Rural Health Transformation Grant Guide — Minnesota

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Minnesota enters the Rural Health Transformation (RHT) Program with a mature Medicaid value-based infrastructure (Integrated Health Partnerships), strong telehealth parity laws, community paramedicine authority, and an active Certified Community Behavioral Health Clinic (CCBHC) framework—all favorable to scoring under the RHT NOFO's technical factors and to rapid execution with rural stakeholders. The RHT Collaborative's members can support Minnesota with interoperable data platforms, remote care services, virtual specialty coverage, cybersecurity hardening, and workforce enablement that align to the NOFO's five strategic goals and the weighted technical factors used in workload funding in each budget period. (mn.gov)

The NOFO makes up to $50B available across FY26–FY30 via one application window (applications due Nov 5, 2025; awards by Dec 31, 2025). Funds split 50% baseline and 50% "workload" based on points, with factor weights specified in Table 3 (e.g., EMS; remote care; data infrastructure). Administrative expenses must be ≤10% per period. Funding for provider payments is capped at 15%; capital and infrastructure at 20%; EMR replacement at 5% if a prior HITECH-certified EMR existed by Sep 1, 2025; and any "rural tech catalyst" initiative at the lesser of 10% or $20M per period. (files.simpler.grants.gov)

Minnesota's rural profile underscores urgency and fit. In 2023, 22.1% of Minnesotans lived in nonmetro areas; the state has 76 Critical Access Hospitals (CAHs), 107 Rural Health Clinics (RHCs), 20 FQHCs, and one Rural Emergency Hospital (REH). Rural broadband at 100/20 Mbps remains uneven (81.7% of rural population with fixed 100/20, vs 99.3% urban). Maternal-infant indicators show 2023 preterm birth at 9.4% and infant mortality at 4.7 per 1,000. Drug overdose mortality was 23.6 per 100,000 in 2025 CDC reporting. The RHT Collaborative can support targeted initiatives—virtual behavioral health, RPM for chronic disease, tele-OB networks, and EMS modernization—that map directly to NOFO scoring and use-of-funds categories. (ruralhealthinfo.org)

Highest-leverage Collaborative offerings for Minnesota include: statewide virtual specialty backstops (tele-ER/ICU/hospitalist) to stabilize CAHs and RHCs; continuous remote monitoring for chronic disease and post-acute care; retail-pharmacy–enabled screening and adherence programs; and secure, FHIR-based data exchange with analytics and cybersecurity protections. These offerings have been implemented by Collaborative members (e.g., Avel eCare, BioIntelliSense, eClinicalWorks/healow, Microsoft, Walgreens/CVS) and are designed to integrate with Minnesota's existing provider networks and Medicaid payment models, subject to contracting and State oversight.

One-page printable summary (for distribution with stakeholders)

- RHT NOFO at a glance
    - Applicant: States only; one application; LOI optional by Sep 30, 2025; application due Nov 5, 2025; award by Dec 31, 2025. Executive Order 12372 does not apply (SF-424 Item 19c = "No"). Admin cap ≤10%. (files.simpler.grants.gov)
    - Distribution: 50% equal baseline; 50% workload via points (recalculated annually for technical factors; rural factors set once using Q4-2025 data). (files.simpler.grants.gov)
    - Key caps: Provider payments ≤15%; Capital/Infrastructure ≤20%; EMR replacement ≤5% (if prior HITECH-certified EMR as of 9/1/2025); "rural tech catalyst" ≤10% or $20M per period. (files.simpler.grants.gov)
- Minnesota context (most recent available)
    - 22.1% of population nonmetro (ACS 2023). 76 CAHs; 107 RHCs; 20 FQHCs; 1 REH. (ruralhealthinfo.org)
    - Rural 100/20 Mbps fixed coverage 81.7% vs 99.3% urban (FCC data summarized by Blandin, 2024). (blandinonbroadband.org)
    - Preterm births 9.4% (2023); infant mortality 4.7/1,000 (2023). Overdose mortality 23.6/100,000 (2025 data page). (marchofdimes.org)
- Collaborative alignment to NOFO weights (examples)
    - EMS (C.2): tele-ER/tele-ICU support, community paramedicine enablement.
    - Remote care services (F.1): BioButton continuous monitoring; statewide telehealth networks.
    - Data infrastructure (F.2): cloud analytics, TEFCA/QHIN-enabled exchange, cybersecurity hardening.
    - Consumer tech (F.3): multilingual intake/triage; retail-based screenings; patient engagement.

