Rural Health Transformation Grant Guide — Iowa

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Iowa can use the Rural Health Transformation (RHT) Program to stabilize rural access, modernize care delivery, and strengthen rural provider sustainability over FY26–FY30. CMS will award cooperative agreements only to States, with $50B total funding, equal baseline shares plus a points-based "workload" share, and awards announced by December 31, 2025. Applications are due November 5, 2025; an optional LOI was due September 30, 2025. The NOFO specifies one official State application, no cost sharing, and five budget periods (spend-forward allowed into the following fiscal year). Executive Order 12372 does not apply (check "No" on SF-424 item 19c). (files.simpler.grants.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Iowa's plan with: statewide virtual specialty backup and hospital support (Avel eCare), remote patient monitoring and exception-based care (BioIntelliSense), consumer-facing triage and medication safety tools (Humetrix), population analytics to close care gaps (Pangaea Data), Microsoft's secure cloud and cybersecurity capabilities, pharmacy-enabled access models (Walgreens, Walmart), and Cibolo Health's rural provider High Value Network (HVN) frameworks for shared services and governance. These offerings align with RHT allowable uses (e.g., technology, workforce, innovative care, consumer technology, partnerships) and the technical scoring factors.

Under the RHT NOFO's points system (50% rural facility/population factors; 50% technical factors), Iowa can earn conditional points in Year 1 for policy commitments (e.g., licensure compacts, EMS, scope of practice), convert to full points upon enactment (by 12/31/2027, or by 12/31/2028 for two specified factors), with recovery of funds tied to any unfulfilled commitments. The NOFO also caps certain uses (e.g., provider payments ≤15% of award; category J capital/infrastructure ≤20%; EMR replacement ≤5% if a prior HITECH-certified EMR is in place; "Rural Tech Catalyst"-type initiatives ≤ the lesser of 10% or $20M per budget period), and limits administrative/indirects to ≤10% of each budget period allotment. (files.simpler.grants.gov)

Given Iowa's rural profile—roughly 36.8% of residents in rural areas in 2020, a large network of Critical Access Hospitals (CAHs), and hundreds of Rural Health Clinics (RHCs)—the Collaborative's capabilities are well matched to Iowa's needs in tele-specialty coverage, data interoperability, consumer engagement, workforce upskilling, value-based payment support, and secure cloud modernization. (extension.iastate.edu)

One-page printable summary (for distribution with leadership briefing)

- What RHT funds: Technology, workforce, consumer tech, innovative care/payment, capital/IT upgrades, partnerships—use at least three categories; no construction; follow caps and federal cost rules. (files.simpler.grants.gov)
- How money flows: Cooperative agreements to States; five budget periods FY26–FY30; 50% equal baseline; 50% points-based workload recalculated; awards announced by 12/31/2025. (files.simpler.grants.gov)
- Iowa fit: 82 CAHs; 212 RHCs; 61 rural-located FQHC sites; CyncHealth operates the state HIE; Iowa participates in IMLC (physician), NLC (nursing), EMS Compact; Iowa joined the PA Licensure Compact in 2025; not a PSYPACT state. (ruralhealthinfo.org)
- Collaborative value propositions (conditional on contracting and integration): virtual hospital services (Avel eCare); continuous monitoring and exception-based care (BioIntelliSense); multilingual triage & medication safety (Humetrix); AI-enabled care-gap closure (Pangaea Data); cybersecurity & data platforms (Microsoft); retail pharmacy access models (Walgreens, Walmart); rural HVN governance and shared services (Cibolo Health).
- Guardrails from NOFO: provider payments ≤15%; capital/infrastructure (J) ≤20%; EMR replacement ≤5% (if prior certified EMR); Rural Tech Catalyst-type ≤ the lesser of 10% or $20M; administrative/indirects ≤10%. (files.simpler.grants.gov)

2. Eligibility and RFP Fit

- Eligible applicant: Only U.S. States (DC and territories ineligible). Governor designates the lead agency; an AOR must sign. One official application per State; the latest on-time submission counts. (files.simpler.grants.gov)
- Deadlines: LOI due 9/30/2025 (optional); application due 11/5/2025 11:59 p.m. ET; decisions by 12/31/2025. (files.simpler.grants.gov)
- Funds & distribution: $50B total across FY26–FY30; 50% equal baseline; 50% workload based on point system (rural facility/population plus technical factors). (files.simpler.grants.gov)

