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

1. Executive Summary Connecticut is eligible to apply for CMS's Rural Health Transformation (RHT) cooperative agreement, a five-year, ~$50B program that allocates funding to approved states through an equal "baseline" share and a performance-weighted "workload" share. Applications are due November 5, 2025, with optional letters of intent due September 30, 2025; awards are expected by December 31, 2025. Only the 50 states are eligible; the District of Columbia and territories are ineligible. (cms.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Connecticut's RHT plan with: (a) technology and data infrastructure (secure cloud, cybersecurity, interoperability); (b) clinical operations via tele-specialty, remote monitoring, behavioral health, and pharmacy-enabled chronic disease programs; (c) program management, analytics, and evaluation capacity; and (d) governance models for provider networks and payment reform. These capabilities align with RHT uses of funds (e.g., prevention/chronic disease, technology adoption, workforce, behavioral health, innovative care models) and with CMS's program structure.

Three high-leverage areas for rapid impact in Connecticut's rural regions are: (1) virtual specialty coverage and emergency/ICU backup for low-volume hospitals and EDs; (2) continuous remote physiologic monitoring and pharmacy-anchored chronic disease management to reduce preventable utilization; and (3) a secure statewide data backbone with dashboards to track outcomes and support CMS reporting and workload-point re-calculation. The Collaborative's tele-ICU/tele-ER (Avel eCare), remote monitoring (BioIntelliSense), retail pharmacy and telehealth partners (CVS Health, Walgreens, Teladoc), and analytics/cybersecurity platforms (Microsoft; systems integrators) directly address these needs.

Connecticut's policy posture—now including implementation of the Nurse Licensure Compact effective October 1, 2025, and participation in the Interstate Medical Licensure Compact and PSYPACT—positions the state to score competitively on licensure and scope-of-practice-related technical factors and to scale telehealth-enabled models across borders. (portal.ct.gov)

One-page printable summary (for circulation)

- Key RHT dates (ET): Optional LOI 9/30/2025; Application 11/5/2025; Awards 12/31/2025. (aha.org)
- Eligibility and structure: Only 50 states; 50% equal baseline + 50% workload allocation; uses of funds include prevention, provider payments (capped), consumer tech, workforce, IT/cyber, behavioral health, innovative models. (cms.gov)
- Connecticut rural snapshot (most recent available): 13.7% rural population (2020); no CAHs; no CMS-certified Rural Health Clinics; 16 HRSA-funded health center awardees served ~446k patients (2024); large BEAD broadband initiative with $144.2M federal allocation (2024). (ncsl.org)
- 2024 overdose trend: CT reported a 26% decline vs. 2023 (990 deaths, ~76% involved fentanyl), creating an opportunity to consolidate harm-reduction and recovery supports in rural corridors. (portal.ct.gov)
- Collaborative fit: Tele-ER/ICU backup; RPM for CHF/COPD/diabetes; retail-pharmacy chronic disease workflows; AI triage and risk stratification; statewide data/cyber platform; governance and value-based payment design.

2. Eligibility and RFP Fit 2.1 What the NOFO requires (summary)

- Applicant: A U.S. state (one application). Only the 50 states are eligible. (cms.gov)
- Timeline: Application instructions released mid-September; submissions close early November; awards by 12/31/2025. Optional LOI due 9/30/2025. (cms.gov)
- Funding formula: 50% equally distributed to approved states; 50% allocated based on state factors specified by CMS in the NOFO and ongoing performance. (cms.gov)
- Uses of funds: Projects must address three or more categories (e.g., prevention/chronic disease, provider payments, consumer tech, training/TA for advanced tech, workforce recruitment/retention, IT/cybersecurity, right-sizing services, behavioral health/OUD, innovative payment/care models). (cms.gov)
- Common caps and guardrails cited in NOFO briefings: provider payments ≤15% of annual award; infrastructure/"minor renovation and equipment" ≤20%; EMR replacement (if previously HITECH-certified) ≤5%; optional technology acceleration funds limited to the lesser of 10% or $20M per period; administrative expenses ≤10%. (Summarized by national health-law analyses of the NOFO.) (foleyhoag.com)

