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

1. Executive Summary New York can leverage the Rural Health Transformation (RHT) Program cooperative agreement to stabilize rural access, modernize digital infrastructure, and accelerate clinically-validated chronic disease and behavioral health interventions. The RHT Collaborative can support New York with interoperable data platforms, cyber-hardening, remote and virtual care, primary care enablement, pharmacy-based access points, and program management aligned to the RHT statute and NOFO requirements. The RHT NOFO caps administrative costs at 10% (including indirects), limits provider payments to 15% and minor capital to 20%, and prohibits certain uses; the Collaborative's deliverables can be planned and tracked to those constraints. (files.simpler.grants.gov) (files.simpler.grants.gov)

The NOFO anticipates up to 50 state awards, with funding from FY2026–FY2030, a single application per state, optional LOI by September 30, 2025, application due November 5, 2025 at 11:59 p.m. ET, and earliest start on December 31, 2025. Executive Order 12372 does not apply; SF-424 item 19c must be checked "No." (files.simpler.grants.gov) (files.simpler.grants.gov)

Funds are apportioned 50% baseline and 50% by a workload/points method; points include "rural facility and population" and "technical" factors, with initiative-based scoring for later-year allocations. The technical factors and weights are specified (e.g., B.1–F.3 components totaling 50%). Conditional points can be credited in Year 1 for proposed state policy actions but must be finalized by defined deadlines or the points — and related funds — are recouped. (files.simpler.grants.gov) (files.simpler.grants.gov) (files.simpler.grants.gov)

Highest-leverage Collaborative offerings for New York include: (a) statewide virtual specialty backup (tele-ED/ICU/hospitalist) to keep care local; (b) chronic disease prevention and home monitoring (wearables + analytics) with pharmacy-enabled access; (c) cyber and data modernization to support program metrics, interoperability, and payment integrity; and (d) formation of rural High Value Networks (HVNs) to coordinate investments and contracting. These are supported in the Collaborative catalog.

1.1 One-page printable summary

- What RHT funds: multi-year state award, five budget periods (FY26–FY30), admin ≤10%, provider payments ≤15%, capital/infrastructure ≤20%, EMR replacement ≤5% if a HITECH-certified system already existed on 9/1/2025; narrow prohibitions apply (e.g., specified sex-trait modification procedures at 45 CFR 156.400). (files.simpler.grants.gov) (files.simpler.grants.gov)
- Timeline (2025): LOI 9/30; application 11/5; awards/earliest start 12/31; check "No" on SF-424 item 19c. (files.simpler.grants.gov) (files.simpler.grants.gov)
- Scoring: half on rural facility/population factors; half on technical factors (policy levers and initiative strength). Conditional points permitted but must be enacted by deadlines or points/funds are recovered. (files.simpler.grants.gov) (files.simpler.grants.gov)
- New York context anchors (latest available):
  - Rural population share: 12.9% (2023). (americashealthrankings.org)
  - Medicaid enrollment: 6.91 million (June 2025). Majority in managed care (monthly MMC reports). (healthweb-back.health.ny.gov) (healthweb-back.health.ny.gov)
  - HPSA: rural counties face primary care, dental, and mental health shortages; all 16 examined rural counties have at least two shortage designations (2025). (osc.ny.gov)
  - Community health centers: 2.35 million patients served (2024). (data.hrsa.gov)
- Where the Collaborative can support New York most quickly (subject to state procurement):
  1. Tele-specialty/tele-EMS across rural hospitals/EMS; 2) Chronic disease screening/RPM + pharmacy workflows; 3) Cybersecurity + data pipes for measures, payment, and reporting; 4) Rural provider HVNs for governance and sustainability.

2. Eligibility and RFP Fit 2.1 Snapshot of the NOFO (CMS-RHT-26-001)

- Eligible applicant: One of the 50 U.S. States; DC and territories are ineligible. Governor designates lead; AOR must sign. One official application; latest on-time submission counts. (files.simpler.grants.gov)
- Key dates: Optional LOI by 9/30/2025; application due 11/5/2025 11:59 p.m. ET; earliest start 12/31/2025; applicant webinars 9/19 and 9/25. (files.simpler.grants.gov)
- Funds: ~$50B over FY26–FY30; equal baseline portion and points-based portion. Uses include prevention/chronic disease, provider payments, consumer tech, training/TA for tech-enabled care, workforce, IT/cyber, right-sizing services, behavioral health (OUD/SUD, MH), innovative/value-based models, minor renovations/equipment, partnerships. (cms.gov)
- Compliance: Admin ≤10% (direct + indirect); provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% (if a HITECH-certified system already existed on 9/1/2025); rural tech catalyst-like initiatives ≤ the lesser of 10% or $20M. Telecom/video surveillance restrictions per 2 CFR 200.216; E.O. 12372 does not apply (SF-424 19c "No"). (files.simpler.grants.gov) (files.simpler.grants.gov) (files.simpler.grants.gov)