- Key compliance: Exec. Order 12372 does not apply; check "No" on SF-424 Item 19c; 2 CFR Part 200/Part 300 and HHS GPS apply; telecom/video surveillance restrictions (2 CFR 200.216); cost caps and specific prohibitions (e.g., 45 CFR 156.400). (files.simpler.grants.gov)
- Application contents and page limits: Project summary (1p), Project Narrative (≤60p; 12-pt; double-spaced main text), Budget Narrative (≤20p; single-spaced), Governor's letter (≤4p), Business assessment (≤12p), Program duplication assessment (≤5p), and required SF forms. (files.simpler.grants.gov)

RFP requirement → Collaborative capability → Evidence

- Technology and cybersecurity advances; remote care and consumer tech (Uses A, C, D, F) → Microsoft secure cloud/cyber; BioIntelliSense RPM; Humetrix consumer triage/PHR; Viz.ai acute detection; Walgreens/Walmart consumer access →
- Training/TA for tech-enabled care → Avel eCare tele-mentoring & virtual hospital services; systems integrators (Accenture, KPMG, PwC, AVIA) for adoption and PMO →
- Workforce recruitment/retention with rural service commitments → Pharmacy workforce pipelines; ambient documentation to reduce burnout; HVN-based shared staffing models →
- Innovative care/value-based models and statewide partnerships → Cibolo Health HVNs; payer engagement via integrators; analytics for VBC →
- Data interoperability and HIE alignment → State HIE (CyncHealth Iowa) connectivity; TEFCA-aligned exchanges supported by Collaborative platforms → (cynchealth.org)

3. Iowa Context Snapshot

- Rural demographics: In 2020, 63.2% of Iowans lived in urban areas (36.8% rural) per the 2020 Census urban/rural reclassification analysis by Iowa State University Extension. (extension.iastate.edu)
- Rural facility mix (as of 2025): 82 CAHs; 212 RHCs; 61 rural-located FQHC sites; 11 short-term/PPS rural sites; zero Rural Emergency Hospitals. (RHIhub, updated Sept. 11, 2025.) (ruralhealthinfo.org)
- Health information exchange: CyncHealth operates Iowa's HIE (formerly IHIN) and offers provider portal and direct messaging services; 2025 updates emphasized near-real-time access for authorized users. (cynchealth.org)
- Medicaid: Iowa Health Link MCOs in 2025—Wellpoint (formerly Amerigroup Iowa), Iowa Total Care, and Molina. D-SNPs operating include Aetna, Wellpoint, Humana, and UnitedHealthcare. (hhs.iowa.gov)
- Licensure compacts (technical scoring D.2): Iowa participates in the Interstate Medical Licensure Compact and the Nurse Licensure Compact; participates in the EMS (REPLICA) compact; joined the PA Licensure Compact (HF 300) in May 2025; not a PSYPACT member. (imlcc.com)
- Certificate of Need (CON): CON program active; transferred to Iowa HHS effective July 1, 2025 (HF 972). (hhs.iowa.gov)
- Broadband: State Broadband Availability Map v6 published April 10, 2025, classifies served/unserved/underserved locations; useful for targeting telehealth and remote monitoring build-outs. (dom.iowa.gov)
- Maternal/infant health: Iowa's infant mortality rate was 6.82 per 1,000 live births in 2023 (CDC NCHS), with national 2022–2023 increases; maternal outcomes remain an equity priority. (cdc.gov)
- Behavioral health/SUD: CDC NCHS reports Iowa's drug overdose death rate at 15.3 per 100,000 (latest CDC state profile page); national provisional data show 2024 declines overall, underscoring opportunity for prevention. (cdc.gov)