2.2 Requirement-to-capability mapping (evidence table)

Requirement (NOFO/program) → Collaborative capability → Evidence

- Prevention & chronic disease: Deploy RPM, AI triage, retail-clinic screening, pharmacist-enabled hypertension/diabetes workflows → BioIntelliSense, Humetrix, Viz.ai risk detection, CVS/Walgreens programs.
- Telehealth & hospital support: 24/7 tele-ER/ICU/hospitalist, tele-pharmacy → Avel eCare; regional

tele-specialty clinics.
- IT modernization & cybersecurity: HIPAA/FHIR-based cloud platform; statewide data exchange, dashboards; cyber hardening of rural facilities → Microsoft cloud/security; systems integrators (Accenture/KPMG/PwC/AVIA).
- Workforce & licensure mobility: NLC (effective 10/1/2025), IMLC, PSYPACT; digital skilling; provider-to-provider tele-mentoring → Cross-state staffing and virtual care; training programs via Collaborative partners. (portal.ct.gov)
- Innovative care/payment models: High Value Networks (HVNs) for independent rural providers; value-based design/actuarial tools; ACO/alternative payment enablement → Cibolo Health; integrators' payment analytics.
- Behavioral health/OUD: Tele-behavioral access, 24/7 crisis support; patient-facing OUD risk tools; 988 implementation experience → Avel eCare, Teladoc, Humetrix; advisory experience with 988.

3. Connecticut Context Snapshot 3.1 Population and geography

- Rural share: 13.7% of residents lived in rural areas in 2020 (U.S. Census urban–rural classification compiled by NCSL). Rural population ≈ 496k in 2020. (ncsl.org)
- Frontier designation: Not applicable in Connecticut (no "frontier" counties by western-state definitions). [Assumption—confirm with CMS scoring definitions.]

3.2 Rural facility mix

- Critical Access Hospitals (CAHs): 0 (July 2025 CAH map; CT shown with no CAH locations). (flexmonitoring.org)
- Rural Health Clinics (RHCs): 0 CMS-certified RHCs (HRSA allocation and program summaries). (hrsa.gov)
- Health centers: 16 HRSA-funded awardees reported 445,612 patients in 2024; CT's primary care safety-net reach is extensive in rural towns in the Northwest/East planning regions. (data.hrsa.gov)
- EMS and hospital service lines: Recent closures of rural labor & delivery units (Windham approved closure 12/2023; Johnson Memorial settlement/fine for prior closure; Sharon Hospital L&D closure denied in final decision) underscore service fragility in rural markets. (ctpublic.org)

3.3 Workforce indicators and HPSAs

- Licensure compacts: NLC implemented 10/1/2025; IMLC participation since 10/1/2022; PSYPACT effective 10/1/2022—supporting telehealth and cross-border staffing. (portal.ct.gov)
- HPSAs: CT Primary Care Office (DPH) manages HPSA designations; March 2025 summaries indicate mental health HPSAs covering ~802k residents and a shortfall of ~53 practitioners in New England tables. (portal.ct.gov)
- Implication: Compacts + Collaborative virtual models can mitigate access gaps while recruitment pipelines are strengthened.

3.4 Medicaid, payment, and waivers (selected)

- Program structure: HUSKY Health (Medicaid/CHIP) administered by DSS; operations supported by non-risk Administrative Services Organizations (e.g., Community Health Network of Connecticut, as medical ASO). (portal.ct.gov)
- Waivers: CMS-approved 1115 "Covered Connecticut" (effective 12/15/2022–12/31/2027) and 1115 SUD Demonstration. (medicaid.gov)
- Payment pressure points: Safety-net dental service curtailments in 2025 attributed to reimbursement shortfalls. These dynamics heighten the value of RHT payment and analytics investments. (ctinsider.com)

3.5 Broadband and digital readiness

- BEAD allocation: $144.18M; Initial Proposal approved July 2024; Final Proposal in 2025. State reports indicate broadband access at 99.6% of locations and adoption at 92.2% by late-2024, with targeted rural build-outs ongoing. (ntia.gov)
- Implication: Adequate infrastructure to support RPM/telehealth statewide, with Collaborative cybersecurity and interoperability services strengthening rural deployments.

3.6 Maternal, behavioral health, and SUD

- Overdose deaths declined 26% in 2024 vs. 2023 (990 deaths; ~76% fentanyl), creating momentum for scaling evidence-based rural harm-reduction, treatment, and recovery coordination under RHT. (portal.ct.gov)

3.7 Metrics-to-capability pairing (examples)

Metric (year, source) → Collaborative capability (how it can support)

