Rural Health Transformation Grant Guide — Vermont

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary Vermont enters the CMS Rural Health Transformation (RHT) Program with a uniquely rural profile—64.9% of residents live in rural areas per the 2020 Census—amplifying the impact of investments in access, workforce, data, and care innovation (2020). (ncsl.org) The RHT Collaborative can support Vermont's application and execution by aligning pre-validated, standards-based technology and operating models with statutory requirements, scoring factors, and caps in the federal NOFO (CMS-RHT-26-001). (files.simpler.grants.gov)

Priority capabilities for Vermont include: (a) stabilizing rural acute and emergency capacity through tele-hospitalist, tele-ICU, tele-pharmacy, and tele-behavioral support backed by a Joint Commission–accredited virtual hospital model, which has been designed around rural operations; (b) scaling chronic disease prevention/management and behavioral health with remote physiologic monitoring, retail-pharmacy–enabled screening/engagement, and virtual visits; and (c) hardening cyber/data infrastructure and analytics to meet reporting, evaluation, and privacy requirements.

These capabilities map to the NOFO's five strategic goals (prevention, sustainable access, workforce, innovative care, tech innovation) and to the technical-factor scoring domains (B–F), including explicit support for State policy actions where Vermont chooses to pursue conditional points (with enactment by Dec 31, 2027—or by Dec 31, 2028 for nutrition/health/lifestyle factors—per NOFO). (files.simpler.grants.gov) The Collaborative's governance and program-management partners can support Vermont's grant administration, subrecipient oversight, dashboarding, and evaluation, while rural provider High Value Networks (HVNs) can provide a vehicle for transparent deployment and stewardship of funds.

Importantly, all proposals must respect NOFO financial limits (e.g., ≤10% administrative; ≤20% Category J capital/renovations; ≤15% provider payments within Category B; ≤5% EMR replacement where a HITECH-certified system existed as of 9/1/2025) and prohibitions (e.g., construction, lobbying with federal funds, covered telecom under 2 CFR 200.216). (files.simpler.grants.gov) This guide translates those guardrails into Vermont-specific program design choices, with explicit dependencies, risks, and measurable outcomes.

One-page printable summary

- Vermont context (latest available):
    - 64.9% rural population (2020). (ncsl.org)
    - 8 Critical Access Hospitals (CAHs); 11 FQHC awardees (2024 UDS); ≈10 Rural Health Clinics (RHCs). (healthvermont.gov)
    - ≈167 EMS/first responder agencies; ≈3,000 licensed EMS practitioners (2024–2025). (healthvermont.gov)
    - Opioid overdose deaths declined from 236 (2023) to 183 (2024), −22% (Vermont DOH, 2025). (healthvermont.gov)
    - BEAD/VCBB plan coverage: applications received for 100% of eligible locations; 95% with fiber proposals (2025). (benton.org)
- Highest-leverage RHT initiatives for Vermont (examples):
    - Rural Acute Support and Stabilization (tele-ER/ICU/pharmacy + behavioral crisis support).
    - Hypertension/diabetes control at scale (retail pharmacy engagement + RPM + virtual primary/specialty).
    - Behavioral Health and SUD integration (tele-psychiatry; risk analytics; crisis response).
    - Cyber and data modernization (cloud security, interoperability, analytics, TEFCA-aligned exchange).
- Compliance anchors (CMS-RHT-26-001):
    - Single State applicant; LOI by Sep 30, 2025 (optional); application due Nov 5, 2025; awards by Dec 31, 2025. (files.simpler.grants.gov)
    - Funds: 50% baseline; 50% workload (points); five budget periods; spend by end of following fiscal year. (files.simpler.grants.gov)
    - Key caps/prohibitions listed above; 2 CFR Part 200/Part 300, HHS GPS apply. (files.simpler.grants.gov)

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

- Eligibility: Only the 50 States; DC/territories ineligible; Governor designates lead agency; AOR signature required. (files.simpler.grants.gov)
- Key dates: Optional LOI 9/30/2025; application due 11/5/2025 (11:59 p.m. ET); awards/earliest start 12/31/2025. (files.simpler.grants.gov)

