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

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; retail screenings; telehealth visit capacity subject to credentialing and payer contracting. → BioIntelliSense, Humetrix, Higi/Topcon; Avel eCare/Teladoc; CVS/Walgreens. → Collaborative consensus PDF descriptions and deployments.
  - Data infrastructure & interoperability (F.2): FHIR-based data layer; TEFCA connectivity; analytics; privacy/consent tooling; cybersecurity services. → Microsoft Azure; eClinicalWorks/PRISMA(QHIN); advisory SIs. → Collaborative consensus PDF.
  - EMS and hospital stabilization (C.2): tele-ER/ICU/hospitalist backup; tele-pharmacy; clinical mentoring; community paramedicine support. → Avel eCare programs; retail pharmacy triage; training modules. → Collaborative consensus PDF.
  - Workforce recruitment/retention (D.1): ambient clinical documentation, tele-mentoring, pharmacist scope pilots aligned to Minnesota law; training pathways. → Microsoft ambient tools; Avel eCare mentoring; Walgreens/CVS workforce initiatives. → Collaborative consensus PDF.
  - Value-based care/payment design (E.1, I): actuarial modeling, provider incentive design, claims exchange modernization. → Accenture/KPMG/PwC; secure claims/data fabric. → Collaborative consensus PDF.

3. Minnesota Context Snapshot 3.1 Demography and rural footprint

- Nonmetro population: 1,264,289 (22.1%) of 5.71M (ACS 2023 5-year). (ruralhealthinfo.org)
- Key rural facility mix (outside urban areas, July 2025): 76 CAHs; 1 REH; 107 RHCs; 20 FQHCs; 25 PPS hospitals. (ruralhealthinfo.org)
- Rural broadband (FCC-reported, summarized 2024): 81.7% of rural residents have fixed 100/20 Mbps vs 99.3% urban; fixed+mobile combined is 55.6% rural. Gaps correlate with several northern and central counties. The Collaborative's network and cybersecurity tools can support site readiness and remote care adoption in these gaps, subject to local connectivity. (blandinonbroadband.org)

3.2 Workforce, HPSA indicators, and EMS

- Physician distribution and intent to leave: MDH-presented data show only 4.4% of physicians practice in rural MN while 15% of Minnesotans live in rural areas; 19% of physicians intend to leave in 1–5 years, with documentation burden a top driver. Collaborative tools (ambient scribing, shared virtual specialty coverage) can support retention. (mnmed.org)
- HPSA status: Minnesota has numerous primary care, dental, and mental health HPSA designations; HRSA's dashboards and November 2024 FR notice provide current lists/filters. Collaborative workforce and tele-access solutions can target these areas. (data.hrsa.gov)
- EMS strain: Minnesota EMS reports staffing shortages and financial stress; community paramedicine is authorized in statute and covered by Medical Assistance under defined conditions—positioning Minnesota to expand community paramedicine and tele-EMS with Collaborative support (subject to payer agreements and medical direction). (mnems.org)

3.3 Maternal, behavioral health, and chronic disease signals

- Maternal/infant: Preterm births 9.4% (2023), infant mortality 4.7 per 1,000 (2023). National evidence shows widespread OB service losses at rural hospitals; Minnesota communities have experienced scaled-back inpatient services—supporting use of virtual OB consults and tele-triage. (marchofdimes.org)
- Behavioral health/SUD: Drug overdose death rate reported by CDC for Minnesota is 23.6 per 100,000 on state data page; virtual behavioral health and CCBHC integration can extend access upstream and in crises. (espanol.foodsafety.gov)
- Chronic disease: Collaborative RPM and retail-enabled screening can address hypertension/diabetes gap closure and adherence in counties with constrained access.

3.4 Medicaid and payment landscape

- Medicaid enrollment: 1.26M average monthly (21.7% of population) in FY2024; Minnesota maintains substantial managed care and ACO-like IHP participation, enabling value-based levers for RHT initiatives. (usafacts.org)
- CCBHC: Minnesota operates a CCBHC PPS via SPA with quality bonuses (pending/approved as published by DHS); this supports behavioral integration with rural primary care and retail partners. (mn.gov)

3.5 Telehealth policy enablers

- Coverage and payment parity: Minnesota Stat. 62A.673 requires telehealth coverage and reimbursement parity; definitions include telemonitoring. This supports statewide virtual programs under commercial and Medicaid managed care contracts, subject to contract terms. (law.justia.com)
- Licensure compacts: Minnesota participates in the Interstate Medical Licensure Compact (physicians), while it is not an NLC (nurses). This context informs staffing, credentialing, and policy-action scoring under the NOFO's D.2 and D.3 factors. (mn.gov)

3.6 Metric-to-capability table (selected)

- Rural broadband (100/20, 2024) → 81.7% rural coverage → Remote care (F.1), data (F.2) with offline-tolerant workflows, device kitting, cellular fallback; cybersecurity hardening. (blandinonbroadband.org)
- CAHs (76, 2025) → Tele-ICU/tele-ER, inpatient consults, e-Pharmacy, transfer coordination; rural network governance (HVNs). (ruralhealthinfo.org)
- Infant mortality (4.7/1,000; 2023) → Tele-OB triage, remote BP monitoring, pharmacist-enabled perinatal HTN adherence models with retail partners. (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

- Tele-ER/ICU setup → equipment/services (J, F) → Months 3–9 → RHT funds within 20% cap → 24/7 coverage SLAs; credentialing; SOPs. (files.simpler.grants.gov)
- RPM program → devices/services (A, C, F) → Months 4–24 → RHT funds + plan reimbursement → Device logistics; clinical protocols; navigator training.
- Data/cyber → platform/cyber (F.2) → Months 1–24 → RHT funds + in-kind → Data lake; dashboards; SOC processes.

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
  - 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 mgmt.
  - 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)

- Broadband limitations in target counties → Mitigation: cellular-enabled devices; offline workflows; navigator support. Owner: RPM lead. (blandinonbroadband.org)
- Credentialing/licensure delays (tele-specialists) → Mitigation: IMLC pathway; early privileging. Owner: Hospital CMO. (mn.gov)
- EMS staffing fluctuations → Mitigation: phased coverage; community paramedicine scheduling; tele-supervision. Owner: EMS medical director. (mnems.org)
- Data-sharing/consent for SUD/behavioral data → Mitigation: patient consent tooling; 42 CFR Part 2 compliant workflows. Owner: Data governance.
- Budget cap overruns (Category J/B) → Mitigation: PMO cap ledger; pre-award reviews. Owner: PMO finance. (files.simpler.grants.gov)
- Security incidents → Mitigation: SOC monitoring, MFA, patching; tabletop exercises. Owner: CISO.
- Provider adoption/burnout → Mitigation: ambient scribing; training; feedback loops. Owner: Clinical ops.
- Retail program integration challenges → Mitigation: MOUs; HIPAA BAAs; data specs. Owner: Retail partner lead.
- Evaluation data gaps → Mitigation: unified data model; HIE connectors; data QA. Owner: Analytics lead.
- Policy-action slippage (e.g., licensure compacts, scope) → Mitigation: early legislative analysis; conditional points tracking. Owner: 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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