Rural Health Transformation Grant Guide — Nevada

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Nevada can compete strongly for CMS's Rural Health Transformation (RHT) cooperative agreement by pairing the state's broadband buildout and behavioral health reforms with a focused, data-driven delivery and payment transformation. CMS has posted the RHT program overview, uses of funds, and timeline; applications close in early November 2025 (CMS's press release specifies November 5, 2025), with awards by December 31, 2025. (cms.gov)

The Rural Health Transformation Collaborative (the Collaborative) offers modular clinical, technology, workforce, and integration capabilities that align to the RHT "uses of funds" categories (e.g., prevention/chronic disease, technology-enabled care, workforce, IT/cybersecurity, partnerships). Examples include 24/7 tele-specialty/virtual hospital support for rural facilities (Avel eCare), continuous remote monitoring for chronic and post-acute care (BioIntelliSense BioButton), statewide program PMO/system integration (Accenture/KPMG/PwC/AVIA), consumer screening/navigation and multi-language triage (Humetrix), and cybersecurity and data platforms (Microsoft). These capabilities are built to HIPAA/FHIR standards and support statewide data exchange and analytics.

Nevada's context strengthens the case for high-impact, scalable initiatives. The state is among the most urban by population, yet its rural and frontier regions face long transport distances (average 118 miles from many rural hospitals to higher-level care) and limited specialty access. Nevada's State Office of Rural Health reports 13 Critical Access Hospitals (CAHs) serving nearly 300,000 rural/frontier residents. (med.unr.edu) At the same time, the state is executing a large broadband expansion (BEAD and state investments) to connect more than 40,000–43,700 unserved/underserved locations—an enabler for telehealth, remote monitoring, and secure data exchange in rural communities. (gov.nv.gov)

This guide is an enabling, public-ready reference for Nevada to frame an RHT application that is both ambitious and implementation-credible. It translates RHT program requirements into Nevada-specific options and shows how the Collaborative's offerings can support delivery system change, analytics, and governance—subject to State priorities, procurement, contracting, and integration. (cms.gov)

One-page printable summary (for circulation)

- RHT program (cooperative agreement): Posted mid-Sep 2025; application due Nov 5, 2025; awards by Dec 31, 2025. Uses of funds span chronic disease, provider payments (program-specific limits apply), consumer tech, workforce (≥5-year rural service commitments), IT/cybersecurity, right-sizing service lines, behavioral health, innovative/value-based models, and partnerships. (cms.gov)
- Nevada opportunity:
    - 13 CAHs; ~300k rural/frontier residents; long referral distances (avg. 118 miles). (med.unr.edu)
    - Broadband: BEAD Final Proposal approved; >$416M to connect ~43,700 locations; additional state middle-mile investments targeting >40,000 un/underserved locations. (ntia.gov)
    - Behavioral health: 1115 SUD demonstration active (through 12/31/2027); 2025 updates in progress. (medicaid.gov)
- Collaborative alignment (illustrative):
    - Facility support: 24/7 tele-ER/ICU/hospitalist; tele-behavioral crisis; specialty e-consult hubs.
    - Chronic disease/home-based care: continuous vitals monitoring; remote exception-based workflows; retail pharmacy-enabled BP/diabetes programs.
    - Data & cyber: HIPAA/FHIR cloud platform, statewide analytics, program dashboards; rural hospital cybersecurity program at national scale.
    - Workforce: training, tele-mentoring; Ambient documentation to reduce burnout; pharmacist-enabled chronic care models (subject to state policy).

