programs. [10][12][13] (ntia.gov)
- Components: Secure cloud lakehouse; near-real-time dashboards; prior-auth optimization; payment integrity; Microsoft rural cyber program enrollment; TEFCA/HIE connections. [12][4] (news.microsoft.com)
- Payment logic: IT/cyber allowable use; admin ≤10% for PMO; evaluation line items. [3] (cms.gov)

6. Governance and Collaborative Roles 6.1 Structure (illustrative)

- State RHT Lead Agency (designated by Governor) holds award; PMO coordinates Medicaid, Office of Rural Health, broadband office, HIE, hospital association, FQHC PCA, Tribal/IHS (as applicable).
- Rural Provider High Value Network (HVN) for member-owned governance of CAHs/RHCs/FQHCs; transparent investment tracking and outcomes reporting. [4]
- Collaborative members provide tele-clinical services, pharmacy programs, analytics, cybersecurity, and integration support. [4]

6.2 RACI (selected)

- State Health/Medicaid: Accountable for strategy, compliance, SPA/waiver alignment; Consulted on initiative selection; Informed on performance. [3] (cms.gov)
- Hospital Association/HVNs/FQHC PCA: Responsible for provider engagement, deployment sequencing, and data-sharing agreements. [4]
- Collaborative systems integrators: Responsible for program management, integration, and dashboards; Consulted on evaluation. [4]
- Payers: Consulted/Accountable for value-based arrangements and quality incentive alignment. [4]

7. Payment and Funding 7.1 Paths consistent with RHT

- Value pathways: rural global budget pilots (HVN-level), care management fees (chronic disease, behavioral health), performance incentives (control rates, avoidable transfers), and duals integration elements. [2][5] (cms.gov)
- Compliance caps: provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5%; admin ≤10%. [3] (cms.gov)

7.2 Illustrative budget mapping (per period, planning placeholder as suggested in webinar)

- Categories and ROM amounts (example with $200M placeholder for table creation; final awards vary): • Tele-hospital/EMS services; • Pharmacy-enabled chronic care + RPM (includes devices, logistics, training); • Behavioral health/SUD integration; • Data/cyber platform and analytics; • Evaluation; • Administration (≤10%). [3] (cms.gov)

8. Data, Measurement, and Evaluation

- Core metrics: access (tele-consult response times; OB tele-consult uptake; EMS handoff), quality (HbA1c ≥9% rate; HTN control; 30-day readmits), financial (transfer reductions; avoidable ED), workforce (vacancy/turnover), technology (cyber maturity; HIE transactions), maternal (postpartum hypertension follow-up), behavioral (SUD treatment retention). [3][5] (cms.gov)
- Data sources: Medicaid claims, HIE, EHRs, RPM feeds, EMS data, pharmacy MTM, community screening, broadband availability layers. [4][10] (ntia.gov)
- Evaluation cadence: quarterly dashboards; annual re-indexing of applicable technical factors and initiative outcomes per reporting guidance. [5] (cms.gov)

9. Implementation Plan Gantt-style 24-month workplan (illustrative; all dates subject to award and

contracting)

- Workstream | Start | End | Owner | Outputs • Program Mobilization/PMO | Jan 2026 | Mar 2026 | State PMO + SI | Charter; risk plan; reporting calendar. • Cybersecurity Baseline + Enrollment | Jan 2026 | Jun 2026 | Hospitals + Cyber partner | Assessments; prioritized remediation; training. • Tele-Hospital Phase 1 (10 CAHs) | Feb 2026 | Sep 2026 | Tele-hospital partner + CAHs | 24/7 coverage; protocols; KPIs baseline. • RPM/Pharmacy Wave 1 (15 counties) | Mar 2026 | Oct 2026 | FQHC/PBMs/Pharmacies | Enrolled cohorts; device ops; outcomes plan. • Behavioral Health/SUD | Apr 2026 | Dec 2026 | BH network + Medicaid | 24/7 tele-BH; crisis protocol; IMD transition workflow. • Data Platform/Evaluation | Jan 2026 | Dec 2027 | SI + State + HIE | Data lakehouse; dashboards; Year-1 evaluation. • Expansion Waves (tele-hospital, RPM, BH) | Oct 2026 | Dec 2027 | PMO + Providers | Scale to additional counties; mid-course correction. [3][12] (cms.gov)