- Scoring: Table 3 weights rural facility/population (50%) and technical (50%); initiative-based matrix sets potential later-year points. Conditional points may be claimed at application for policy commitments; if not enacted by specified deadlines (most by 12/31/2027; certain health/lifestyle/Nutrition CME factors by 12/31/2028), funds tied to those points are recovered. (files.simpler.grants.gov) (files.simpler.grants.gov) (files.simpler.grants.gov)

2.2 Requirement-to-Capability mapping (evidence cited)

- Table: Requirement → Collaborative capability → Evidence

RHT NOFO requirement	Collaborative capability (conditional on contracting/integration)	Evidence
≥3 eligible use-of-funds categories	Portfolio covering prevention/RPM, tele-health/virtual hospital, cyber/data, workforce training, pharmacy-enabled access	NOFO uses summary. (cms.gov) Collaborative catalog.
Payment integrity/claims modernization	Cloud analytics for payment integrity and prior auth support	Collaborative SI description.
Tech innovation and cybersecurity	Azure-based security program in rural hospitals; cyber TA	Collaborative catalog.
Right-sizing service lines and access	Tele-ICU/ED/hospitalist, tele-behavioral, retail-pharmacy linkages	Avel eCare/retail segments.
Initiative-based outcomes with monitoring	Metrics tooling and PMO with outcome tracking	Collaborative PMO/value tracking.
State policy actions (technical factors)	SME support on licensure compacts, scope, EMS, ACO/value models	Collaborative policy levers.

3. New York Context Snapshot (why these capabilities matter)

- Rural population share: 12.9% (2023 ACS 1-year). Concentrations in North Country, Southern Tier, Western NY, Adirondacks. (americashealthrankings.org)
- Land area: 47,126 sq. miles; rural land predominates outside metro corridors (2010 land area). (census.gov)
- Rural facility mix: CAH presence spans multiple counties; example: Alice Hyde Medical Center (Malone) certified as a CAH on 10/1/2023 (25 beds). (flexmonitoring.org)
- Workforce/HPSA: Comptroller (Aug 2025) finds severe shortages across 16 rural counties; all 16 had shortage designations in ≥2 disciplines; mental health shortages were widespread. (osc.ny.gov)
- Medicaid coverage and managed care: Total Medicaid enrollment 6.91M (June 2025); New York reports monthly MMC enrollment by plan/region (majority of enrollees). (healthweb-back.health.ny.gov) (healthweb-back.health.ny.gov)
- 1115 landscape: CMS approved New York's "Health Equity Reform" 1115 amendment (Jan 9, 2024) with investments in primary care, behavioral health, HRSN, and workforce; MRT 1115 is effective through March 31, 2027 (pending amendments). (cms.gov) (medicaid.gov)
- Behavioral health/SUD: NYC overdose deaths fell 1% in 2023 to 3,046; provisional statewide analyses (media summary of CDC provisional data) indicate a 2024 decline; local context underscores BH access needs. (nyc.gov) (healthbeat.org)
- FQHC footprint: 2.35M patients served in 2024 by New York health center awardees (UDS). (data.hrsa.gov)

3.1 Metrics-to-Capability table

Metric (latest)	Value & year	Source	Matching Collaborative capability
Rural share of population	12.9% (2023)	America's Health Rankings	Consumer-facing screening and pharmacy access to reach dispersed populations. (americashealthrankings.org)
Medicaid enrollment	6.91M (Jun 2025)	NYSDOH Enrollment Databook	Claims exchange, payment integrity, MMC analytics. (healthweb-back.health.ny.gov)
Rural HPSA burden	Shortages across 16 rural counties; many have pediatric/OB-GYN gaps (2025)	NY Comptroller	Tele-ED/ICU/behavioral backup; recruitment supports. (osc.ny.gov)

Metric (latest)	Value & year	Source	Matching Collaborative capability
FQHC reach	2.35M patients (2024)	HRSA UDS State Report	FQHC-integrated RPM, data exchange, and workflows. (data.hrsa.gov)
Overdose mortality (NYC)	3,046 deaths (–1%) in 2023	NYC DOH (2024)	CCBHC-aligned tele-BH and crisis care linkages. (nyc.gov)