Assumptions and Open Questions (verify against the final NOFO)

- The public CMS overview/FAQ confirm timeline, eligibility, uses of funds, and cooperative-agreement oversight; the detailed scoring weights, financial caps (e.g., provider payment/administrative/capital limits), and formatting/page limits are in the NOFO on Grants.gov. This guide cites CMS's public pages; specific caps and scoring tables should be confirmed from the NOFO at submission. (cms.gov)

2. Eligibility and RFP Fit

2.1 Program purpose, structure, and timeline

- Goal: Transform rural healthcare access, quality, and outcomes through state-led systems change. Funding: $50B over FY26–FY30; 50% distributed equally across approved states; 50% based on factors (rural population/facilities and other metrics specified in the NOFO). Application: posted mid-September 2025; submissions close early November 2025; awards by December 31, 2025. (cms.gov)
- CMS press release sets the application deadline on November 5, 2025. (cms.gov)
- Eligibility: Only the 50 states (DC and territories ineligible). One application per state; the Governor designates the lead agency; a Governor's endorsement letter is required. (cms.gov)
- Cooperative agreement model with significant CMS engagement; CMS will maintain ongoing technical assistance and require regular reporting and performance monitoring. (cms.gov)

2.2 Uses of funds (high-level categories)

RHT allows expenditures across multiple categories; states must address at least three. Examples include chronic disease prevention/management, provider payments (per NOFO limits), consumer-facing tech, training/technical assistance for technology-enabled care, workforce recruitment/retention (≥5-year rural service commitments), IT/cybersecurity, right-sizing service lines, behavioral health/SUD, innovative/value-based models, and partnerships. (cms.gov)

2.3 Funds distribution

Half of each year's funding is distributed equally; the other half is distributed to at least 25% of approved states based on points (method specified in the NOFO). (cms.gov)

2.4 Fit: mapping RFP requirements to Collaborative capabilities

Requirement (from CMS overview/FAQ) → Collaborative capability → Evidence

- Chronic disease prevention/management → Statewide RPM program (BioIntelliSense), retail pharmacy BP/diabetes management and follow-up (Walgreens/CVS), tele-specialty clinics (Avel) →
- Consumer-facing technology and triage → Multi-language, voice-enabled intake/triage; consumer PHR and risk alerts (Humetrix) →
- Technology-enabled care, AI, and robotics → Tele-ER/ICU/hospitalist support; ambient documentation; AI clinical summarization; workflow and prior-auth analytics →
- Workforce recruitment/retention and training → Tele-mentoring; digital training modules; pharmacy workforce pipelines; burnout reduction via ambient tools →
- IT advances, cybersecurity, interoperability → HIPAA/FHIR cloud platform, rural hospital cybersecurity scaling; analytics dashboards for program performance →
- Right-sizing service lines/partnerships → Growth and footprint analytics; service-line modeling; creation of provider High-Value Networks (HVNs) →
- Innovative/value-based models → Shared-savings/risk models for rural networks; ACO reporting connectors →

3. Nevada Context Snapshot

3.1 Geography and rural population

- Nevada is highly urban by population (about 94.1% urban, 5.9% rural in 2020). Rural areas are geographically vast, with long distances to higher-level care (average 118 miles reported for rural to tertiary). (ncsl.org)
- Nevada's State Office of Rural Health identifies 13 CAHs serving nearly 300,000 rural/frontier residents. (med.unr.edu)

3.2 Facility mix (selected indicators)

- CAHs: 13 (State Office of Rural Health). (med.unr.edu)
- HRSA Health Center Program (FQHC) awardees: 7 in 2024 (128,018 patients). (data.hrsa.gov)
- EMS: Nevada DPBH oversees statewide EMS licensure, training, and ambulance services; rural EMS upskilling and coordination remain priorities. (dpbh.nv.gov)

3.3 Workforce and HPSA indicators

- Primary care HPSA footprint: secondary analysis of HRSA's 3/31/2025 HPSA data shows Nevada had 74 HPSA designations, with an estimated shortage of 183 primary care clinicians (interpret as provisional; confirm with HRSA's current HPSA dashboard). (commentary.healthguideusa.org)