2. Eligibility and RFP Fit

2.1 Program essentials (for application compliance)

- Eligibility: Only the 50 U.S. States; DC/territories ineligible. Governor designates lead agency; AOR signature required. One application per State; latest on-time submission counts. (files.simpler.grants.gov)
- Key dates: Optional LOI by Sep 30, 2025; application due Nov 5, 2025, 11:59 p.m. ET; expected awards Dec 31, 2025. (files.simpler.grants.gov)
- Funds: $50B FY26–FY30; each year's funds available into the following fiscal year. Admin costs ≤10% per period. (files.simpler.grants.gov)
- Distribution: 50% equal baseline; 50% workload via points; workload recalculated each period using reporting; rural/population facility factors set once (Q4-2025). (files.simpler.grants.gov)
- Scoring weights (Table 3): rural facility & population (50%) and technical (50%), with sub-weights for EMS, remote care, data, consumer tech, etc. (files.simpler.grants.gov)
- Use-of-funds caps and prohibitions: 15% provider payments; 20% capital/infrastructure; 5% EMR replacement (if prior HITECH-certified EMR existed as of 9/1/2025); "rural tech catalyst" ≤ the lesser of 10% or $20M/period; covered telecom/video surveillance restrictions per 2 CFR 200.216; construction not allowable as a direct cost. (files.simpler.grants.gov)
- Forms and intergovernmental review: Submit SF-424/SF-424A/SF-LLL/Project Site; check "No" for EO 12372; Grants.gov only. (files.simpler.grants.gov)

2.2 Requirement-to-Collaborative capability mapping

Requirement	Collaborative capability	Evidence
Remote care services and consumer technologies (F.1, F.3)	RPM wearables, multilingual intake and triage, retail screenings, statewide telehealth visit capacity (subject to credentialing and contracting).	Collaborative consensus PDF descriptions and deployments.
Data infrastructure & interoperability (F.2)	FHIR-based data layer, TEFCA connectivity, analytics, privacy/consent tooling, cybersecurity services.	Collaborative consensus PDF.
EMS and hospital stabilization (C.2)	Tele-ER/ICU/hospitalist backup, tele-pharmacy, clinical mentoring, community paramedicine enablement.	Collaborative consensus PDF.
Workforce recruitment/retention (D.1)	Ambient clinical documentation, tele-mentoring, pharmacist scope pilots aligned to Minnesota law, training pathways.	Collaborative consensus PDF.
Value-based care/payment design (E.1, I)	Actuarial modeling, provider incentive design, claims exchange modernization.	Collaborative consensus PDF.

3. Minnesota Context Snapshot

3.1 Demography and rural footprint

Indicator	Latest value	RHT implications
Nonmetro population share	1,264,289 residents (22.1%) of 5.71M (ACS 2023 5-year). (ruralhealthinfo.org)	Large rural population underpins baseline funding and technical scoring tied to rural factors.

Indicator	Latest value	RHT implications
Rural facility mix (July 2025)	76 CAHs, 1 REH, 107 RHCs, 20 FQHCs, 25 PPS hospitals outside urban areas. (ruralhealthinfo.org)	Defines priority network for tele-specialty, RPM, and governance investments.
Rural broadband 100/20 Mbps coverage	81.7% of rural residents with fixed 100/20 Mbps vs 99.3% urban; combined fixed+mobile 55.6%. (blandinonbroadband.org)	Highlight counties needing connectivity support, cellular fallback, and cybersecurity hardening before deployment.

3.2 Workforce, HPSA indicators, and EMS

Workforce/EMS indicator	Current status	Implications for RHT planning
Physician distribution and retention	4.4% of physicians practice in rural MN while 15% of residents live there; 19% intend to leave within 1–5 years, citing documentation burden. (mnmed.org)	Prioritize ambient documentation, tele-specialty coverage, and retention supports within workforce factor scoring.
HPSA designations	Multiple primary care, dental, and mental health HPSAs statewide per HRSA dashboards and Nov 2024 FR notices. (data.hrsa.gov)	Target Collaborative tele-access and workforce programs to designated shortage areas.
EMS capacity	Ongoing staffing shortages and financial stress; community paramedicine authorized and reimbursable under Minnesota Medical Assistance. (mnems.org)	Use tele-EMS, community paramedicine, and training investments to score under technical factor C.2.