- Funds: $50B total (FY26–FY30); one application; five annual budget periods with spend-through to the next fiscal year. (files.simpler.grants.gov)
- Distribution: 50% baseline equal split; 50% workload by points (Table 3 weights for rural facility/population and technical factors). (files.simpler.grants.gov)
- Application components and format: project summary; 60-page project narrative; 20-page budget narrative; required forms (SF-424 family, SF-LLL) and attachments, including Governor's endorsement letter. (files.simpler.grants.gov)
- Funding policies and limits: ≤10% administrative; Category J capital ≤20%; Category B provider payments ≤15%; EMR replacement ≤5% (where HITECH-certified EMR existed as of 9/1/2025); constraints on certain telecom equipment (2 CFR 200.216); and other statutory limits. (files.simpler.grants.gov)
- State policy action points: conditional credit in Year 1; enactment generally due by 12/31/2027 (12/31/2028 for specified factors) to retain points. (files.simpler.grants.gov)

2.2 Requirement-to-Capability Mapping (examples)

- Requirement: Address ≥3 "Uses of Funds" categories. Capability: Collaborative portfolio spans prevention/RPM (A/C), provider payment analytics (B), training/TA for tech-enabled care (D), cybersecurity/data infrastructure (F), behavioral health (H), innovative care/value arrangements (I), and minor renovations/equipment (J). Evidence: partner descriptions and deployments.
- Requirement: Outcome-oriented initiatives and monitoring. Capability: Analytics stack with dashboards, claims/HIE/EHR integration, and evaluation teaming. Evidence: Microsoft/analytics descriptions; program-management toolkits.
- Requirement: Rural acute and emergency access. Capability: Avel eCare virtual hospital services (hospitalist, ICU, ED, pharmacy) and 24/7 tele-behavioral crisis support. Evidence: Avel profile.
- Requirement: Chronic disease prevention/management. Capability: BioIntelliSense continuous monitoring; pharmacy-enabled screenings and adherence; virtual care. Evidence: BioIntelliSense kit; retail health profiles.
- Requirement: Tech modernization and interoperability. Capability: HIPAA/FHIR platforms, cyber-hardening; TEFCA/QHIN connectivity through participating EHR networks. Evidence: technology section.
- Requirement: Strategic partnerships. Capability: Cibolo-enabled HVNs for rural providers; payer engagement; NACHC training networks. Evidence: HVN model; non-profit roles.

3. Vermont Context Snapshot 3.1 Rural demographics and geography

- Rural share: 64.9% of Vermonters live in rural areas (2020). (ncsl.org)
- EMS footprint: ~167 ambulance/first responder agencies; ~3,000 licensed EMS practitioners (2024–2025). (healthvermont.gov)
- BEAD-enabled broadband expansion: applications received for 100% of eligible addresses with 95% proposing fiber; plan targets near-universal coverage. (benton.org)

3.2 Rural facility mix and networks (illustrative)

- Hospitals: 8 CAHs statewide; the Department of Health identifies 15 nonprofit hospitals overall (including CAHs and mid-size rural hospitals). (healthvermont.gov)
- Community Health Centers: 11 FQHC awardees reported in 2024 UDS (210,641 patients served). (data.hrsa.gov)
- RHCs: ~10 CMS-certified Rural Health Clinics (2022 HRSA testing allocation dataset; consistent with 2023 QCOR-derived counts). (hrsa.gov)
- HIE/data environment: Vermont's EMS uses the SIREN NEMSIS-compliant platform; statewide EMS protocols updated in 2025. (healthvermont.gov)

3.3 Workforce, payment, and policy environment

- Medicaid demonstration: CMS approved Vermont's Global Commitment to Health 1115 extension through 12/31/2027, continuing a managed-care-like delivery system and enabling innovative pilots (including HRSN components approved 1/2/2025). (cms.gov)
- All-Payer ACO model: CMS Medicare ACO initiative tailored to Vermont, aligned with Medicaid via the 1115 demonstration. (cms.gov)
- Licensure compacts: Vermont participates in the Nurse Licensure Compact (effective Feb 1, 2022) and in the Interstate Medical Licensure Compact (IMLC) as a member (non-SPL), supporting multi-state licensure pathways.

(sos.vermont.gov)

- Certificate of Need: Green Mountain Care Board administers CON under Title 18, Ch. 221 and Rule 4.000. (gmcboard.vermont.gov)

3.4 Behavioral health and SUD

- Opioid overdose deaths fell from 236 (2023) to 183 (2024), −22%—first sustained annual decrease since 2019—while fentanyl remained involved in 93% of opioid fatalities (2024). (healthvermont.gov)

3.5 Broadband and telehealth readiness

- VCBB reports preliminary and full BEAD applications cover nearly every eligible address; 95% of eligible locations have fiber proposals (2025), supporting remote care models contingent on last-mile buildout. (benton.org)