3.4 Medicaid delivery system and waivers

- Managed care organizations (MCOs): Nevada Medicaid lists Anthem, CareSource, Health Plan of Nevada, and Molina; NV has announced expansion of Medicaid managed care statewide by 2026 (transition details to be finalized). (medicaid.nv.gov)
- 1115 SUD demonstration: Approved 12/29/2022; effective 1/1/2023–12/31/2027; ongoing monitoring and proposed amendments (e.g., IMD coverage and HRSN supports). (medicaid.gov)

3.5 Broadband, digital equity, and telehealth enablers

- BEAD Final Proposal approved Jan 16, 2025; >$416M to connect ~43,700 locations statewide; middle-mile expansions to reach >40,000 additional unserved/underserved locations (state investments). (ntia.gov)
- OSIT's High Speed NV initiative is executing multi-year mapping, middle-mile, and CAI connectivity projects. (osit.nv.gov)

3.6 Maternal/behavioral health and SUD signals (selected)

- Maternity access: March of Dimes reports persistent "maternity care deserts" nationally, with rural areas disproportionately affected; state-specific access varies across Nevada's frontier counties. (marchofdimes.org)
- Overdose: CDC provisional reports show a national decline in 2024; Nevada was among a few states with slight increases vs. 2023; prior "NV Stats" page shows a drug overdose death rate reported for Nevada among key indicators (rate labeling varies by year—use with caution and confirm the latest state rate as part of application narrative). (cdc.gov)

3.7 Policy environment relevant to RHT technical scoring

- Licensure compacts: Nevada participates in the Interstate Medical Licensure Compact; in 2025 enacted the Audiology & Speech-Language Pathology Compact; Nurse Licensure Compact legislation has not passed to date (debate ongoing). These are potential Year-1 "conditional points" areas if the NOFO credits compacts. (leg.state.nv.us)

3.8 Nevada metrics to capability mapping (examples)

Metric (year, source) → Gap/need → Collaborative capability

- 13 CAHs; ~300k rural/frontier residents (2025, SORH) → After-hours specialty coverage, transfer delays → Tele-ER/ICU/hospitalist; e-consults; transfer coordination (Avel/Cibolo). (med.unr.edu)
- Avg. 118 miles to tertiary care (SORH) → High risk for delayed care → Remote monitoring; local stabilization via tele-specialty; paramedicine workflows. (med.unr.edu)
- 7 FQHC awardees; 128k patients (2024 HRSA) → Chronic disease scale, care coordination → RPM + pharmacist-enabled chronic care; patient engagement apps. (data.hrsa.gov)
- BEAD/OSIT connectivity (~43.7k locations + middle-mile) → Telehealth + data exchange feasibility → HIPAA/FHIR cloud, cybersecurity, statewide dashboards. (ntia.gov)

- SUD 1115 demo active → BH integration opportunity → Tele-behavioral crisis, 988 support, MAT navigation and risk alerts. (medicaid.gov)

4. Strategy Aligned to RFP

We outline a Nevada Rural Health Transformation model that is statewide in analytics/governance and regional in clinical deployment, progressively shifting care to lower-acuity settings while protecting rural facility viability.

- Access and right-sizing: Tele-ER/ICU/hospitalist and specialty clinics (Avel) to stabilize patients locally; service-line planning using demand/footprint analytics to right-size offerings by region.
- Chronic disease and home-based care: Continuous monitoring for CHF/COPD/diabetes and post-surgical care (BioIntelliSense) with exception-based workflows; pharmacist-enabled hypertension/diabetes programs linked to primary care.
- Behavioral health integration: Tele-behavioral crisis support and on-demand psychiatry; patient risk signals and medication safety alerts; alignment with Nevada's 1115 BH/SUD demonstration. (medicaid.gov)
- Workforce: Digital training, tele-mentoring, and ambient documentation to reduce administrative burden and support rural retention.
- Data and cybersecurity: HIPAA/FHIR cloud, statewide dashboards for outcomes and spend, and a rural-hospital cybersecurity program scaled nationally.
- Governance and sustainability: Provider-owned High-Value Networks (HVNs) for joint planning and transparent fund stewardship; value-based payment model design for rural viability.