Metric (latest year) → Value → Source → Collaborative capability aligned

- Rural share (2020) → 36.8% → ISU/Census analysis → Retail/consumer access + RPM (Walgreens/Walmart; BioIntelliSense). (extension.iastate.edu)
- CAHs (2025) → 82 → RHIhub → Avel eCare virtual hospital and tele-ER/ICU support. (ruralhealthinfo.org)
- RHCs (2025) → 212 → RHIhub → Pharmacy integration and community-based chronic care. (ruralhealthinfo.org)
- HIE operator (2025) → CyncHealth Iowa → CyncHealth/Microsoft data stack interoperability. (cynchealth.org)
- Infant mortality (2023) → 6.82/1,000 → CDC NCHS → Prenatal RPM, tele-MFM consults, pharmacy BP management. (cdc.gov)
- Overdose death rate (CDC state page) → 15.3/100k → CDC NCHS → Tele-behavioral health, medication safety alerts, care-gap analytics. (cdc.gov)

4. Strategy Aligned to RFP

Proposed transformation model (conditional on contracting and integration):

- Right-sized rural networks: Organize rural providers into High Value Networks (HVNs) for shared services (tele-ICU/ER/hospitalist, pharmacy services, care management, analytics) with common governance, quality/financial dashboards, and payment alignment. Cibolo Health provides HVN frameworks; integrators configure governance, change management, and value tracking.
- Tech-enabled access: Avel eCare's virtual hospital services, BioIntelliSense continuous monitoring with exception management, Viz.ai for time-sensitive conditions, and Humetrix multilingual intake/PHR tools to expand access and reduce avoidable transfers.
- Consumer-centric primary and chronic care: Retail pharmacy partners (Walgreens, Walmart) to support hypertension/diabetes adherence, telepharmacy, and point-of-care testing integrated with local clinics.
- Data and cyber: Microsoft cloud and security services; alignment with CyncHealth Iowa HIE and TEFCA-oriented exchanges, with privacy, role-based access, and auditability.

Equity strategy (rural and Tribal):

- Deploy consumer tools in rural pharmacies and community venues with multilingual interfaces; measure uptake by geography and demographic segments; prioritize counties with maternal/infant risks and overdose burdens.
- Partner with FQHCs via Iowa PCA and with local health departments for outreach and BP screening events (AHA/ASA collaboration).

Data use & privacy:

- Use CyncHealth's HIE services plus State and MCO claims, EHR, EMS, and social services datasets; enforce HIPAA, 42 CFR Part 2 where applicable; implement zero-trust security with continuous monitoring. (cynchealth.org)

5. Program Design Options (Iowa-tuned; not prescriptive)

Option A. Rural Virtual Care & Exception-Based Monitoring Network

- Target: CAHs/RHCs in counties with long transfer times and higher infant mortality or chronic disease burden.
- Problem: Avoidable transfers/readmissions; limited 24/7 specialty coverage.
- Components: Avel eCare virtual hospital services; BioIntelliSense RPM; Viz.ai acute detection; Humetrix triage/med safety; Microsoft cyber/data.
- Payment logic: Incentivize reduction in avoidable transfers and readmissions via performance payments to rural networks (Meets E.1). (files.simpler.grants.gov)
- Policy enablers: Support licensure compacts utilization (IMLC/NLC/EMS; PA Compact newly enacted); consider pharmacy scope adjustments (if pursued by State) to earn policy points. (imlcc.com)
- Pros/risks: Pros—keeps care local, measurable outcomes; Risks—connectivity, adoption; Mitigation—broadband map targeting; integrator-led training. (dom.iowa.gov)

Option B. Rural Maternal & Infant Health Access Bundle

- Target: Counties with higher infant mortality (6.82 per 1,000 in 2023 statewide benchmark). (cdc.gov)
- Components: Tele-MFM consults through CAHs; pharmacy BP management; remote BP/weight/glucose monitoring; doula/CHW programs; linkage to IH+ (IowaHealth+) FQHC network for wraparound care. (iowahealthplus.com)
- Payment logic: MCO prenatal/postpartum quality incentives; tie to BP control, timely postpartum visits, reduced ED use. (hhs.iowa.gov)

Option C. Behavioral Health and SUD Access Acceleration

- Target: Areas with overdose death rate around 15.3/100k and limited specialists. (cdc.gov)
- Components: Tele-psychiatry, medication safety alerts (Humetrix), pharmacy naloxone education, care-gap analytics (Pangaea) to proactively identify undertreated conditions; EMS tele-consult pathways.
- Payment logic: Value-based metrics tied to ED utilization and continuity of MOUD; align with D-SNP integration where relevant. (hhs.iowa.gov)

