Rural Health Transformation Grant Guide — Idaho

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Idaho can leverage the Rural Health Transformation (RHT) Program cooperative agreement to stabilize rural access, modernize care delivery, and build durable regional partnerships. The NOFO provides ~$50B across FY26–FY30, with a one-time application due November 5, 2025 and earliest start December 31, 2025 [1]. Funding is split each year: 50% baseline equally across approved States and 50% workload based on points across rural facility/population metrics and technical policy/implementation factors [2]. (files.simpler.grants.gov) (files.simpler.grants.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Idaho's plan development and execution through: (a) virtual specialty and acute support (tele-ER, tele-ICU, tele-behavioral) for Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs); (b) remote physiologic monitoring and consumer-facing triage to shift care to lower-acuity settings; (c) secure, interoperable cloud data infrastructure with analytics/cybersecurity; and (d) governance and program management to coordinate multi-stakeholder initiatives and reporting. These capabilities are documented across partner portfolios (Avel eCare, BioIntelliSense, Microsoft, eClinicalWorks/healow, Viz.ai, Cibolo Health, AVIA/Accenture/KPMG/PwC, retail health partners), and are designed to integrate with State policy levers referenced in the NOFO scoring [3]–[9].

Given Idaho's scale (≈2.00M residents in 2024) and geography (82,643 square miles), rural and frontier contexts dominate large regions of the State, with older age structures in many rural counties (for example, Lemhi County had 31.5% residents aged 65+ in 2024) [10][11]. Targeted use of virtual specialty support, rural care networks, analytics-guided chronic care, and EMS strengthening can reduce avoidable transfers, expand access to maternal/behavioral health, and better align financing with value. (census.gov) (census.gov)

The guide that follows maps RHT NOFO requirements to Collaborative capabilities; situates Idaho's current landscape; and outlines program design options, governance, funding, measurement, and a 24-month implementation plan. All implementation statements are conditional and subject to State priorities, procurement, legal review, contracting, and technical integration.

One-page printable summary (for distribution)

- Program window and deliverables
    - Single NOFO, one application per State; due Nov 5, 2025; earliest start Dec 31, 2025 [1]. 50% baseline + 50% points-based workload each budget period; weights in Table 3 of NOFO [2][12]. (files.simpler.grants.gov) (files.simpler.grants.gov) (files.simpler.grants.gov)
- Idaho opportunity snapshot
    - 26.4% non-metro population (ACS 2019–2023); 27 CAHs; ~57 RHCs; 14 HRSA Health Center awardees (2024) [13][14][15]. Behavioral health benefits consolidated under a single MCO (IBHP) since July 1, 2024 [16]. Medicaid expansion enrollment ≈89k (Dec 2024) with 2025 legislation directing a transition to broader managed care by 2029 [17][18]. (ruralhealthinfo.org) (ruralcenter.org) (ruralhealthinfo.org) (data.hrsa.gov) (healthandwelfare.idaho.gov) (idahocapitalsun.com)
- Highest-leverage Collaborative supports for Idaho
    - Avel eCare tele-ER/ICU/behavioral, retail-enabled access, and CAH/RHC network strengthening [3][5][9]. Remote monitoring via BioIntelliSense; consumer triage and multilingual intake (Humetrix) [4][6]. Secure cloud, data interoperability, and cyber hardening (Microsoft) [7]. Analytics for population risk and payment integrity (Accenture/Pangaea Data) [6][8].
- Compliance highlights (caps & controls)
    - Admin ≤10%; Provider payments ≤15%; Capital & infrastructure ≤20%; EMR replacement ≤5% (if HITECH-certified system in place as of 9/1/2025); no funding for defined specified sex-trait modification procedures (45 CFR 156.400); 2 CFR 200.216 telecom restrictions; SF-424 box 19c "No" [19]. (files.simpler.grants.gov)