3.3 Maternal, behavioral health, and chronic disease signals

Health signal	Current data	Collaborative response
Maternal and infant outcomes	Preterm birth 9.4% (2023); infant mortality 4.7 per 1,000 live births (2023); rural OB services continue to contract. (marchofdimes.org)	Deploy tele-OB consults, remote BP monitoring, and retail pharmacy navigation to maintain access.
Behavioral health and SUD	Drug overdose mortality 23.6 per 100,000 per CDC reporting; persistent rural access gaps. (espanol.foodsafety.gov)	Scale virtual behavioral health, integrate with CCBHC PPS, and extend crisis response via telehealth.
Chronic disease burden	Rural hypertension/diabetes management gaps noted statewide; access constraints hinder adherence.	Use RPM, pharmacist-led adherence programs, and consumer engagement tools to reduce avoidable admissions.

3.4 Medicaid and payment landscape

Payment element	Details	RHT takeaways
Medicaid enrollment and value programs	1.26M average monthly enrollees (21.7% of population) in FY2024; extensive managed care and IHP value-based arrangements. (usafacts.org)	Enables shared-savings alignment, PMPM incentives, and SPA updates to support RHT initiatives.

Payment element	Details	RHT takeaways
CCBHC prospective payment system	State operates CCBHC PPS with quality bonuses per DHS policy. (mn.gov)	Facilitates behavioral integration with rural primary care, retail partners, and virtual psychiatry under RHT funding.

3.5 Telehealth policy enablers

Policy lever	Current status	Planning considerations
Telehealth coverage and payment parity	Minnesota Stat. 62A.673 enforces coverage and reimbursement parity, including telemonitoring. (law.justia.com)	Supports scaling statewide virtual programs with Medicaid MCOs and commercial plans (subject to contract specifics).
Licensure compacts	Minnesota participates in the Interstate Medical Licensure Compact; the state is not in the Nurse Licensure Compact. (mn.gov)	Guides credentialing strategy and policy-action scoring under NOFO factors D.2 and D.3.

3.6 Metric-to-capability table (selected)

Metric	Latest value	Collaborative capability alignment	Source
Rural broadband (100/20 Mbps, 2024)	81.7% rural coverage vs 99.3% urban; fixed+mobile 55.6% rural.	Remote care (F.1) with offline-tolerant workflows, device kitting, cellular fallback, and cybersecurity hardening.	blandinonbroadband.org
Critical Access Hospitals (2025)	76 CAHs statewide (plus 1 REH, 107 RHCs, 20 FQHCs).	Tele-ICU/tele-ER consults, e-Pharmacy, transfer coordination, and HVN governance.	ruralhealthinfo.org
Infant mortality (2023)	4.7 deaths per 1,000 live births; preterm birth 9.4%.	Tele-OB triage, remote BP monitoring, pharmacist-enabled perinatal hypertension adherence models.	marchofdimes.org

4. Strategy Aligned to RFP

Minnesota can frame a Rural Health Transformation Plan that focuses on: (1) stabilizing rural access via virtual backstops and community paramedicine; (2) reducing avoidable transfers and readmissions using continuous monitoring and digital engagement; (3) integrating behavioral health through CCBHC-enabled networks and retail-based touchpoints; and (4) strengthening data, interoperability, and cybersecurity to support analytics and evaluation. This approach maps to technical factors B–F and to allowed use categories A, C–K, within NOFO caps. (files.simpler.grants.gov)

- EMS (C.2): Avel eCare tele-ER/ICU/hospitalist and tele-pharmacy can support CAHs and RHCs to manage acuity locally, with 24/7 consult coverage, subject to credentialing and workflows.
- Remote care services (F.1): BioIntelliSense BioButton continuous vitals with exception dashboards for CHF/COPD/diabetes and post-acute care management, including training for digital health navigators.
- Data infrastructure (F.2): Cloud data fabric, TEFCA/QHIN exchange (eClinicalWorks PRISMA/PRISMANet), identity, consent, and analytics; program dashboards for outcomes and spend.
- Consumer-facing tech (F.3): Multilingual intake/triage and engagement (Humetrix); pharmacy-based screenings and adherence interventions; digital front door models.
- Partnerships (C.1): Cibolo Health convenes member-owned High Value Networks (HVNs) to coordinate investments, negotiate value-based arrangements, and steward funds with transparency, subject to State oversight.