10. Risk Register (selected)

- Broadband gaps delay tele-services → Mitigation: target BEAD/Bridge overlap; deploy low-bandwidth workflows; offline data sync. Owner: State Broadband + PMO. [10] (ntia.gov)
- Cyber incident disrupts rollout → Mitigation: enroll all rural sites in Microsoft/AHA program; phased hardening and staff training. Owner: Hospitals + Cyber partner. [12][13] (news.microsoft.com)
- Workforce burnout/adoption barriers → Mitigation: ambient documentation tools; 24/7 consult back-up; training incentives. Owner: Provider orgs + SI. [4]
- Data-sharing hesitancy → Mitigation: DUA templates; TEFCA/HIE alignment; patient consent UX. Owner: PMO + Legal. [3][4] (cms.gov)
- Pharmacy scope variability → Mitigation: targeted CPAs; alignment with Medicaid quality incentives. Owner: Boards of pharmacy + Medicaid. [4]
- Procurement timelines → Mitigation: modular contracting; piggyback options where permissible. Owner: State procurement.
- Maternal equity risks → Mitigation: prioritize MCTA/HPSA counties; doula/community health worker supports. Owner: PMO + Local partners. [15] (mchbtvis.hrsa.gov)
- Consent and privacy for SUD data → Mitigation: 42 CFR Part 2 workflows; role-based access. Owner: BH network + State.
- Evaluation complexity → Mitigation: early baseline, clear measure specs, independent evaluator. Owner: PMO + Evaluator.
- Financial sustainability post-grant → Mitigation: payer contracts (ACO/shared savings), Medicaid SPAs for ongoing services. Owner: HVN + Medicaid.

11. Draft RFP Response Language (Nebraska-tailored, paste-ready; statements are enabling, not prescriptive) 11.1 Rural Health Needs and Target Populations (excerpt) “Nebraska’s rural profile includes 34.4% of residents living in nonmetro areas (2023), with 62 CAHs, 128 RHCs, 25 FQHC sites outside urban areas, and one Rural Emergency Hospital (July 2025). Our application targets frontier counties and counties designated as Maternity Care Deserts by the March of Dimes (2024), and counties with OB/GYN and behavioral HPSA designations. We will prioritize CAHs/RHCs/FQHCs in these areas for tele-hospital services, pharmacy-enabled chronic disease programs, tele-behavioral care, and remote monitoring.” [1][11][15] (ruralhealthinfo.org)

11.2 Strategy and Initiatives (excerpt) “Subject to procurement and integration, the State will activate a Rural Connected Care Grid consisting of: (1) a virtual hospital layer (tele-ER/ICU/hospitalist; tele-pharmacy; tele-behavioral), (2) pharmacy-enabled chronic care with remote monitoring, and (3) a secure data/cyber backbone for outcomes measurement and payment alignment. This model advances RHT goals (prevention, sustainable access, workforce, innovative care, tech innovation) and addresses technical scoring factors for EMS, partnerships, licensure compacts, remote care, data infrastructure, and consumer-facing technologies.” [2][5][12] (cms.gov)

11.3 Budget Narrative (excerpt) “We propose an initial period plan (using the webinar’s $200M placeholder for table construction, subject to final award) that allocates funds across tele-hospital/EMS, pharmacy-enabled chronic care plus RPM, behavioral health/SUD integration, data/cyber infrastructure, evaluation, and administration (≤10%). Provider payments will not exceed 15% of the award; capital/infrastructure ≤20%; and any EMR replacement ≤5% where applicable.” [3] (cms.gov)

11.4 Metrics and Evaluation (excerpt) “We will report quarterly on access, quality, financial, workforce, technology, maternal, and behavioral measures; cooperate with CMS evaluation; and maintain a robust data platform to support analytic re-indexing for workload scoring.” [3][5] (cms.gov)

11.5 Stakeholder Engagement (excerpt) “We will formalize a rural provider High Value Network governance structure to align CAHs, RHCs, FQHCs, and regional systems; convene payers, the hospital association, the FQHC PCA, and the state broadband office; and engage Tribal partners as appropriate.” [4]