2. Eligibility and RFP Fit

2.1 Snapshot of the NOFO

- Eligibility: Only the 50 U.S. States may apply; DC and territories ineligible [1]. [1] (files.simpler.grants.gov)
- Key dates: Optional LOI Sep 30, 2025; Application due Nov 5, 2025, 11:59 p.m. ET; expected award/earliest start Dec 31, 2025; applicant webinars Sep 19 and 25, 2025 [1]. [1] (files.simpler.grants.gov)
- One application per State; latest on-time submission counts; no cost sharing [1]. [1] (files.simpler.grants.gov)
- Funds distribution: ~$50B total (FY26–FY30). Each budget period: 50% baseline equally among approved States; 50% workload via points. Workload funding recalculates technical factors annually; rural facility/population factors fixed based on Q4 2025 data [2]. [2] (files.simpler.grants.gov)
- Workload formula: Total Available Workload Funding × (Your State's Total Points ÷ Sum of All Approved States' Points) [12]. [12] (files.simpler.grants.gov)
- Scoring weights: Table 3 (Rural facility/population 50% + Technical factors 50% with detailed sub-weights) [12]. [12] (files.simpler.grants.gov)
- State policy actions: Conditional Year-1 points for proposed policy changes; must finalize by Dec 31, 2027 (by Dec 31, 2028 for factors B.2 Health & lifestyle and B.4 Nutrition CME) or points drop to zero and related funds may be recovered [12]. [12] (files.simpler.grants.gov)
- Allowable uses: Approved categories include prevention/chronic disease; provider payments (capped); consumer tech; training/TA for tech-enabled care; workforce; IT/cyber; right-sizing service lines; behavioral health/Substance Use Disorder (SUD); innovative care/value-based; minor capital/equipment; and partnerships [19]. [19] (files.simpler.grants.gov)
- Budget/admin caps & prohibitions: Admin ≤10%; provider payments ≤15%; capital ≤20%; EMR replacement cap 5% (if HITECH-certified EMR in place as of 9/1/2025); limits on "Rural Tech Catalyst Fund"-type initiatives (≤10% or $20M, whichever is less); telecom/video surveillance per 2 CFR 200.216; specified sex-trait modification procedures prohibited under 45 CFR 156.400 [19]. [19] (files.simpler.grants.gov)
- Required content & format: Project summary; Project narrative (≤60 pages, 12-pt, double-spaced main body, tables/footnotes single-spaced); Budget narrative (≤20 pages, single-spaced); Governor's endorsement letter (≤4 pages); Business assessment (≤12); Program duplication assessment (≤5); required forms SF-424/424A/LLL + Site Locations; SF-424 box 19c "No" (EO 12372 not applicable) [20]. [20] (files.simpler.grants.gov)

2.2 Mapping RFP requirements to Collaborative capabilities

Requirement → Collaborative capability → Evidence

- Strategy addressing access/outcomes/technology/workforce/partnerships/data/financial solvency → Tele-ER/ICU/pharmacy/behavioral coverage; RPM; consumer screening; AI-supported workflows; HVN governance → Avel eCare; BioIntelliSense; Humetrix; Viz.ai; Microsoft; Cibolo; SI partners [3][4][6][7][8][9].
- ≥4 measurable outcomes per initiative; dashboards and real-time tracking → Program management toolbox; dashboards; evaluation support → SI partners (Accenture/KPMG/PwC/AVIA) [6][8].
- Interoperability and cybersecurity → Azure-based secure cloud, data exchange, TEFCA/QHIN connectivity; cyber hardening → Microsoft; eClinicalWorks PRISMA/PRISMANet QHIN [7].
- Right-sizing and service-line optimization → GrowthOS analytics; demand forecasting; regional referral/tele-specialty linkages → Accenture; Avel eCare [8].
- Workforce recruitment/retention and training → Digital training modules; ambient clinical AI; tele-mentoring; retail health clinical pathways → NACHC; Microsoft; Avel eCare; Walgreens/CVS/Walmart [5][6].
- Value-based models and payment integrity → Claims modernization, payment analytics, ACO reporting connectors → Accenture; connectors to ONC-certified servers [9].