- Rural population 13.7% (2020, NCSL/Census) → Retail-pharmacy screening + virtual primary/specialty clinics to extend access. (ncsl.org)
- CAHs 0; RHCs 0 (2025/2021, Flex Monitoring/HRSA) → Tele-ER/ICU, e-consults, and hospitalist support to keep care local. (flexmonitoring.org)
- Health centers 16 awardees; 445,612 patients (2024, HRSA UDS) → Data-driven chronic disease and pharmacy-enabled care pathways at FQHCs. (data.hrsa.gov)
- BEAD $144M; access 99.6% (2024–2025, NTIA/DEEP) → Secure cloud + RPM/telehealth scale; rural facility cyber-hardening. (ntia.gov)
- 26% overdose decline (2024, DPH) → Tele-behavioral, OUD risk tools, crisis support to sustain reductions. (portal.ct.gov)

4. Strategy Aligned to RFP Connecticut's proposed model emphasizes: (1) virtualizing scarce specialties; (2) modernizing data and cybersecurity statewide; (3) deploying pharmacy-anchored chronic disease programs; (4) integrating behavioral health/OUD with primary care; and (5) aligning payment incentives through rural provider networks.

RHT pillars and evidence alignment

- Prevention/chronic disease: Retail-based BP/diabetes screening, AI-aided risk detection, and home RPM; documented partner experience and toolsets.
- Sustainable access/right-sizing: Tele-ER/ICU and specialty clinics to stabilize low-volume service lines; governance frameworks for shared services.
- Workforce: Cross-state licensure (NLC, IMLC, PSYPACT) and provider-to-provider tele-mentoring; ambient clinical documentation to reduce burden. (portal.ct.gov)
- Innovative care/payment: HVNs and actuarial modeling for rural value-based arrangements (e.g., prospective/quality-tied payments).
- Tech innovation: HIPAA/FHIR cloud, interoperability, and cyber programs with dashboards for RHT metrics and workload scoring in continuation years.

Equity and Tribal considerations

- Target rural towns in Northeastern and Northwestern planning regions with higher uninsured and broadband adoption gaps; leverage retail and community venues; ensure language access and disability accommodations in digital tools. (benton.org)

Data use and privacy

- Use Azure-based data platform with role-based access, auditability, and de-identification for evaluation; align with HIPAA and 42 CFR Part 2 where applicable.

5. Program Design Options (Connecticut-tuned) Option A. Rural hospital and ED stabilization via virtual specialty grid

- Target: Windham/Johnson Memorial/Sharon catchment areas plus EMS partners.
- Problem: L&D service reductions and specialist shortages elevate transfer rates and delays. (ctpublic.org)
- Collaborative services: Tele-ER/ICU/hospitalist, tele-pharmacy, on-demand consults; cyber hardening; incident command dashboards.
- Payment logic: Global service support fees to rural hospitals; ED throughput incentives; avoidable-transfer metrics.
- Enablers: NLC/IMLC/PSYPACT; HIE interop; EMS integration. (portal.ct.gov)
- Pros/risks: Rapid coverage; dependency on reliable connectivity; credentialing throughput.

Option B. Pharmacy-enabled chronic disease and RPM bundle (hypertension/diabetes/HF)

- Target: Rural adults with uncontrolled HTN/diabetes/HF in FQHC and primary care panels.
- Problem: High chronic disease burden with access constraints; varying adherence.
- Collaborative services: Kiosks/mobile screening; RPM via BioIntelliSense; pharmacist titration protocols; virtual visits.
- Payment logic: Per-member-per-month care management; performance bonuses for BP/HbA1c control and hospital-use reduction.
- Pros/risks: Strong evidence and partner capacity; requires payer alignment and data exchange agreements.

Option C. Behavioral health/OUD integration with rural primary care

- Target: Rural residents with SUD, co-occurring mental health conditions.

- Problem: Access gaps; need to sustain 2024 overdose declines. (portal.ct.gov)
- Collaborative services: Tele-behavioral, 24/7 crisis support, peer navigation; patient-facing risk alerts.
- Payment logic: Bundled episodes for OUD initiation/retention; contingency management pilots (subject to state policy).
- Pros/risks: Aligns with SUD 1115; stigma and workforce shortages mitigated by tele-supports. (medicaid.gov)

Option D. Data and Cyber Core ("Rural Health Data Backbone")

- Target: State, hospitals, FQHCs, EMS, and community organizations.
- Problem: Fragmented data and cyber risk; need for RHT reporting and workload scores.
- Collaborative services: Secure cloud/LHIN connectors, dashboards for performance metrics, incident response playbooks.
- Payment logic: Capitalizable IT within RHT caps; operating support via PMPM assessments; shared services agreements.
- Pros/risks: High leverage for all initiatives; up-front integration effort.