Option D. Rural HVN Shared-Services and VBC Readiness

- Target: Independent CAHs/RHCs/FQHCs.
- Components: HVN governance (Cibolo), shared coding/billing, quality & analytics, contract modeling; integrators to implement outcomes tracking and financial models.
- Payment logic: Migration path to global/shared-savings arrangements or network-level pay-for-performance (Meets I; supports E.1). (files.simpler.grants.gov)

6. Governance and Collaborative Roles

Illustrative governance (conditional):

- State Lead Agency (Governor-designated): Accountable for grant, reporting, policy actions.
- Medicaid (Iowa HHS): Payment alignment with MCOs; SPA/contract levers; duals/D-SNP coordination. (hhs.iowa.gov)
- HIE (CyncHealth Iowa): Data services, provider portal interoperability. (cynchealth.org)
- Provider networks (HVN via Cibolo Health): Member governance, shared services, and performance management.
- Collaborative members: Avel eCare (tele-hospital), BioIntelliSense (RPM), Humetrix (consumer/analytics), Microsoft (cloud/cyber), Viz.ai (acute AI), Walgreens/Walmart (retail access), Integrators (Accenture/KPMG/PwC/AVIA) for PMO and outcomes tracking.

RACI (selected tasks)

- Program management office & reporting: State (R), Integrators (A/C), Collaborative vendors (C), Providers (I).
- Data integration & security plan: State/CyncHealth (R), Microsoft (A), Providers (C/I). (cynchealth.org)
- Clinical operations (tele-ICU/ER/hospitalist): Providers (R), Avel eCare (A), State (I).
- RPM deployment: Providers (R), BioIntelliSense (A), State (I), MCOs (C).
- Consumer tech roll-out: Providers/Retail pharmacies (R), Humetrix (A), State (I).

7. Payment and Funding

- RHT mechanics: No cost sharing; funds in five periods; spend-forward allowed to end of following fiscal year. 50% equal baseline; 50% points-based workload. If all 50 States are approved, the equal baseline pool ($25B over five periods) implies about $100M per State per year as a rough baseline illustration (actual depends on number of awardees). (files.simpler.grants.gov)
- Caps: Provider payments ≤15% of a year's award; Category J capital/infrastructure ≤20%; EMR replacement ≤5% (where a prior certified EMR exists); Rural Tech Catalyst-type ≤ lesser of 10% or $20M; admin/indirects ≤10%. (files.simpler.grants.gov)
- Medicaid alignment opportunities: MCO quality withholds/bonuses, primary care alternatives, network-level P4P/ACO approaches; D-SNP/dual integration touchpoints. (hhs.iowa.gov)

Illustrative cost/RoM (subject to awards and caps; example only)

Initiative	**RHT uses**	**Planning notes**
Virtual hospital and RPM package across a multi-county HVN	F, I, J	Map initiative-level OPEX/CAPEX; ensure Category J ≤20% and admin ≤10%.
Consumer engagement and medication safety	A, C, D, F	Partner with pharmacies; keep within provider-payment cap when applicable.
Data/cyber modernization and HIE integration	F	Align with 2 CFR 200.216 telecom/video surveillance restrictions. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Core measures: avoidable transfers/readmissions; ED use; chronic disease control (BP <140/90; A1c); prenatal/postpartum visit timeliness and BP control; behavioral/SUD engagement; network financial sustainability; cybersecurity posture; program implementation metrics. (NOFO requires robust metrics and cooperation with CMS evaluations.) (files.simpler.grants.gov)
- Data sources: CyncHealth HIE; MCO and Medicaid claims; provider EHRs; RPM devices; EMS datasets; social services data (as available). (cynchealth.org)
- Evaluation cadence: Quarterly performance dashboards; annual continuation applications (non-competing) per NOFO; iterative risk/benefit updates. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; illustrative Gantt)

Workstream	Start	End	Lead	Outputs
HVN governance setup	Q1-2026	Q2-2026	Cibolo/Providers	Charter, bylaws, shared services MoU.
Tele-hospital services go-live (pilot 5-10 sites)	Q2-2026	Q4-2026	Avel/Providers	24/7 coverage, KPI baseline.
RPM cohort (CHF/HTN/DM)	Q2-2026	Q4-2026	BioIntelliSense/Providers	Enrolled panel, exception workflows.
Consumer tools + med safety	Q2-2026	Q4-2026	Humetrix/Retail	Multilingual intake, PHR adoption.
Data/cyber platform uplift	Q1-2026	Q3-2026	Microsoft/CyncHealth	Cloud landing zone, security runbooks.
VBC analytics & payment model design	Q2-2026	Q4-2026	Integrators/Medicaid/MCOs	P4P/VBC specs, provider reports.