3. Idaho Context Snapshot

Assumptions and Open Questions (for internal use)

- We rely on the CMS NOFO PDF (posted 9/15/2025) and the CMS RHT Program webpage; if CMS issues errata before award, scoring or caps may shift. Idaho should validate final points methodology tables and Appendix definitions on submission day [1][2][12]. (files.simpler.grants.gov) (cms.gov)

- Idaho's Certificate-of-Need (CON) status: NCSL's 4/29/2025 brief catalogs states with CON; Idaho does not appear among states operating a CON program; Idaho to confirm current statutory posture for NOFO factor C.3 [21]. (ncsl.org)

3.1 Population, geography, and rurality

- State population 2,001,619 (July 1, 2024 estimate) [10]. Non-metro share ≈26.4% (ACS 2019–2023) [13]. Idaho land area 82,643 sq mi; low population density (historical 2010 density 19.0/sq mi) [22]. [10][13][22] (census.gov) (ruralhealthinfo.org) (census.gov)
- Rural aging: Rural Idaho counties skew older; Lemhi County had 31.5% 65+ in 2024; statewide rural counties ~21.4% 65+ per Idaho Department of Labor (2023 estimates) [11][23]. [11][23] (census.gov) (idahoatwork.com)
- Frontier indicators: Several counties (e.g., Butte, Custer, Clark) exhibit very low population densities consistent with frontier definitions (<7 persons/sq mi) based on 2020 Census county data [24]. [24] (en.wikipedia.org)

3.2 Rural facility mix (indicative)

- Critical Access Hospitals (CAHs): 27 (Idaho State Flex profile) [14]. [14] (ruralcenter.org)
- Rural Health Clinics (RHCs): ~57 statewide (RHIhub State Guide as of 9/11/2025) [13]. [13] (ruralhealthinfo.org)
- Health Center Program (FQHC) awardees: 14 reporting awardees; 241,014 patients in 2024 (UDS) [15]. [15] (data.hrsa.gov)
- EMS: Idaho participates in the EMS Licensure Compact (REPLICA); Idaho Bureau of EMS confirms remote state recognition and compact processes [25][26]. EMS not designated as an "essential service" in statute per the State's EMS Sustainability Task Force materials [27]. [25][26][27] (emscompact.gov) (healthandwelfare.idaho.gov) (healthandwelfare.idaho.gov)

3.3 Medicaid, behavioral health, and managed care

- Medicaid expansion: ~89k enrolled (Dec 2024) [17][28]. 2025 legislation directs a transition to comprehensive managed care, with IDHW indicating a 2029 start for the new MCO contract to reduce implementation risk [18]. Behavioral health consolidated into the Idaho Behavioral Health Plan (IBHP) administered by a single MCO from July 1, 2024 [16]. [16][17][18][28] (healthandwelfare.idaho.gov) (cdapress.com)

3.4 Behavioral health and SUD

- CDC reports provisional national overdose deaths fell ~27% in 2024 to ~80,391 [29]; Idaho's Office of Drug Policy reports 264 opioid-involved deaths (68% of overdose fatalities) in 2023, with fentanyl in 197 deaths [30]. These trends underscore need for tele-behavioral, MAT access, and community-based risk monitoring. [29][30] (cdc.gov) (odp.idaho.gov)

3.5 Maternal health access

- March of Dimes' 2024 Maternity Care Deserts report documents significant national access gaps concentrated in rural counties—relevant to Idaho's rural regions [31]. Collaborative partners can support tele-OB consults, monitoring, and retail-based prenatal support. [31] (marchofdimes.org)

3.6 Broadband and digital readiness

- Independent analyses suggest Idaho's served/unserved reporting may be over-stated; BroadbandNow estimates ~48% over-reporting compared to FCC estimates (interpret with caution) [32]. The Collaborative's platform design includes offline-tolerant workflows and cybersecurity hardening for rural providers [7]. [32] (broadbandnow.com)

3.7 Metrics–capability alignment (illustrative)

Metric (Year) → Source → Collaborative capability

- Non-metro population 26.4% (ACS 2019–2023) → RHIhub State Guide [13] → Regional tele-specialty coverage; retail access nodes; RPM to reduce travel [3][4][5]. (ruralhealthinfo.org)
- 27 CAHs → State Flex profile [14] → Tele-ICU/tele-ER; transfer avoidance; quality dashboards [3]. (ruralcenter.org)
- 14 FQHC awardees; 241k patients (2024) → HRSA UDS [15] → eClinicalWorks integration; risk strat; consumer engagement [7]. (data.hrsa.gov)
- EMS Compact participation; EMS not "essential" → EMS Compact; IDHW EMSSTF [25][27] → Tele-EMS consults; community paramedicine; 988/virtual crisis support [9]. (emscompact.gov) (healthandwelfare.idaho.gov)