6. Governance and Collaborative Roles 6.1 Structure (illustrative)

- State lead (Governor-designated agency) sets strategy and oversees funds.
- Steering group: Medicaid (DSS), DPH, OHS, Office of State Broadband (DEEP), State Office of Rural Health, hospital association, FQHC PCA (CHC/ACT), payers, EMS, consumer/orgs.
- Implementation "PMO": State + systems integrator; provider networks (HVNs) for field execution; HIE/data team; evaluation partner.

6.2 RACI (selected)

- Strategy and compliance: State lead (R), DSS/DPH/OHS (A); Collaborative advisors (C).
- Clinical operations (tele-ER/ICU/RPM): Providers/HVNs (R), Avel/BioIntelliSense (C), State (A).
- Data/cyber backbone: Microsoft/integrators (R), State CIO/health data teams (A).
- Stakeholder engagement and workforce skilling: PCA, AHA/ASA, integrators (R/C).

7. Payment and Funding

- Alignment with NOFO caps: Provider payments structured ≤15%; infrastructure ≤20%; EMR replacement ≤5%; administrative overhead ≤10%; tech-acceleration initiatives ≤10% or $20M per period—subject to CMS approval and documentation. (foleyhoag.com)
- Medicaid alignment: Use IMLC/NLC to expand network capacity; leverage 1115 SUD waivers for OUD care; consider SPA updates for RPM and pharmacist services consistent with federal policy. (portal.ct.gov)

Illustrative cost/deliverables table (ROM, to be finalized in budget narrative)

- Virtual specialty/ED stabilization: Tele-ICU/ER subscriptions, equipment carts, credentialing; deliverables: coverage matrix, transfer-avoidance metrics.
- RPM chronic disease bundle: Wearables, dashboards, clinical protocols, pharmacy workflows; deliverables: BP control, HbA1c, readmissions.
- Data & cyber core: Cloud tenancy, data pipelines, dashboards, cyber hardening; deliverables: quarterly RHT scorecards; incident response SLAs.

8. Data, Measurement, and Evaluation

- Measures: Access (virtual coverage hours, wait times), quality (HEDIS-like control rates), utilization (ED, readmissions, avoidable transfers), financial (NRD/Medicaid claims), workforce (vacancy/time-to-fill), tech adoption (uptime, MFA penetration), program implementation (milestones).
- Data sources: Medicaid claims, FQHC UDS feeds, HIE events, EHR data, EMS ePCR, pharmacy data, survey tools; integrated via HIPAA/FHIR cloud.
- Evaluation: Dashboards with quarterly updates; independent evaluation support; alignment to CMS continuation scoring. (cms.gov)

9. Implementation Plan (12–24 months) Gantt-style overview (illustrative)

- Workstream | Start | End | Owner | Outputs
- Program governance & PMO | Jan 2026 | Mar 2026 | State+Integrator | Charter; RACI; risk plan.
- Data & cyber core setup | Feb 2026 | Aug 2026 | Microsoft+State | Tenancy; connectors; dashboards.
- Tele-ER/ICU onboarding | Mar 2026 | Sep 2026 | Avel+Hospitals | Coverage go-live; transfer KPIs.
- RPM cohort wave 1 | Apr 2026 | Dec 2026 | BioIntelliSense+FQHCs | Enrolled pts; adherence metrics.
- Behavioral health integration | Apr 2026 | Dec 2026 | Teladoc/Avel+FQHCs | Access metrics; retention.

- Workforce skilling & compacts ops | Jan 2026 | Ongoing | DPH+PCA+Integrators | Cross-state onboarding; training. (portal.ct.gov)

10. Risk Register (selected)

- Rural facility financial stress → Mitigation: global support fees + virtual coverage; Owner: State+Hospitals.
- Clinician shortages → Mitigation: NLC/IMLC activation; tele-mentoring; Owner: DPH+Hospitals. (portal.ct.gov)
- Cyber incident risk → Mitigation: Microsoft security controls; tabletop exercises; Owner: State+CIO+Hospitals.
- Data-sharing delays → Mitigation: template DUAs, FHIR mapping sprints; Owner: PMO+Integrators.
- Broadband gaps → Mitigation: BEAD coordination with DEEP; Owner: DEEP+Providers. (portal.ct.gov)
- Community adoption barriers → Mitigation: multilingual tools; retail outreach; Owner: PCA+Retail partners.
- Policy timing (e.g., telehealth parity) → Mitigation: align with legislative calendars; Owner: State policy leads. (cthosp.org)
- Payment cap noncompliance → Mitigation: track caps (15/20/5/10%); Owner: Grants/Budget. (foleyhoag.com)
- Maternal service access → Mitigation: perinatal tele-consults; transport protocols; Owner: Hospitals+EMS. (ctpublic.org)
- Quality variation → Mitigation: standardized pathways and audit; Owner: PMO+Providers.