Assumptions and Open Questions (affects technical scoring timelines)

- Licensure compacts (IMLC/eNLC/PSYPACT/REPLICA) and scope-of-practice status in New York require confirmation to plan conditional point claims under D.2/D.3; positions here are illustrative. (files.simpler.grants.gov)
- The RHT NOFO requires listing current CCBHCs (as of 9/1/2025) and the count of hospitals receiving Medicaid DSH for the most recent State Plan Rate Year; those lists should be compiled from SAMHSA/NYSDOH sources during application finalization. (files.simpler.grants.gov) (samhsa.gov)

4. Strategy Aligned to RFP 4.1 Model: Rural Access and Outcomes Acceleration (RAOA)

- Access: 24/7 virtual hospital services (tele-ED, tele-ICU, tele-hospitalist, tele-pharmacy) layered onto rural hospitals and EMS to reduce avoidable transfers and support lone clinicians.
- Outcomes: RPM for cardiometabolic conditions (e.g., FDA-cleared wearable with exception-based alerts) plus pharmacy-enabled hypertension/diabetes workflows, and AI decision support to surface unmet needs.
- Technology: Secure, HIPAA/FHIR-based cloud, HIE connectors, dashboards for NOFO metrics, and cyber hardening; consumer tools for multi-language intake/triage and personal health record access.
- Sustainability: Member-owned rural HVNs to coordinate shared services, purchasing, data, and payer alignment; analytics for ROI and value tracking.

4.2 Alignment to all RHT pillars and scoring dimensions

- Prevention & chronic disease: Retail kiosk and mobile screening (BP/vision), RPM, and pharmacist-driven protocols; documented use across partners.
- Innovative care/value: HVN-based shared savings arrangements and ACO reporting connectors; actuarial/benchmark modeling support.
- Workforce: Ambient documentation and tele-mentoring to reduce burnout and build rural capacity; structured training curricula.
- Tech innovation & cyber: Microsoft rural hospital program footprint and cyber assistance; data pipelines for measures and dashboards.
- Partnerships: Cibolo-enabled HVNs; payer and provider convenings; AHA/ASA community screenings.

4.3 Equity for rural and Tribal communities

- Targeting based on HPSA, social risk, and language needs; multi-language triage and navigation; community-based screening; pharmacy access in rural towns. (osc.ny.gov)

4.4 Data use and privacy

- HIPAA/FHIR architecture; TEFCA-aligned exchange; privacy consent management; audit trails; Blue Button integration for consumer access; adherence to 2 CFR/IP terms in NOFO. (files.simpler.grants.gov)

5. Program Design Options (tailored to New York; all subject to policy, contracting, and local integration)
Option A: Rural Tele-Specialty Backbone + EMS Support

- Target: CAHs and rural PPS hospitals; EMS agencies in North Country/Western NY.
- Problem: Night/weekend coverage and transfer burden; HPSA-driven access gaps. (osc.ny.gov)
- What the Collaborative provides: 24/7 tele-ED/ICU/hospitalist, tele-pharmacy; tele-EMS consult; stroke AI alerts; clinical documentation relief.
- Payment logic: Align with NOFO allowable uses (F.1 remote care) plus Medicaid managed care quality incentives; no provider-payment spend >15%. (files.simpler.grants.gov)
- Policy enablers: EMS protocols and interstate tele-practice flexibilities (conditional points under C.2/D.2). (files.simpler.grants.gov)
- Staffing/IT: Virtual command center; local nurse/CHW extenders; secure video endpoints; SOC-aligned cyber controls.
- Pros/risks: Keeps patients local; dependency on bandwidth/cyber posture (mitigated by security program).

Option B: Cardiometabolic Home Monitoring + Pharmacy Integration

- Target: Medicaid and duals with HTN/DM in rural counties; FQHC primary care panels. (data.hrsa.gov)
- Problem: Elevated rural HTN/DM burden and limited specialty access; travel barriers.
- What the Collaborative provides: FDA-cleared wearable RPM; multi-language app; pharmacy BP workflows; population analytics to identify untreated/undertreated.
- Payment logic: RPM under Medicaid (as permitted), quality-linked incentives, and NOFO categories A/C/D/F; map spend to 20% capital cap and 10% admin cap. (files.simpler.grants.gov)
- Pros/risks: Reduced readmissions/ED use; device logistics and engagement risk (mitigated by CHW/digital navigator training).