4. Strategy Aligned to RFP

4.1 Idaho's rural transformation model (conditional concept)

- Goal: Stabilize rural access; reduce avoidable transfers; extend maternal/behavioral services; strengthen chronic disease control; and modernize data/cyber infrastructure—aligned to NOFO uses and scoring [2][12][19]. (files.simpler.grants.gov)
- Core elements (mapped to Table-3 factors):
    - A. Rural facility/population baselines: Leverage CAH/RHC/FQHC network geography to prioritize regions with frontier characteristics and aging populations. Scales to counties with low density and long transport times [12]. (files.simpler.grants.gov)
    - C/F. Partnerships & technology: Avel eCare's tele-hospital hub; RPM via BioIntelliSense; TEFCA/QHIN connectivity; analytics and payment integrity; retail-based clinics/kiosks to extend reach [3][4][5][6][7][8].
    - D. Workforce: Train rural teams with digital tools (ambient documentation, multilingual intake) and tele-mentorship; leverage licensure compacts (IMLC, EMS Compact; NLC) for flexible coverage [25][33]. (emscompact.gov) (imlcc.com)
    - E. Payment/policy: Build toward multi-payer value-based models and Medicaid alignment; use conditional policy factors (e.g., licensure compacts, scope of practice, SNAP waivers, nutrition CME) to capture technical points within statutory timelines [12]. (files.simpler.grants.gov)

4.2 Equity strategy (rural and Tribal)

- Use FQHC/Indian Health Service linkages and mobile/retail nodes to reach remote communities; configure multilingual tools (Humetrix) and consumer notifications; monitor outcomes by geography and demographic subgroups in dashboards [6].

4.3 Data use and privacy

- Deploy secure Azure-based data lake; federated exchange (eClinicalWorks PRISMA/PRISMANet QHIN); adhere to HIPAA and ONC requirements; cyber hardening for CAHs and clinics [7].

5. Program Design Options (tailored to Idaho; for consideration)

Option A. Rural High-Value Network (HVN) of CAHs, RHCs, FQHCs

- Target: CAH/RHC clusters in frontier counties; FQHC primary care hubs.
- Problem statement: 27 CAHs across a dispersed geography with transfer burdens and staffing pressure; EMS not essential in law [14][27]. [14][27] (ruralcenter.org) (healthandwelfare.idaho.gov)
- Collaborative components: Avel eCare tele-ER/ICU; CAH quality/operational dashboards; Viz.ai triage for stroke; network governance via Cibolo Health; PRISMA data exchange [3][7][9].
- Payment logic: Global/episodic budgets for HVN participants with quality gates; EMS community paramedicine billing where permissible; shared savings on avoidable transfers.
- Policy enablers: Licensure compacts, EMS compact utilization, optional CON point (Idaho to confirm status) [21][25]. (ncsl.org) (emscompact.gov)

- Pros/risks: Pros—transfer reduction, stabilized staffing; Risks—24/7 coverage sustainability; Mitigation—tiered tele-specialty SLAs, cross-facility coverage pools (owners: HVN board, CAHs, Avel eCare).

Option B. Idaho Community Paramedicine & 988-linked Virtual Crisis

- Target: Frontier counties with long response/transport times.
- Problem: EMS sustainability; behavioral health crises; 988 integration gaps [27]. (healthandwelfare.idaho.gov)
- Components: Tele-EMS consults; community paramedicine protocols; Avel eCare virtual behavioral crisis support; Magellan IBHP care coordination [9][16]. (healthandwelfare.idaho.gov)
- Payment: Medicaid SPA/waiver alignment for community paramedicine visits; braided State funds; value-based incentives tied to ED avoidance.
- Risks: Scope, liability; Mitigation—protocols via State EMS office; legal review; phased pilots (owners: EMS Bureau, IBHP MCO, Avel eCare).

Option C. Rural Maternal Health Access Bundle

- Target: Counties with limited OB services; FQHC/RHC prenatal touchpoints.
- Problem: National increases in maternity care deserts; rural access constraints [31]. (marchofdimes.org)
- Components: Tele-OB consults; RPM for high-risk pregnancies (BioIntelliSense); retail-based BP/glucose checks; multilingual prenatal education (Humetrix) [4][6].
- Payment: Bundle for prenatal–postpartum episodes; incentives via Medicaid (postpartum coverage period).
- Risks: Broadband/device use; Mitigation—loaner devices; offline-tolerant workflows, cell-first kits (owners: Medicaid, FQHCs, retail partners).