Equity strategy for rural and Tribal communities: combine statewide tele-behavioral access (CCBHCs + virtual psychiatry), multilingual triage, and retail access points in rural towns; integrate with tribal/IHS providers through data-sharing agreements and consent-aware exchange on FHIR/TEFCA rails. Consumer engagement assets include voice-enabled intake and culturally adapted education.

Data use and privacy: use HIPAA-aligned, FHIR-based platforms; apply role-based access, audit, encryption at rest/in transit; implement consent tooling for behavioral/SUD data; maintain cybersecurity per HHS/ONC/OCR expectations and the NOFO's IT advancement emphasis.

5. Program Design Options (tailored for Minnesota)

Option A: Rural Virtual Specialty Safety Net + RPM for High-Risk Chronic Disease

- Target: Rural adults with CHF/COPD/diabetes and recent inpatient/ED events in CAH counties.
- Problem: High readmission/transfer rates; clinician shortages; broadband gaps. RPM and virtual consults can reduce events and support local care. (blandinonbroadband.org)
- Collaborative services: BioButton RPM; Avel tele-hospitalist/ICU/ER; pharmacist-led adherence via Walgreens/CVS; eClinicalWorks care gap identification.
- Payment logic: Care management/RPM codes where covered; PMPM incentives within IHP/shared-savings arrangements; grants fund devices/training within 15% provider-payment and 20% capital caps. (files.simpler.grants.gov)
- Enablers: Telehealth parity; IMLC; data-sharing and TEFCA connections; cybersecurity plan. (law.justia.com)
- Pros/risks: High reach and measurable outcomes; depends on device logistics and broadband reliability; mitigation via cellular fallback and navigator support. (blandinonbroadband.org)

Option B: EMS Modernization + Community Paramedicine Integration

- Target: EMS regions with staffing gaps; post-discharge and high-utilizer cohorts needing in-home services.
- Problem: EMS staffing/financial pressures; delays in transport and interfacility transfers. (mnems.org)
- Collaborative services: Tele-ER guidance; e-Pharmacy med reconciliation; community paramedicine workflows integrated with primary care; training content and QA.
- Payment logic: RHT funds for equipment/tele-EMS; Medical Assistance coverage for community paramedic services under statute; value-based add-ons in IHP. (health.state.mn.us)
- Pros/risks: Improves response and follow-up; requires medical direction protocols and contracting; mitigated via standardized protocols and PMO support.

Option C: Rural Maternal Health Access—Tele-OB + Pharmacist-Enabled Hypertension

- Target: Rural birthing people at risk of preeclampsia/post-partum HTN.
- Problem: OB unit closures nationwide and in some MN communities; distance to care. (twin-cities.umn.edu)
- Collaborative services: Tele-OB consults; home BP RPM; pharmacy BP screening, adherence and navigation.
- Payment logic: Use RHT funds for devices and coordination; align with CCBHC or perinatal care bundles where available; stay within provider/capital caps. (files.simpler.grants.gov)
- Pros/risks: Addresses top drivers of maternal morbidity; requires OB coverage and referral pathways; mitigation via regional MOUs and tele-call schedules.

Option D: Behavioral Health Integration via CCBHC + Virtual Psychiatry

- Target: Rural residents with SUD/mental health needs in HPSAs; dual-eligible adults.
- Problem: Access delays and fragmented care. (data.hrsa.gov)
- Collaborative services: CCBHC PPS operations; virtual psychiatry; multilingual triage; opioid risk alerts to patients/providers; analytics for gap closure.
- Payment logic: CCBHC PPS/quality bonus (per DHS policy); RHT funds for tech/training; VBP incentives in Medicaid MCO/IHP contracts. (mn.gov)

6. Governance and Collaborative Roles

6.1 Structure (illustrative)

- State lead agency (Governor-designated): Grant holder; policy alignment; program oversight; CMS reporting.
- Medicaid agency: Payment alignment (SPA/contract amendments), data sharing; actuarial reviews.
- Office of Rural Health & Primary Care: Provider convening; CAH/RHC technical assistance.
- Hospital association; FQHCs; tribal/IHS: Delivery partners and governance participants.
- Collaborative members (technology, providers, SIs): Solution provisioning subject to contracting and State procurement; PMO/data operations; workforce training; cybersecurity.