3.6 Metrics-to-Capability table (selected)

- Rural share 64.9% (2020) → statewide screening and RPM deployments (retail, community, home). (ncsl.org)
- 8 CAHs → tele-ICU/ED/pharmacy and transfer optimization to reduce avoidable out-migration. (healthvermont.gov)
- 11 FQHC awardees; 210,641 patients (2024) → population health workflows, RPM integration, multilingual intake. (data.hrsa.gov)
- EMS: ~167 agencies; ~3,000 practitioners → tele-EMS consults; protocol-aligned digital tools; SIREN data feeds. (healthvermont.gov)
- Overdose dropped to 183 (2024) → expand hub-and-spoke virtual BH, risk analytics, naloxone distribution tracking. (healthvermont.gov)
- BEAD coverage plan → endpoint device programs, VPN/Zero-Trust, and remote monitoring enablement. (benton.org)

4. Strategy Aligned to RFP 4.1 Vermont's rural transformation model (illustrative)

- Regional "Rural High Value Network" (HVN) linking CAHs, FQHCs, RHCs, EMS, and retail sites, with tele-hospital and virtual specialty backstops, community screening, and home monitoring, backed by state-level data/cyber modernization.
- Measurement framework pairs clinical/financial outcomes (readmissions, ED transfer rate, chronic disease control) and equity indicators with program implementation KPIs, as required by the NOFO. (files.simpler.grants.gov)

4.2 How capabilities map to scoring pillars

- B: Population health clinical infrastructure and Health & lifestyle—RPM (BioIntelliSense), retail screening (Higi/Topcon), multilingual digital intake (Humetrix).
- C: Provider strategic partnerships and EMS—Avel eCare virtual hospital, Cibolo HVNs, EMS tele-support.
- D: Talent and licensure compacts—ambient documentation tools; NLC/IMLC policy alignment for multi-state practice. (sos.vermont.gov)
- E: Medicaid provider payment incentives and duals—analytics and value-based design support (e.g., ACO alignment, global budgets), consistent with Vermont's 1115/APM context. (cms.gov)
- F: Remote care services, data infrastructure, consumer-facing tech—cyber-secure cloud, AI decision support, TEFCA-aligned exchange.

4.3 Equity approach

- Target high-need rural geographies using EMS, FQHC, and overdose data; deliver multilingual/low-literacy tools; include community organizations and tribal partners where applicable.

4.4 Data use, privacy, and security

- Utilize HIPAA/FHIR platforms, Zero-Trust security, and role-based access; leverage TEFCA-connected exchange where available; comply with 2 CFR, HHS GPS, and NOFO data/evaluation requirements. (files.simpler.grants.gov)

5. Program Design Options (tuned to Vermont) Option A. Rural Acute Support and Stabilization

- Target: CAHs and rural EDs statewide; EMS interfacing.
- Problem: Limited on-site specialty coverage elevates transfer rates and cost. Vermont maintains 8 CAHs with broad geographic dispersion (2025). (healthvermont.gov)
- Collaborative services: 24/7 tele-hospitalist/ICU/ED; tele-pharmacy; stroke AI triage; BH crisis tele-support.

- Payment logic: RHT funds for service enablement, devices, and shared services; Ongoing sustainment via ACO/shared-savings/global budget alignment (not provider-payment >15% cap). (files.simpler.grants.gov)
- Enablers: Vermont 1115/APM alignment; EMS protocols and SIREN integration. (cms.gov)
- Pros/risks: Reduces avoidable transfers; risk—staff adoption and credentialing; mitigation—credentialing playbooks and tele-mentoring.

Option B. Hypertension/Diabetes Control via Community Pharmacies + RPM

- Target: Adults with uncontrolled HTN/diabetes served by FQHCs/RHCs/retail pharmacies.
- Problem: Rural cardiovascular risk prevalent; retail touchpoints frequent.
- Services: Pharmacy-enabled screening, adherence programs, pharmacist-physician collaboration, virtual follow-up, continuous monitoring.
- Payment logic: RHT supports equipment/training; Medicaid value-incentive pilots under E.1. (files.simpler.grants.gov)
- Pros/risks: Improved control rates; risk—scope-of-practice variation; mitigation—protocols and standing orders.