Option D. Chronic Disease and Readmission Reduction

- Target: Heart failure/COPD/diabetes panels across CAHs/FQHCs.
- Problem: Travel burden, monitoring gaps; staffing documentation burden.
- Components: RPM (BioIntelliSense); ambient clinical documentation; pharmacy-enabled adherence; analytics to find unmet needs (Pangaea Data) [4][6].
- Payment: Care management fees; shared savings with multipayer alignment; hospital-at-home pilots.
- Risks: Clinician adoption; Mitigation—training/TA, phased enrollment (owners: State PMO, provider leads, SI partner).

6. Governance and Collaborative Roles

6.1 Decision structure (text diagram)

- State Lead Agency (Governor-designated): sets strategy, signs award, oversees compliance.
- Idaho Medicaid: payment alignment, SPA/waiver drafting, data feeds (claims).
- State Office of Rural Health & Primary Care: convening, rural TA.
- HVN Board (if established): provider representation; quality/finance subcommittees.
- Collaborative members:
    - Avel eCare: clinical tele-services operations; 24/7 hub [3].
    - BioIntelliSense: RPM devices, dashboards, training [4].
    - eClinicalWorks/healow: EHR/HIE connectors (PRISMA/QHIN) [7].
    - Microsoft: cloud, security, identity, compliance [7].
    - SI partners (Accenture/KPMG/PwC/AVIA): PMO, analytics, evaluations [6][8].
    - Retail partners (CVS/Walgreens/Walmart): access points, screenings [5].

6.2 RACI (illustrative; owners/participants)

- Strategy & NOFO compliance: State Lead (R/A); Medicaid (C); Collaborative PMO (C); HVN (I).
- Clinical tele-services ramp: Avel eCare (R); CAHs/FQHCs (A); State (C); PMO (C).
- RPM & consumer tech: BioIntelliSense (R); FQHCs/RHCs (A); PMO (C).

- Data & cyber: Microsoft + State IT (R/A); eClinicalWorks (C); SI (C).
- Evaluation/reporting: PMO/SI (R); State Lead (A); providers (C); Medicaid (C).
- Stakeholder engagement: State Lead + SORH (R/A); HVN board (C); Collaborative (C).

7. Payment and Funding

7.1 Paths aligned to the NOFO

- Use of funds mapped to categories A–K with caps enforced; provider payments limited to ≤15%/period; capital ≤20%; admin ≤10% [19]. [19] (files.simpler.grants.gov)
- Medicaid alignment: actuarial modeling of chronic/RPM bundles; SPAs for community paramedicine; value-based HVN contracts; connectors for ACO reporting [9].

7.2 Costing and deliverables (illustrative)

Cost category → ROM (per year placeholder) → Funding source → Collaborative deliverables

- Tele-ER/ICU network → $25–35M → RHTP Cat. I/K; hospital co-funds → Clinical hub staffing, devices, SLAs [3].
- RPM kits + services (first 10k pts) → $10–15M → RHTP Cat. A/F/I → Devices, dashboards, training [4].
- Data/cyber platform → $8–12M → RHTP Cat. F; State IT → Secure cloud, HIE/QHIN connectors [7].
- Retail access pilots → $5–8M → RHTP Cat. C/K → Screening, pharmacist-led pathways [5].
- PMO & evaluation → $6–9M → Admin (≤10%) + Cat. K → PMO, dashboards, NCC reporting [6][8].

8. Data, Measurement, and Evaluation

- Core measures: access (time-to-specialist, transfers avoided), quality (HEDIS-like), maternal (prenatal visits, postpartum visit rate), behavioral (ED BH revisits, 7-day follow-up), chronic (RPM alert-to-intervention, readmissions), workforce (vacancy/retention), tech (downtime, security incidents).
- Data sources: Medicaid claims; hospital ADT/encounters; FQHC EHR; HIE/QHIN; EMS (NEMSIS); retail interventions; IBHP data feeds. Integration via cloud platform and PRISMA [7].
- Evaluation cadence: Quarterly dashboards; annual non-competing continuation packets; cooperation with CMS/third-party evaluators per NOFO [20]. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; conditional)