Procurement/legal gating (illustrative): Master agreements with core vendors; BAAs and data use agreements; HIE participation; MCO addenda for incentives (subject to State procurement). (cynchealth.org)

10. Risk Register (illustrative)

Risk	Mitigation	Owner
Broadband gaps impede telecare	Target sites using State Broadband Map v6; include offline-tolerant workflows. (dom.iowa.gov)	DoIT/CyncHealth/Integrators
Provider-payment cap (15%) constrains incentives	Emphasize non-payment enablers (data/tele, workforce); structure VBC via MCO contracts. (files.simpler.grants.gov)	Medicaid/MCOs
Capital cap (20%) limits facility upgrades	Prioritize right-sizing and IT infrastructure; stage multi-year upgrades. (files.simpler.grants.gov)	State/Providers
Policy commitments not enacted by deadlines	Focus on feasible compacts (IMLC, NLC, EMS, PA enacted) and document legislative timelines; monitor conditional points. (files.simpler.grants.gov)	State/Leg Affairs

Risk	Mitigation	Owner
Security incidents	Microsoft security stack; SOC monitoring; incident playbooks and tabletop exercises.	State/CyncHealth/Microsoft
Adoption/clinical workflow burden	Tele-mentoring and ambient documentation; phased cohorts.	Avel/Microsoft/Providers
Data-sharing resistance	Use HIE governance and consent tools; TEFCA alignment. (cynchealth.org)	CyncHealth/Providers
Budget overrun vs. admin ≤10%	Track admin in PMO; allocate to programmatic lines; audit quarterly. (files.simpler.grants.gov)	State/PMO
Retail/clinic integration complexity	Establish referral and feedback loops; sequence pilots before scaling.	Integrators/Providers
Equity gaps persist	Target maternal/SUD hotspots; monitor uptake by rural and underserved groups; adjust outreach. (cdc.gov)	State/FQHCs

11. Draft RFP Response Language (paste-ready; tailor as needed)

11.1 Rural Health Needs & Target Population (excerpt)

"Iowa's rural population remains material (36.8% in 2020), with significant service access variation across counties. The State's rural delivery system includes 82 Critical Access Hospitals, 212 Rural Health Clinics, and 61 rural-located FQHC sites. We will prioritize counties with higher infant mortality (6.82 per 1,000 in 2023) and SUD burden (drug overdose death rate 15.3 per 100,000) for early interventions." (extension.iastate.edu)

11.2 Goals, Strategies, and Policy Actions (excerpt)

"Our plan advances tele-specialty backup, exception-based remote monitoring, consumer-facing triage and medication safety, and HVN shared services. We will leverage existing interstate compacts (IMLC, NLC, EMS) and recent enactment of the PA Licensure Compact to expand workforce mobility; we are not a PSYPACT member and will assess feasibility of enabling legislation to improve behavioral access." (imlcc.com)

11.3 Proposed Initiatives (excerpt)

"Rural Virtual Care & Monitoring Network (Uses: A, C, D, F/I/J as applicable). Outcomes include reduced avoidable transfers/readmissions, improved chronic disease control, and increased timely postpartum follow-up. Implementation is supported by Avel eCare, BioIntelliSense, Humetrix, Viz.ai, Microsoft, and the State HIE."