Option C. Behavioral Health and SUD Access Integration

- Target: Rural residents with OUD/SUD and co-occurring conditions; priority counties with higher fatality rates (183 deaths in 2024 statewide). (healthvermont.gov)
- Services: Tele-psychiatry; 24/7 crisis tele-support; risk analytics; medication safety supports; EMS collaboration.
- Payment logic: Blend RHT funding (H/I uses) with Medicaid 1115 SUD initiatives. (cms.gov)

Option D. Cyber/Data Modernization and TEFCA-Aligned Exchange

- Target: CAHs, FQHCs, RHCs, EMS.
- Services: Cloud security hardening, identity/access, data lake/analytics, TEFCA/QHIN connectivity.
- Payment logic: RHT F/tech investments (respect ≤20% cap under Category J for capital); sustained via operating budgets/ACO savings. (files.simpler.grants.gov)

6. Governance and Collaborative Roles 6.1 Structure

- State lead (Governor-designated agency) holds the cooperative agreement and overall accountability; Green Mountain Care Board engaged for CON awareness; Medicaid (DVHA) for payment alignment. (files.simpler.grants.gov)
- HVN: member-owned rural provider network convened to steward subawards and shared services.
- Program management/Systems integrators provide workplan control, vendor integration, and outcomes tracking.

6.2 RACI (illustrative)

- State lead: R (governance, reporting), A (NOFO compliance).
- Medicaid (DVHA): R (payment models, SPA/contracting), C (evaluation).
- GMCB: C (CON interface).
- CAHs/FQHCs/RHCs/EMS: R (site implementation).
- Collaborative SI partners: R (program control, analytics); C (procurement support).
- HVN (Cibolo): R (subrecipient stewardship, transparency), C (value alignment).

7. Payment and Funding

- RHT funds cannot exceed caps (≤15% Category B provider payments; ≤20% capital; ≤10% admin; EMR replacement ≤5% where applicable). (files.simpler.grants.gov)
- Vermont alignment opportunities:
    - ACO/APM: leverage Medicaid 1115 authority to co-design incentives (E.1), complementary to RHT non-claims funding. (cms.gov)
    - Duals (E.2): analytics to reduce avoidable utilization across Medicare/Medicaid coverage.
- Example budget ROM (illustrative, subject to award and caps):
    - Tele-acute/virtual hospital services (A/F/I): devices, carts, software, training—State-managed shared services and subawards.
    - RPM and community screening (A/C/F): sensors, licenses, outreach.

- Cyber/data (F/J): MFA/IdP, SIEM, data lake, interfaces; limited minor renovations/equipment (≤20% cap).
- Evaluation and PMO (admin ≤10% including indirect).

8. Data, Measurement, and Evaluation

- Core measures (examples): ED transfer rate; 30-day readmissions; BP control; HbA1c control; MOUD initiation/retention; tele-behavioral access; cyber controls maturity; broadband-enabled remote-care penetration.
- Data sources and integrations: Medicaid/Medicare claims; FQHC EHR feeds; EMS SIREN; HIE/TEFCA; retail screening datasets; cybersecurity logs.
- Evaluation: cooperate with CMS and third parties; apply continuous improvement cycle with monthly analytics sprints as required under cooperative agreement. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; illustrative) Gantt-style workplan (calendar quarters; owner abbreviations: State, DVHA, HVN, CAH/FQHC, SI)

- Q1–Q2 2026: Program mobilization; governance; finalize subaward templates; privacy/security baselines (State/SI).
- Q2–Q4 2026: Tele-acute/virtual hospital roll-in to initial CAHs; RPM pilot; community pharmacy collaboratives; data lake stand-up (HVN/CAHs/FQHCs/SI).
- 2027: Scale-up waves; policy checkpoints for conditional points (Dec 31, 2027); statewide dashboards; evaluation baseline and mid-year readouts (State/DVHA/HVN/SI). (files.simpler.grants.gov)

Gantt table (abridged)

- Workstream | Start | End | Owner | Outputs
- Governance & PMO | Q1-26 | Q4-27 | State/SI | Program charter; risk log; dashboards
- Tele-acute enablement (2 CAHs/wave) | Q2-26 | Q4-27 | CAHs/HVN/SI | Go-live reports; transfer metrics
- RPM & community screening | Q2-26 | Q3-27 | FQHCs/RHCs/Retail | Enrollment; control rates
- Cyber/data platform | Q1-26 | Q4-26 | SI/State | Cloud controls; analytics pipelines
- Evaluation & reporting | Q1-26 | Q4-27 | State/SI | CMS reports; public dashboards