Option C: Rural Behavioral Health Integration with CCBHC Linkages

- Target: Rural counties with mental health HPSA status; FQHCs and community BH providers. (osc.ny.gov)
- What the Collaborative provides: Tele-psychiatry coverage; crisis consult; navigation; support for state use of CCBHC infrastructure and training. (samhsa.gov)
- Payment logic: NOFO H/BH category; align with MMC BH benefits and 1115 initiatives. (cms.gov)

Option D: Data and Cyber Modernization for RHT Reporting

- Target: State lead agency, HIEs, rural hospitals/FQHCs.
- What the Collaborative provides: HIPAA/FHIR data fabric; measure dashboards; payment integrity analytics; cyber uplift; TEFCA/QHIN connectivity.
- NOFO fit: F.2/F.3 data/consumer tech; admin ≤10% across PMO and indirects. (files.simpler.grants.gov)

6. Governance and Collaborative Roles 6.1 Roles diagram (description)

- State (Lead/AOR): sets strategy, selects initiatives, manages 2 CFR compliance, reporting, and subrecipient oversight (CMS cooperative agreement). (files.simpler.grants.gov)
- Rural HVN(s) (Cibolo-enabled): shared services, contracting, investment coordination, and transparency.
- Delivery partners: CAHs/PPS hospitals, FQHCs, EMS, retail pharmacies.
- Technology/SI: cloud/data/cyber, HIE connectors, analytics, training.

6.2 RACI (illustrative)

- Table

Task	State lead	Medicaid	Hospital Assn/CAHs	FQHCs	HIE	Collaborative Tech	Collaborative SI	Retail Pharmacies
Strategy & portfolio	A/R	C	C	C	C	C	C	C
Subrecipient framework	A/R	C	I	I	I	C	C	I
Data/Cyber platform	C	C	I	I	A/R	R	R	I
Tele-specialty rollout	C	C	A/R	C	I	C	R	I
RPM/pharmacy program	C	C	C	A/R	I	C	R	R
Reporting (FFR/Performance)	A/R	C	I	I	I	C	C	I

R = Responsible; A = Accountable; C = Consulted; I = Informed.

7. Payment and Funding

- Allowable funding paths: blend initiative spend over A–K categories; track caps (15% provider payments; 20% capital; EMR replacement ≤5% if applicable; admin ≤10%). (files.simpler.grants.gov)
- Medicaid alignment: Build on 1115 (NYHER) investments (HRSN, BH, payment reforms), and MMC value incentives; RHT can fund non-duplicative, transformative elements (no supplanting). (cms.gov) (files.simpler.grants.gov)

7.1 Cost ROM and deliverables table (illustrative; all subject to procurement)

Cost category	ROM (annual)	RHT category	Funding timing	Collaborative deliverables
Tele-specialty coverage	$25–40M	F.1	BP1–BP5	24/7 tele-ED/ICU/hospitalist; quality reports.

Cost category	ROM (annual)	RHT category	Funding timing	Collaborative deliverables
RPM kits + services	$15–25M	A/C/D/F	BP1–BP5	Wearables, dashboards, CHW training.
Data/Cyber modernization	$20–30M	F.2/F.3	BP1–BP3	Data fabric, dashboards, cyber uplift.
Workforce skilling	$5–10M	D/E	BP1–BP3	Curricula, ambient AI rollout.
HVN governance	$3–6M	K/I	BP1–BP5	HVN formation, shared services design.

8. Data, Measurement, and Evaluation

- Core measures: access (tele-ED acceptance; transfers avoided), quality (BP control, A1c), utilization (ED revisits, admits), financial (net cost avoidance), workforce (vacancy, burnout indices), tech adoption (uptime, cyber events).
- Data sources and integrations: claims (Medicaid/MMC), EHRs, HIE, EMS ePCR, RPM feeds, pharmacy data, consumer apps; consent and privacy per state law/HIPAA; dashboards for quarterly reporting per NOFO.
- Evaluation: cooperate with CMS/third-party; use counterfactuals and stepped-wedge where feasible; support recovery audits and initiative score updates for later-year allocations. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; subject to state procurement) 9.1 Gantt-style table (illustrative)