Gantt-style table (start = Dec 2025)

Workstream → Start → End → Owner → Outputs

- Program mobilization & governance → Dec 2025 → Feb 2026 → State PMO/SI → Charter, RACI, risk plan [6][8].
- Security & data platform stood-up → Jan 2026 → Apr 2026 → Microsoft/State IT → Cloud tenancy, data lake, QHIN connector [7].
- Tele-ER/ICU wave 1 (10 CAHs) → Feb 2026 → Aug 2026 → Avel eCare/CAHs → Live coverage, protocols [3].
- RPM cohort 1 (2,500 pts) → Mar 2026 → Sep 2026 → BioIntelliSense/FQHCs → Deployed kits, training [4].
- Maternal access pilots (3 regions) → Apr 2026 → Dec 2026 → FQHCs/RHCs/retail → Tele-OB pathways live.
- EMS/community paramedicine pilots → May 2026 → Dec 2026 → EMS Bureau/partners → Protocols, reporting.
- Wave 2 scale-up (remaining sites) → Oct 2026 → Dec 2027 → PMO/All → Statewide scale with dashboards.

Milestones/gates: security ATO; first-10 hospitals live; RPM N=2,500; preliminary outcomes; budget vs cap checks; annual continuation application.

Procurement/legal: State MSA or competitively procured contracts; BAAs and DPAs; EHR/HIE interface statements of work; compact-based credentialing workflows (IMLC/EMS). (imlcc.com) (emscompact.gov)

10. Risk Register (selected)

- Cyber incident at rural facility → Mitigation: Azure Sentinel/SIEM, MFA, backups; owners: State IT/Microsoft [7].
- Tele-coverage staffing gaps → Mitigation: multi-hub coverage roster, SLAs; owners: Avel eCare/PMO [3].
- Device logistics in frontier areas → Mitigation: logistics vendor, device spares, offline workflows; owners: BioIntelliSense/PMO [4].
- Data-sharing delays → Mitigation: legal templates, QHIN use, HIE bridges; owners: eClinicalWorks/State IT [7].
- Policy points not finalized by deadlines → Mitigation: legislative calendar, public comment plan; owners: State Lead. [12] (files.simpler.grants.gov)
- EMS funding fragility → Mitigation: community paramedicine model, IBHP coordination; owners: EMS Bureau/MCO [16][27]. (healthandwelfare.idaho.gov) (healthandwelfare.idaho.gov)
- Broadband constraints → Mitigation: cellular-first kits, compressed video, store-and-forward; owners: PMO/IT [32]. (broadbandnow.com)
- Clinician adoption → Mitigation: training, ambient AI documentation; owners: providers/Microsoft [6].
- Budget cap exceedance risks → Mitigation: quarterly cap checks (admin 10%, provider 15%, capital 20%); owners: PMO/Finance [19]. (files.simpler.grants.gov)
- Evaluation under-performance → Mitigation: early baseline capture; corrective action plans; owners: PMO/SI [20]. (files.simpler.grants.gov)

11. Draft RFP Response Language (Idaho-tailored; paste-ready paragraphs)

11.1 Rural Health Needs and Target Population (excerpt)

Idaho is a predominantly rural state with approximately 26.4% of residents living in non-metro areas (ACS 2019–2023). Rural age structure skews older, with select counties above 30% aged 65+ (e.g., Lemhi County, 2024). The State's rural care network includes 27 Critical Access Hospitals, ~57 Rural Health Clinics, and 14 Health Center Program awardees serving 241,014 patients (2024). These patterns, compounded by frontier geographies and EMS sustainability challenges, necessitate a coordinated approach to reduce avoidable transfers, expand behavioral/maternal access, and manage chronic disease closer to home [13][11][14][15][27]. (ruralhealthinfo.org) (census.gov) (ruralcenter.org) (data.hrsa.gov) (healthandwelfare.idaho.gov)

11.2 Goals, Strategies, and Policy Commitments (excerpt)

We will deploy a statewide rural transformation model integrating: (a) tele-ER/ICU/behavioral coverage for CAHs; (b) RPM and consumer-facing triage; (c) secure, interoperable data and cybersecurity; (d) community paramedicine and 988-linked crisis response; and (e) a High-Value Network governance construct. Idaho will pursue policy actions in the NOFO technical factors (e.g., licensure compacts utilization, workforce recruitment, EMS strengthening) within the timelines specified (general policy finalization by Dec 31, 2027; B.2/B.4 by Dec 31, 2028) to optimize points [12]. (files.simpler.grants.gov)