12. References
13. Nebraska – State Profile (Rural Health). Rural Health Information Hub (RHIhub). https://www.ruralhealthinfo.org/states/nebraska. Accessed 2025-10-14. (ruralhealthinfo.org)
14. Rural Health Transformation Program — Overview. Centers for Medicare & Medicaid Services (CMS). https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview. Accessed 2025-10-14. (cms.gov)
15. RHT NOFO Applicants Webinar Slides (Sep 19, 2025). CMS. https://www.cms.gov/files/document/rht-program-applicants-webinar-presentation.pdf. Accessed 2025-10-14. (cms.gov)
16. Rural Health Transformation Collaborative. R1. 10-11-25 (consensus catalog). Internal collaborative document. Accessed 2025-10-14.
17. RHT Scoring Slides (distribution, factors). CMS NOFO Webinar, slides 43–48. https://www.cms.gov/files/document/rht-program-applicants-webinar-presentation.pdf. Accessed 2025-10-14. (cms.gov)
18. CMS Grants — Current Opportunities (CMS-RHT-26-001). CMS. https://www.cms.gov/about-cms/grants-cooperative-agreements/currentnts-funding-opportunities. Accessed 2025-10-14. (cms.gov)
19. Nebraska Medicaid Provider Directory (Heritage Health plans). Nebraska DHHS. https://mltcfindprovider-dhhs.nebraska.gov/. Accessed 2025-10-14. (mltcfindprovider-dhhs.nebraska.gov)
20. Nebraska SUD 1115 Demonstration Extension (2025–2030). Nebraska DHHS. https://dhhs.ne.gov/Pages/Substance-Use-Disorder-Demonstration.aspx. Accessed 2025-10-14. (dhhs.ne.gov)
21. Medicaid Enrollment — Nebraska (FY2024). USAFacts (CMS source). https://usafacts.org/answers/how-many-people-are-on-medicaid-in-the-us/state/nebraska/. Accessed 2025-10-14. (usafacts.org)
22. Nebraska — BEAD Allocation and Program Updates. NTIA. https://www.ntia.gov/report/2024/office-internet-connectivity-and-growth-2023-annual-report/implementation-partnering-in-the-field-part-two/states-territories/nebraska. Accessed 2025-10-14. (ntia.gov)
23. Nowhere to Go: Maternity Care Deserts (2024) — Summary. March of Dimes. https://www.marchofdimes.org/about/news/maternity-care-desert-report-reveals-millions-unable-to-access-care and https://www.marchofdimes.org/maternity-care-deserts-report. Accessed 2025-10-14. (marchofdimes.org)
24. Microsoft Cybersecurity Program for Rural Hospitals — Launch and Features (2024–2025). AHA News and Microsoft. https://www.aha.org/news/headline/2025-03-06-microsoft-says-550-hospitals-have-joined-rural-cybersecurity-program-created-aha; https://blogs.microsoft.com/on-the-issues/2025/03/05/enhancing-cybersecurity-rural-health/; https://news.microsoft.com/source/2024/06/10/microsoft-to-help-rural-hospitals-defend-against-rising-cybersecurity-attacks/. Accessed 2025-10-14. (aha.org)
25. AHA Center for Health Innovation — Rural Cybersecurity Participation Update (2025). AHA. https://www.aha.org/aha-center-health-innovation-market-scan/2025-07-15-microsoft-plan-help-rural-care-facilities-improve-cybersecurity-gains. Accessed 2025-10-14. (aha.org)
26. Nebraska Broadband Bridge Program Awards (Jan 14, 2025). Nebraska PSC. https://psc.nebraska.gov/for-consumers/psc-awards-20-million-nebraska-broadband-bridge-program-grants. Accessed 2025-10-14. (psc.nebraska.gov)
27. Title V Information System — Nebraska Shortage Designations (May 2022). HRSA/MCHB. https://mchbtvis.hrsa.gov/Print/c1045845-5969-483c-b365-13b0ee743f58. Accessed 2025-10-14. (mchbtvis.hrsa.gov)
28. CAH Closures and Rural Hospital Landscape (Nebraska). Center for Rural Affairs. https://www.cfra.org/news-release/center-rural-affairs-paper-explores-how-new-designation-can-keep-rural-hospitals-open. Accessed 2025-10-14. (cfra.org)
29. Nebraska Broadband Maps. Nebraska Broadband Office. https://broadband.nebraska.gov/nebraska-broadband-maps/. Accessed 2025-10-14. (broadband.nebraska.gov)
30. Certificate of Need — Nebraska. National Conference of State Legislatures. https://www.ncsl.org/health/certificate-of-need-state-laws. Accessed 2025-10-14. (ncsl.org)
31. Licensure Compacts — Nebraska DHHS. https://dhhs.ne.gov/licensure/Pages/Licensure-Compacts.aspx. Accessed 2025-10-14. (dhhs.ne.gov)

Assumptions and Open Questions

- Executive Order 12372 / SF-424 Box 19c: The webinar and CMS webpages reviewed do not explicitly state the intergovernmental review applicability; if the NOFO includes a “No” response for Box 19c, Nebraska will follow the NOFO text. (Assumption pending direct NOFO PDF verification.) [3] (cms.gov)
- SNAP waivers and nutrition CME (technical factors): We have not independently validated Nebraska’s current status; proposed points would follow any state commitments Nebraska elects to include in its application. [5] (cms.gov)

Checklists

- RHT Application Content (cross-walked to webinar) • Project summary; Project narrative; Budget narrative. [3] (cms.gov) • Attachments: Governor letter; indirect cost rate (if used); business assessment;

duplication assessment; supporting docs. [3] (cms.gov) • Forms: SF-424; SF-424A; SF-LLL; Project/Performance Site Location(s). [3] (cms.gov)
- Funding guardrails • Provider payments ≤15% • Capital/infrastructure ≤20% • EMR replacement ≤5% (if applicable) • Admin ≤10%. [3] (cms.gov)
- Timeline (2025) • Optional LOI: Sep 30 • Application: Nov 5 11:59 p.m. ET • Awards: Dec 31. [3] (cms.gov)

Gantt-style table (summary)

- Mobilization (PMO) Jan–Mar 2026; Cyber baseline Jan–Jun 2026; Tele-hospital P1 Feb–Sep 2026; RPM/Pharmacy Wave 1 Mar–Oct 2026; BH/SUD Apr–Dec 2026; Data/Eval Jan 2026–Dec 2027; Expansion Oct 2026–Dec 2027. [3] (cms.gov)

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