Workstream	Start	End	Owner	Outputs/milestones
Governance & HVN setup	Jan 2026	Apr 2026	State + HVN convener	HVN bylaws; subrecipient SOPs; procurement plan.
Cyber/data platform	Jan 2026	Sep 2026	Tech + SI	Data fabric live; security baseline; metric dashboards.
Tele-specialty rollout (wave 1: 10 sites)	Mar 2026	Aug 2026	State + Avel + sites	Tele-ED/ICU SLAs; clinical protocols; go-live.
RPM/pharmacy pilots (5 regions)	Apr 2026	Oct 2026	State + FQHC + retail	Cohort enrollment; BP/A1c baselines; navigator training.
BH/CCBHC linkages	May 2026	Nov 2026	State + BH orgs	Tele-BH coverage hours; referral pathways; crisis escalation.
Evaluation & NCC application #1	Aug 2026	Oct 2026	State	Annual performance + continuation app per NOFO. (files.simpler.grants.gov)

10. Risk Register (selected)

- Procurement delays: Mitigation—pre-compete master agreements; phased waves; SI support. Owner: State Procurement.
- Cyber incident: Mitigation—baseline hardening, 24/7 monitoring, response playbooks. Owner: Tech lead.
- Workforce acceptance/uptake: Mitigation—tele-mentoring, ambient scribe tools, incentives. Owner: Clinical leads.
- Connectivity constraints: Mitigation—offline-capable tools; site surveys; prioritization. Owner: SI/Tech.
- Policy points risk (missed enactment): Mitigation—early legislative calendar alignment; alternative factors. Owner: State Policy. (files.simpler.grants.gov)
- Data sharing barriers: Mitigation—TEFCA/QHIN connectors; consent management. Owner: HIE/Tech.
- Duplicative funding risk: Mitigation—duplication assessment and SOPs; audited mapping. Owner: State Finance. (files.simpler.grants.gov)
- Payment integrity disputes: Mitigation—transparent analytics, appeals workflow. Owner: State/Plans.
- Retail scope variability: Mitigation—pilot geographies aligned with permissible scope; evaluate outcomes. Owner: Pharmacy partner.
- Community trust: Mitigation—AHA/ASA and CHWs lead screening/education. Owner: Non-profit partners.

11. Draft RFP Response Language (paste-ready; conditional and non-prescriptive) 11.1 Rural needs and target population (excerpt) “New York’s rural residents (12.9% of the state population in 2023) face persistent access barriers that contribute to avoidable transfers and unmet behavioral health needs. Medicaid covered 6.91 million New Yorkers as of June 2025, with the majority enrolled in Medicaid managed care; rural counties exhibit pronounced HPSA designations across primary, dental, and mental health disciplines. The proposed RHT portfolio focuses on rural hospitals (including CAHs), FQHCs, EMS, and pharmacy access points in high-need counties.” (americashealthrankings.org) (healthweb-back.health.ny.gov) (healthweb-back.health.ny.gov) (osc.ny.gov)

11.2 RHT Plan: goals & strategies (excerpt) “We will improve rural access and outcomes by layering virtual specialty capacity (tele-ED/ICU/hospitalist), home physiologic monitoring for cardiometabolic disease, and

behavioral health consults onto existing rural delivery assets, while modernizing data and cybersecurity to support reporting and payment integrity. We will structure rural High Value Networks to coordinate shared services and align incentives. Program-level objectives will track access, quality, utilization, workforce, and technology adoption over FY2026–FY2030."

11.3 Proposed initiatives & use of funds (excerpt) "Initiative A: Statewide Tele-Specialty Backbone (Use-of-funds F.1; F.2). Target: 20+ rural hospitals/EMS agencies. Outcomes: transfer rate –10%, door-to-decision times –15%. Funding estimates and timeline attached."

"Initiative B: Cardiometabolic RPM with Pharmacy Integration (A/C/D/F). Target: 10,000 Medicaid/duals. Outcomes: controlled BP +8 p.p.; A1c ≥1% reduction among uncontrolled."

11.4 Implementation plan & timeline (excerpt) "Phased rollout over 12–18 months; cyber/data foundation first; tele-specialty wave 1 sites by month 6; RPM and pharmacy workflows by month 7–9; statewide monitoring dashboards by month 9."

11.5 Stakeholder engagement (excerpt) "Rural HVNs will include CAHs, PPS hospitals, FQHCs, EMS, retail pharmacies, and community organizations; AHA/ASA will lead community screening events and education; we will coordinate with MMC plans on value incentives."

11.6 Metrics & evaluation (excerpt) "We will report quarterly on access, quality, financial, and workforce metrics; cooperate with CMS/third-party evaluation; support recovery of conditional points if policy enactments lag, per NOFO." (files.simpler.grants.gov)

12. References

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