Equity (rural/frontier and Tribal): Leverage retail and community settings for outreach and screening, multi-language mobile tools, and regionally governed HVNs that include FQHCs and Tribal providers as core partners, subject to Tribal consultation and data-sharing agreements.

Privacy and data use: All solutions operate under HIPAA, apply role-based access, and use FHIR APIs; State data-sharing agreements and 42 CFR Part 2 protections would be embedded in integration plans.

5. Program Design Options (Nevada-tuned)

Option A. Rural Virtual Hospital and Transfer Optimization

- Target: CAHs and small rural hospitals in frontier counties with extended transport times.
- Problem signal: Long distances to tertiary care (118 miles avg.); staffing variability for nights/weekends. (med.unr.edu)
- Components: 24/7 tele-ER/ICU/hospitalist; e-specialty clinics; transfer coordination; paramedicine protocols.
- Payment logic: Facility support under RHT "appropriate care availability" and "innovative care"; explore value-based add-ons with Medicaid MCOs for reduced transfers and readmissions (subject to actuarial analysis and SPA amendments as needed).
- Policy enablers: IMLC; EMS telehealth protocols; data-sharing with State HIE. (leg.state.nv.us)
- Partners/IT: Avel eCare; Cibolo HVNs; Microsoft cloud; dashboards for ED boarding/transfer times.
- Pros/risks: Rapid access gains; dependency on broadband reliability; mitigation via OSIT middle-mile routes and failover. (gov.nv.gov)

Option B. Statewide Remote Physiologic Monitoring (RPM) for CKD/CVD/COPD/Diabetes

- Target: FQHCs, RHCs, and rural primary care practices; high-risk Medicare/Medicaid adults.
- Problem: Chronic disease drives avoidable utilization; access to frequent follow-up is constrained.
- Components: BioButton-based monitoring with exception alerts; pharmacy-based BP/diabetes support; multi-language patient guidance and medication safety notifications.
- Payment: RHT prevention/consumer tech/IT categories; align with Medicaid quality withholds or shared-savings pilots (managed care expansion).
- Policy: Pharmacist scope pilots (if pursued) and Medicaid quality incentive alignment.
- Pros/risks: Prevents exacerbations; device logistics and adherence—mitigate via device navigators and retail pickup.

Option C. Rural Behavioral Health Access and 988 Integration

- Target: Rural EDs/EMS; counties with limited psychiatry.
- Problem: Behavioral crises and SUD; Nevada's 1115 SUD demo can anchor scalable supports. (medicaid.gov)
- Components: Tele-behavioral crisis coverage; two-way texting/peer supports; overdose risk alerts; linkage to MAT and CCBHCs (where designated).
- Payment: RHT behavioral health category; braid with 1115 authorities for IMD/HRSN supports (if approved).
- Pros/risks: Reduces ED boarding; ensure privacy/Part 2 compliance and local warm handoffs.

Option D. Maternal Health Access in Frontier Counties

- Target: Obstetric care deserts/frontier areas.
- Problem: Distance to birthing facilities; prenatal visit drop-off. (marchofdimes.org)
- Components: Tele-OB and remote BP/glucose monitoring for high-risk pregnancy; multi-language triage and appointment navigation; mobile/retail screening days; linkages to Level II/III centers.
- Payment: RHT prevention/consumer tech/workforce; braid with Medicaid maternity/transport benefits.
- Pros/risks: Early risk detection; ensure transport plans and liability coverage.

Recommended primary path: Option A + B as statewide backbone (near-term impact and measurable outcomes), with Option C and D layered by region.