11.3 Proposed Initiatives & Uses of Funds (excerpt)

Initiative names, descriptions, beneficiaries, ≥4 measurable outcomes with baselines/targets, FIPS-coded geographies, and budget estimates are provided in the attached matrix. Each initiative aligns to ≥3 NOFO categories (e.g., A, F, I), enforces caps (admin ≤10%; provider payments ≤15%; capital ≤20%; EMR replacement ≤5%), and includes sustainability pathways with Medicaid and commercial payer alignment [19]. (files.simpler.grants.gov)

11.4 Implementation, Stakeholder Engagement, and Evaluation (excerpt)

Implementation follows a 24-month phased plan beginning Dec 2025. Governance includes a State PMO and a provider-led HVN board. Idaho will cooperate with CMS and third-party evaluators; quarterly dashboards will monitor progress and inform corrective actions as required by the NOFO [20]. (files.simpler.grants.gov)

12. References

[1] Rural Health Transformation Program NOFO (CMS-RHT-26-001), CMS. https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf (Accessed 2025-10-14). (files.simpler.grants.gov)
[2] CMS RHT Program — Overview page, CMS. https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview (Accessed 2025-10-14). (cms.gov)
[3] Rural Health Transformation Collaborative PDF — Avel eCare profile and tele-hospital model. (Collaborative file)
[4] Rural Health Transformation Collaborative PDF — BioIntelliSense description and RPM capabilities. (Collaborative file)
[5] Rural Health Transformation Collaborative PDF — Retail health (CVS/Walgreens/Walmart) roles. (Collaborative file)
[6] Rural Health Transformation Collaborative PDF — Population analytics, training, PMO/evaluation. (Collaborative file)
[7] Rural Health Transformation Collaborative PDF — Microsoft cloud/interoperability/cyber; eClinicalWorks PRISMA/QHIN. (Collaborative file)
[8] Rural Health Transformation Collaborative PDF — Governance/HVN, GrowthOS analytics. (Collaborative file)
[9] Rural Health Transformation Collaborative PDF — Value-based models, ACO reporting connectors, payment analytics. (Collaborative file)
[10] U.S. Census QuickFacts: Idaho (V2024 estimates). https://www.census.gov/quickfacts/fact/table/ID (Accessed 2025-10-14). (census.gov)
[11] U.S. Census QuickFacts: Lemhi County, Idaho (V2024). https://www.census.gov/quickfacts/fact/table/lemhicountyidaho (Accessed 2025-10-14). (census.gov)
[12] RHT NOFO — Table 3 weights and workload formula (pp. 51–52). Same as [1]. (files.simpler.grants.gov) (files.simpler.grants.gov)
[13] Rural Health Information Hub — Idaho State Guide (last updated 2025-09-11). https://www.ruralhealthinfo.org/states/idaho (Accessed 2025-10-14). (ruralhealthinfo.org)
[14] National Rural Health Resource Center — Idaho State Flex profile ("Number of CAHs: 27"). https://www.ruralcenter.org/spotlight/idaho-bureau-rural-health-primary-care (Accessed 2025-10-14). (ruralcenter.org)
[15] HRSA UDS State Report — Idaho (2024). https://data.hrsa.gov/topics/healthcenters/uds/overview/state/id/ (Accessed 2025-10-14). (data.hrsa.gov)
[16] Idaho DHW — Idaho Behavioral Health Plan implementation update (Magellan go-live 7/1/2024). https://healthandwelfare.idaho.gov/news/idaho-behavioral-health-plan-implementation-update (Accessed 2025-10-14). (healthandwelfare.idaho.gov)
[17] Boise State Public Radio — Medicaid expansion enrollment and legislation (2/4/2025). https://www.boisestatepublicradio.org/... (Accessed 2025-10-14). (boisestatepublicradio.org)
[18] Idaho Capital Sun — Medicaid to be privately managed in 2029 (6/2/2025). https://idahocapitalsun.com/... (Accessed 2025-10-14). (idahocapitalsun.com)
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13. AI Generation Notice

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