11. Draft RFP Response Language (Connecticut-tailored, paste-ready) Project narrative excerpt—Goals and strategies “Connecticut will strengthen sustainable rural access to emergency, inpatient, maternal, primary, and behavioral health care through a statewide virtual specialty grid, pharmacy-enabled chronic disease programs, and a secure data/cyber backbone. The approach addresses at least three RHT uses of funds—prevention/chronic disease, technology adoption and cybersecurity, workforce, behavioral health/OUD, and innovative models—consistent with CMS guidance.” (cms.gov)

“Connecticut will leverage licensure compacts (NLC, IMLC, PSYPACT) to expand the pool of qualified clinicians serving rural communities via telehealth and temporary practice privileges. These compacts support faster onboarding and broader after-hours coverage.” (portal.ct.gov)

“Initial RHT funding will prioritize: (1) virtual ER/ICU and tele-specialist coverage for rural hospitals; (2) remote physiologic monitoring and pharmacy-anchored chronic disease management; and (3) a statewide data and cybersecurity platform to support RHT reporting and evaluation.”

Budget narrative excerpt—Caps and tracking “Planned provider payments will not exceed 15% of the annual award; infrastructure outlays for minor renovations/equipment will not exceed 20%; EMR replacement activities (where applicable) will remain within 5%; administrative costs will remain ≤10%. The PMO will track these caps at the initiative and portfolio levels.” (foleyhoag.com)

Evaluation excerpt—Measures and data “Connecticut will report quarterly on access, quality, utilization, workforce, technology, and implementation measures using Medicaid claims, UDS extracts, HIE messages, EMS ePCR, and EHR data integrated on a HIPAA/FHIR cloud with role-based access and auditability.”

12. References

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23. (Same as 22) Tele-ER/ICU and virtual hospital services (Avel eCare); RPM (BioIntelliSense); retail, analytics, cybersecurity, and SI roles.
24. (Same as 22) Governance, HVN construct (Cibolo Health) and payment model design.

13. Assumptions and Open Questions

- The final CMS NOFO PDF (CMS-RHT-26-001) is referenced via CMS’s program page and national summaries; section/page citations will be added when the PDF file reference is available for public download on Grants.gov (the Grants.gov detail page was accessible but the PDF was not retrievable through this interface on 2025-10-14). This guide uses the CMS overview and recognized secondary summaries for caps and guardrails and will be updated to cite the NOFO by section/page upon retrieval. (cms.gov)
- Frontier metric applicability for Connecticut appears negligible; confirm CMS’s exact frontier scoring definition in the NOFO appendix before finalizing point projections.
- The “count of hospitals receiving Medicaid DSH (most recent SPRY)” and “CCBHC list as of Sep 1, 2025” will be inserted from DSS and SAMHSA/DMHAS sources in the application exhibits (data pull pending).

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Appendix — Checklists (abbreviated)

- NOFO conformance (narrative ≤ page limits; required attachments; SF-424/424A/LLL; site locations). [Confirm exact page limits and SF-424 Item 19c instruction in NOFO PDF upon download.]
- Content completeness: needs assessment; goals/strategies; initiatives with ≥4 outcomes each; implementation plan and timelines; stakeholder engagement; metrics/evaluation; sustainability; policy actions and timelines; required lists (CCBHCs; DSH count).
- Funding caps tracking: provider payments ≤15%; infrastructure ≤20%; EMR replacement ≤5%; administrative ≤10%; tech acceleration funds ≤10%/$20M; telecom/surveillance restrictions; no supplanting. (foleyhoag.com)

Appendix — Gantt summary (12–24 months)

- Q1–Q2 2026: PMO, governance, data backbone setup; compacts operationalization support. (portal.ct.gov)
- Q2–Q3 2026: Tele-ER/ICU go-lives at priority hospitals; RPM cohort initiation at FQHCs; BH tele-access launch.
- Q3–Q4 2026: Scale to additional sites; dashboards for CMS performance reporting; interim evaluation.

Notes on language and dependencies

- All implementation statements herein are conditional on contracting, regulatory approvals, data-use agreements, technical integration, and site readiness. The Collaborative's roles are supportive and non-directive to internal state processes.