11.4 Implementation & Timeline (excerpt)

"We will phase deployment starting in Q2-2026 with 5–10 CAHs and affiliated clinics, expanding statewide by Q4-2027. Major procurements occur in early 2026; policy actions will follow a 2026 session introduction with target enactment by 12/31/2027 (or 12/31/2028 for factors B.2/B.4), consistent with NOFO timelines." (files.simpler.grants.gov)

11.5 Metrics & Evaluation (excerpt)

"We will report quarterly on access, quality, financial stability, workforce, technology adoption, and implementation fidelity, cooperate with CMS evaluations, and maintain data privacy and cybersecurity per 2 CFR Part 200/Part 300 and State/HIE policies." (files.simpler.grants.gov)

12. References

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8. RHIhub — Iowa State Guide (facility counts), ruralhealthinfo.org/states/iowa, updated 2025-09-11, accessed 2025-10-14. (ruralhealthinfo.org)
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11. Iowa HHS — Medicaid Contracts & Rates (D-SNPs list), accessed 2025-10-14. (hhs.iowa.gov)
12. Interstate Medical Licensure Compact — participating states (Iowa), imlcc.com, accessed 2025-10-14. (imlcc.com)
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14. EMS Compact (REPLICA) — member states (Iowa), emscompact.gov, accessed 2025-10-14. (emscompact.gov)
15. PA Licensure Compact — Iowa joins (HF 300 signed May 27, 2025), AAPA, accessed 2025-10-14. (aapa.org)
16. PSYPACT map — Iowa not enacted, psypact.gov, accessed 2025-10-14. (psypact.gov)
17. Iowa Certificate of Need Program — moved to Iowa HHS (HF 972, 2025), Iowa HHS, accessed 2025-10-14. (hhs.iowa.gov)
18. Iowa Broadband Availability Map v6 (Apr 10, 2025), Iowa DoM DoIT, accessed 2025-10-14. (dom.iowa.gov)
19. CDC NCHS — Iowa state profile (overdose rate, births), cdc.gov/nchs/pressroom/states/iowa, accessed 2025-10-14. (cdc.gov)
20. CDC NCHS Data Brief 530 — infant mortality by state (2022–2023), cdc.gov/nchs/products/databriefs/db530.htm, accessed 2025-10-14. (cdc.gov)

Assumptions and Open Questions

- The guide uses the official RHT NOFO (CMS-RHT-26-001) for all programmatic requirements; any additional numerical illustrations (e.g., rough baseline share) are explicitly labeled as illustrative and depend on the number of awardees. (files.simpler.grants.gov)
- Iowa's current status for certain NOFO technical factors (e.g., SNAP waivers, "nutrition CME") may change; final scoring should use Q4-2025 status per the NOFO. Confirmation required from the State.
- Medicaid payment constructs (e.g., specific VBC incentives) will be finalized with Iowa HHS and MCOs; D-SNP alignment opportunities depend on plan readiness. (hhs.iowa.gov)
- The State will provide required counts (e.g., hospitals receiving Medicaid DSH in the most recent SPRY; CCBHC sites as of 9/1/2025) per the NOFO. (files.simpler.grants.gov)

Checklists

- Compliance checklist (excerpt):
    - One State application; AOR signature; Governor's letter (≤4p). (files.simpler.grants.gov)
    - Project Narrative (≤60p), Budget Narrative (≤20p), formatting per NOFO. (files.simpler.grants.gov)
    - SF-424, SF-424A, SF-LLL, Site Locations; check "No" on SF-424 19c. (files.simpler.grants.gov)
    - Admin ≤10%; caps on categories B/J/EMR/Catalyst; 2 CFR and HHS GPS compliance. (files.simpler.grants.gov)

- Technical factors readiness (excerpt):
    - Compacts status documented (IMLC/NLC/EMS/PA; PSYPACT non-member). (imlcc.com)
    - EMS capability and regional partnerships plan included.
    - Data/cyber plan consistent with State HIE and TEFCA; 2 CFR 200.216 considered. (cynchealth.org)

Gantt-style timeline (high-level; 24 months) Phase | Q1-26 | Q2-26 | Q3-26 | Q4-26 | Q1-27 | Q2-27 | Q3-27 | Q4-27

- Governance/HVN | ███ | ███ | | | | | |
- PMO & reporting | ███ | ███ | ███ | ███ | ███ | ███ | ███ | ███
- Tele-hospital pilots | | ███ | ███ | ███ | | | |
- RPM cohorts | | ███ | ███ | ███ | ███ | ███ | |
- Consumer tech | | ███ | ███ | ███ | ███ | ███ | ███ |
- Data/cyber uplift | ███ | ███ | ███ | | | | |
- VBC design & contracts | | ███ | ███ | ███ | ███ | | |

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