6.2 RACI (selected)

- Program management office (PMO): Responsible—SI partners (Accenture/KPMG/PwC) with State oversight; Accountable—State lead agency; Consulted—Medicaid; Informed—stakeholders.
- Tele-ER/ICU: Responsible—Avel eCare with local hospitals; Accountable—participating hospitals; Consulted—Medicaid on reimbursement; Informed—ORHPC.
- RPM: Responsible—BioIntelliSense and participating clinics; Accountable—provider groups; Consulted—Medicaid/health plans; Informed—State PMO.
- Data/cyber: Responsible—platform vendor(s); Accountable—State data governance; Consulted—HIEs; Informed—providers.

7. Payment and Funding

- Alignment with NOFO caps: Plan ≤15% for direct provider payments (Category B); allocate ≤20% to capital/infrastructure (Category J); any EMR replacement within 5% if prior HITECH-certified EMR existed by 9/1/2025; admin ≤10% overall. (files.simpler.grants.gov)
- Medicaid levers Minnesota can use with Collaborative support: actuarial modeling for incentive PMPMs and shared savings; SPA language for tele-RPM/adherence supports where applicable; CCBHC PPS/quality measures integration; IHP contract incentives for rural outcomes. (mn.gov)

Illustrative cost and deliverable table (conceptual; amounts to be finalized in SF-424A)

Workstream	Cost category	Timing	Funding source	Collaborative deliverables	Source
Tele-ER/ICU setup	Equipment/services (Categories J, F)	Months 3–9	RHT funds within 20% cap	24/7 coverage SLAs, credentialing, SOPs.	files.simpler.grants.gov
RPM program	Devices/services (Categories A, C, F)	Months 4–24	RHT funds plus plan reimbursement	Device logistics, clinical protocols, navigator training.	Collaborative catalog
Data/cyber platform	Platform/cyber investments (F.2)	Months 1–24	RHT funds plus in-kind contributions	Data lake, dashboards, SOC processes.	Collaborative catalog

8. Data, Measurement, and Evaluation

- Core measures: avoidable transfers/readmissions; ED visits; BP control; A1c; behavioral engagement; time-to-psychiatry; maternal HTN follow-up; EMS response/turnaround.
- Data sources and integration:
    - Claims (Medicaid/MCO) + IHP: outcomes & cost.
    - EHR/HIE via TEFCA/QHIN: clinical quality, care gaps.
    - RPM device feeds; EMS ePCR; pharmacy data for adherence. The Collaborative stack supports HIPAA/FHIR exchange, identity/consent, and analytics.

- Evaluation cadence: quarterly dashboards; annual updates informing technical factor recalculation for workload funding per NOFO. (files.simpler.grants.gov)

9. Implementation Plan

Gantt-style summary (24 months; subject to procurement/contracting)

Workstream	Start	End	Primary owner	Key outputs	Source
Program mobilization/PMO	M1	M3	State + SI partner	Governance charters, risk/RAID, reporting plan.	
Data/cyber platform	M1	M9	State + platform vendor	Data lake, TEFCA connectivity, SOC runbook.	
Tele-ER/ICU pilots (3 regions)	M3	M10	Hospitals + Avel	Live coverage, protocols, quality KPIs.	
RPM cohort (CHF/COPD/DM)	M4	M24	Clinics + BioIntelliSense	2,000 patients onboarded, exception management.	
Community paramedicine expansion	M6	M18	EMS + clinics	Protocols, billing workflows, QA.	health.state.mn.us
Behavioral integration (CCBHC virtual add-ons)	M6	M20	CCBHCs + tele-BH	Virtual psychiatry slots, referral SLAs.	mn.gov
Retail screening/adherence	M6	M24	Retail partners	BP/diabetes screening volume, MTM metrics.	
Evaluation and sustainment design	M6	M24	State + SI	Annual outcomes, VBP model proposals.	