10. Risk Register (selected)

- Legislative timing risk for policy-action points (deadline 12/31/2027 or 12/31/2028 as applicable). Mitigation: early policy engagement; alternative initiative weighting. Owner: State. (files.simpler.grants.gov)
- Provider-payment cap breach (>15%). Mitigation: structure as enablement/shared services; monitor budget lines. Owner: State/HVN. (files.simpler.grants.gov)
- Capital spending >20% or EMR replacement >5% where restricted. Mitigation: track Category J and EMR budgets; prioritize software/services. Owner: State/SI. (files.simpler.grants.gov)
- Cyber incident risk. Mitigation: cloud security hardening, monitoring, incident response. Owner: SI/Providers.
- Workforce adoption/turnover. Mitigation: training, ambient documentation, tele-mentoring. Owner: Providers/SI.
- Broadband last-mile delays. Mitigation: staging via sites with coverage; contingency cellular/fixed wireless per BEAD phasing. Owner: State/Providers. (benton.org)
- Data-sharing friction. Mitigation: TEFCA-aligned pathways; consent tooling. Owner: SI/Providers.
- Procurement delays. Mitigation: pre-negotiated vehicles and transparent selection criteria; subrecipient TA. Owner: State/SI.
- Performance shortfalls. Mitigation: monthly performance reviews; change packages. Owner: State/HVN/SI. (files.simpler.grants.gov)
- Noncompliance with NOFO limits/prohibitions. Mitigation: compliance reviews; corrective action. Owner: State. (files.simpler.grants.gov)

11. Draft RFP Response Language (paste-ready excerpts; adapt as needed) 11.1 Rural Health Needs & Target Population (Project Narrative section) “Vermont is the most rural state in the nation by population share (64.9% rural, 2020), with 8 Critical Access Hospitals, 11 FQHC awardees, and approximately 10 Rural Health Clinics serving dispersed communities. Vermont’s EMS system comprises ~167 agencies and ~3,000 licensed practitioners (2024–2025). These assets anchor care, yet specialty access, behavioral health needs, and digital resilience remain persistent challenges. Broadband expansion via the BEAD program is advancing toward near-universal coverage, positioning the State to scale remote-care models as infrastructure comes online.” (ncsl.org)

11.2 Goals, Strategies, and State Policy Actions “Our Rural Health Transformation Plan addresses CMS goals—prevention,

sustainable access, workforce, innovative care, and tech innovation—through: (a) statewide tele-acute support for CAHs; (b) community pharmacy-enabled chronic disease control and remote monitoring; (c) integrated tele-behavioral health and SUD supports; and (d) cyber/data modernization. Vermont will consider pursuing conditional technical-factor points for licensure compacts and data infrastructure; any proposed policy changes will be finalized by December 31, 2027 (or by December 31, 2028 as applicable) to retain points." (files.simpler.grants.gov)

11.3 Proposed Initiatives & Uses of Funds "Each initiative is mapped to NOFO categories (A–K), measurable outcomes (≥4 per initiative, including ≥1 community-level), timelines, geographies (FIPS), funding estimates, and partners. Spending will comply with program limits (≤10% administrative; ≤20% Category J capital; ≤15% Category B provider payments; EMR replacement ≤5% where restricted) and prohibitions." (files.simpler.grants.gov)

11.4 Implementation & Evaluation "We will operate within a cooperative-agreement model with substantial CMS involvement, provide required reports, support independent evaluations, and share de-identified data across initiatives. A state-level PMO and rural HVN will track subrecipient performance and outcomes using dashboards aligned to the NOFO." (files.simpler.grants.gov)

12. References

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Assumptions and Open Questions

- Scope of practice details (e.g., APRN and pharmacist authorities) should be confirmed against current Vermont statutes/regulations to precisely score factor D.3 and pharmacy-enabled care models.
- Current counts of VT hospitals receiving Medicaid DSH (latest State Plan Rate Year) to be supplied by AHS/Medicaid for NOFO narrative.
- CCBHC list as of Sep 1, 2025 (sites and locations) to be compiled from SAMHSA and state sources for NOFO attachment.
- Broadband construction timelines/BEAD awards—final approvals and schedules may affect site-by-site activation pacing.

Compliance checklists (abbreviated)

- NOFO key dates and forms (complete): SF-424/SF-424A, SF-LLL, Project/Performance Site form; Governor's endorsement; Business assessment; Program-duplication assessment; Narratives within page/format limits. (files.simpler.grants.gov)
- Funding guardrails: Admin ≤10%; Provider payments ≤15%; Category J capital ≤20%; EMR replacement ≤5% where restricted; telecom restrictions (2 CFR 200.216); lobbying prohibitions; no construction. (files.simpler.grants.gov)
- Policy-action points: any conditional points enacted by 12/31/2027 (12/31/2028 for specified factors) to avoid claw-back. (files.simpler.grants.gov)

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