6. Governance and Collaborative Roles

Conceptual decision-rights diagram (described)

- State lead agency (Governor-designated): strategy, compliance, federal reporting, subrecipient monitoring.
- Nevada Medicaid: payment alignment, SPA/waiver alignment, MCO contracting.
- OSIT/Broadband: digital infrastructure coordination, last-mile prioritization.
- Provider HVNs (Cibolo): regional governance, initiative stewardship, performance tracking.
- FQHCs/CAHs/RHCs: clinical operations, data sharing, workforce participation.
- Collaborative integrators (Accenture/KPMG/PwC/AVIA): PMO, system integration, analytics, value modeling, security.
- Technology/clinical vendors: tele-specialty (Avel), RPM (BioIntelliSense), consumer apps (Humetrix), AI/analytics/cyber (Microsoft).

RACI (abbrev.)

- Program strategy and NOFO compliance: State (R), Medicaid (A/C), Collaborative PMO (C), HVNs (C).
- Clinical model design/deployment: HVNs/Providers (R), Avel/BioIntelliSense (R/C), State (A), PMO (C).
- Data/cyber platform and dashboards: Microsoft/Integrators (R), State CIO/OSIT (A/C), Providers (C).
- Evaluation and reporting: PMO/Integrators (R), State (A), Medicaid (C), Providers (C).

7. Payment and Funding

Payment paths consistent with RHT (illustrative; confirm caps in NOFO):

- RHT funds for: technology-enabled care, workforce recruitment with ≥5-year rural service commitments, IT/cybersecurity, consumer tech, right-sizing access, behavioral health, and provider payments (program-specific caps). (cms.gov)
- Medicaid alignment: actuarial modeling for shared savings/quality incentives in MCO contracts, SPA amendments where needed (e.g., remote monitoring or team-based care codes), and 1115 levers for BH/HRSN. (medicaid.gov)

Cost planning table (rough order of magnitude; subject to procurement/pricing)

Category → Example deliverables → Timing → Potential funding

- Tele-specialty coverage → Tele-ER/ICU/hospitalist contracts, e-consults → Yr1-Yr2 ramp → RHT "innovative care/right-sizing"; facility match optional.
- RPM devices/services → BioButton kits, clinical console, device navigators → Yr1 pilots; Yr2 scale → RHT

prevention/consumer tech.
- Workforce/training → Tele-mentoring, digital curricula, ambient documentation rollout → Continuous → RHT workforce/training.
- Data & cyber → HIPAA/FHIR data lake, dashboards, security hardening → Yr1 build; Yr2 ops → RHT IT/cybersecurity.
- Capital (minor) → Tele rooms, devices, network upgrades → As needed → RHT capital (subject to NOFO limits).

8. Data, Measurement, and Evaluation

Core outcomes (examples; baselines from 2025 data; quarterly updates)

- Access: ED tele-consult response time; transfer interval; tele-clinic volumes; tele-behavioral crisis response time.
- Quality/safety: 30-day readmissions (CHF/COPD), hypertension control rates, remote monitoring adherence and exception resolution time.
- Financial: Avoided transfers; reduction in avoidable ED visits; total cost of care trend in rural populations (Medicaid/MCO).
- Workforce: Rural vacancy/turnover; provider time on documentation (ambient AI deployment).
- Program implementation: Milestone delivery; spend vs. plan; cyber posture improvement KPIs.

Data sources and integrations: Claims (Medicaid/MCO), EHRs, State HIE, EMS run reports, RPM device data, retail screening events, OSIT broadband maps. HIPAA/FHIR interfaces and role-based access; Part 2 where applicable.

Evaluation approach: CMS-aligned annual reporting; external evaluator readiness; value realization tracking (outcomes and cost), with dashboards for State leadership and CMS.