Checklist (compliance-focused)

- SF-424/424A/LLL and required attachments (Governor's endorsement, Business Assessment, Program Duplication Assessment). EO 12372 Box 19c = "No." (files.simpler.grants.gov)
- Admin ≤10% with indirects counted; map each budget line to initiatives; document subaward selection criteria with Federal flow-downs. (files.simpler.grants.gov)
- Use ≥3 allowed categories; observe NOFO caps (15% B; 20% J; EMR 5%; tech catalyst ≤10% or $20M). (files.simpler.grants.gov)

10. Risk Register (top 10)

Risk	Mitigation	Owner	Source
Broadband limitations in target counties	Deploy cellular-enabled devices, offline workflows, navigator support.	RPM lead	blandinonbroadband.org
Credentialing/licensure delays for tele-specialists	Use IMLC pathway and initiate privileging early.	Hospital CMO	mn.gov
EMS staffing fluctuations	Phase coverage, optimize community paramedicine schedules, provide tele-supervision.	EMS medical director	mnems.org

Risk	Mitigation	Owner	Source
Data-sharing/consent hurdles for SUD/BH data	Implement patient consent tooling and 42 CFR Part 2-compliant workflows.	Data governance	
Budget cap overruns (Categories J/B)	Maintain PMO cap ledger and pre-award budget reviews.	PMO finance	files.simpler.grants.gov
Security incidents	Operate SOC monitoring, require MFA, patch regularly, run tabletop exercises.	CISO	
Provider adoption/burnout	Offer ambient scribing, structured training, and feedback loops.	Clinical ops	
Retail program integration challenges	Execute MOUs, HIPAA BAAs, and data specifications.	Retail partner lead	
Evaluation data gaps	Build unified data model, connect HIE feeds, run data QA processes.	Analytics lead	
Policy-action slippage (e.g., licensure, scope)	Conduct early legislative analysis and track conditional points status.	State policy team	files.simpler.grants.gov

11. Draft RFP Response Language (Minnesota-specific; paste-ready)

Program narrative excerpt: goals and strategies " Minnesota will leverage the Rural Health Transformation Program to strengthen sustainable access and outcomes for rural residents statewide. Building on our Integrated Health Partnerships and telehealth parity framework, our Rural Health Transformation Plan activates virtual specialty support for rural hospitals, remote monitoring and retail-enabled screening for chronic disease, EMS modernization with community paramedicine, and CCBHC-enabled behavioral integration. We will use HIPAA-aligned, FHIR-based platforms with TEFCA-enabled exchange, strong cybersecurity controls, and multilingual consumer engagement to expand access while protecting privacy. Our initiatives address at least three allowed funding categories and align to technical factors C.2 (EMS), F.1 (remote care), F.2 (data infrastructure), and F.3 (consumer technology), within NOFO caps and administrative limits. " (files.simpler.grants.gov)

Workload scoring alignment paragraph " Minnesota's proposal targets NOFO Table 3 factors with measurable initiatives and policy actions. For EMS (C.2), we expand tele-ER/ICU coverage. For remote care services (F.1), we deploy continuous RPM and virtual consults. For data infrastructure (F.2), we implement a State data platform with TEFCA connectivity and cybersecurity. For consumer-facing technology (F.3), we scale multilingual triage and pharmacy-based screening and adherence. These activities complement data-driven measures and will be evaluated quarterly, meeting reporting required for annual recalculation of technical scores and workload funding. " (files.simpler.grants.gov)

Use-of-funds and caps paragraph " Minnesota will ensure compliance with program-specific limitations: provider payments will be ≤15% of the annual award; capital/infrastructure (Category J) will be ≤20%; EMR replacement spending, if applicable, will be ≤5% (only if a prior HITECH-certified EMR was in place as of Sept 1, 2025); and any technology seed initiative will be ≤10% or $20M per budget period, whichever is less. Administrative expenses, inclusive of indirects counted as admin, will be ≤10% of the period allotment. " (files.simpler.grants.gov)

Stakeholder engagement paragraph " Minnesota's application is developed with rural stakeholders including CAHs, RHCs, FQHCs, EMS leaders, rural hospital CEOs, CCBHCs, tribal and IHS partners, consumer groups, and retail pharmacies. We will document subaward selection processes, Flow-down Federal terms, and sustainment plans in line with HHS and 2 CFR Part 200. " (files.simpler.grants.gov)

12. References

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13. Assumptions and Open Questions

- HPSA counts: This guide references HRSA dashboards and notices for designations but does not freeze a specific statewide count due to frequent updates; confirm current counts in HRSA's dashboard and MN Primary Care Office materials before submission. (data.hrsa.gov)
- Final initiative scopes and budgets: All program options and tables are illustrative and must be finalized to remain within NOFO caps and Minnesota procurement requirements. (files.simpler.grants.gov)
- Interoperability specifics: TEFCA/QHIN connectivity and vendor choices are subject to State/HIE decisions and

contracting; references to particular platforms are capability examples, not sole sources.

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