9. Implementation Plan (first 18 months)

Gantt-style table (indicative; dates relative to award on 2025-12-31)

Workstream → Start → End → Owner → Key outputs

- PMO setup & governance → Jan 2026 → Feb 2026 → State/PMO → Charter; RACI; reporting calendar.
- Data/cyber platform build → Jan 2026 → Jun 2026 → Microsoft/PMO → Data lake; FHIR APIs; dashboards v1.
- Clinical site onboarding (tele-ER/ICU) → Feb 2026 → Sep 2026 → Avel/HVNs → 10 CAH go-lives; SOPs.
- RPM cohort launch → Mar 2026 → Dec 2026 → BioIntelliSense/FQHCs → 2,500 pts; adherence ops.
- Retail/community screening → Mar 2026 → Dec 2026 → Walgreens/CVS/FQHCs → BP/diabetes events; referrals.
- Behavioral crisis/988 integration → Apr 2026 → Dec 2026 → Avel/State BH → Tele-behavioral SOPs; handoffs.
- Evaluation/metrics v1 → Apr 2026 → Jun 2026 → PMO/Evaluator → Baselines; Q1 report.
- Value/pathway design with MCOs → Jan 2026 → Sep 2026 → Medicaid/Integrators → Draft incentives/shared-savings.
- Year-2 scaling plan → Aug 2026 → Nov 2026 → State/PMO → Continuation application packet.

Procurement/legal: Use state contracting to onboard clinical/tech vendors; ensure federal terms flow-down and 2 CFR Part 200 compliance; no supplanting and program-specific spending limits (verify exact caps in NOFO). (cms.gov)

10. Risk Register (selected)

Risk → Likelihood/Impact → Mitigation → Owner

- Broadband gaps delay tele-care go-lives → M/H → Coordinate with OSIT routes; redundant connectivity; staged sites. → OSIT/PMO. (gov.nv.gov)
- Rural staffing constraints → H/H → Tele-mentoring; ambient tools; incentive alignment with MCOs. → HVNs/PMO.
- Data-sharing hesitancy → M/H → Standard DUAs; FHIR APIs; role-based access; Part 2 workflows. → PMO/Legal.
- Cyber threats → M/H → Security hardening; 24/7 monitoring; tabletop exercises. → State CIO/Providers.
- Device non-adherence (RPM) → M/M → Device navigators; engagement nudges; retail pickup options. → FQHCs/Vendors.

- Sustainability beyond RHT → M/H → Value-based contracts; shared-savings pilots; hospital global-budget exploration. → Medicaid/PMO.
- Policy timing for compacts/scope → M/M → Use "conditional points" approach; contingency glide paths. → State/Legis.
- Reporting burden → M/M → Centralized PMO and dashboards; automate extracts. → PMO.
- Community trust/adoption → M/M → Local champions/retail partners; culturally competent materials. → HVNs/FQHCs.
- Procurement timeline slippage → M/M → Pre-negotiated templates; phased awards; strict milestones. → State/PMO.

11. Draft RFP Response Language (Nevada-ready, paste-able)

11.1 Rural health needs and target population (excerpt)

Nevada's rural and frontier communities represent approximately 5.9% of the state's population by the 2020 Census definition, yet span large geographies with extended time/distance to specialty care. The Nevada State Office of Rural Health reports 13 CAHs serving nearly 300,000 rural/frontier residents and an average distance of 118 miles from many rural hospitals to the next level of care, underscoring access and transfer challenges. (ncsl.org)

11.2 Goals and strategies (excerpt)

The State will reduce avoidable transfers and emergency utilization, increase chronic disease control, strengthen behavioral health crisis response, and protect rural facility viability. Strategies include: (1) regional "virtual hospital" support for CAHs/REHs; (2) statewide chronic disease RPM; (3) tele-behavioral health crisis integration with 988 and 1115 SUD demonstration; (4) cybersecurity and interoperable analytics infrastructure; and (5) formation of provider-owned High-Value Networks for shared services and accountable investment.

11.3 Proposed initiatives (abbrev. examples)

- Initiative 1: Rural Virtual Hospital. Use-of-funds: innovative care, right-sizing, partnerships. Outcomes: transfer interval ↓20%, tele-ER response <5 min, ICU consults within 15 min at 10 CAHs by Q4-2026.
- Initiative 2: Statewide RPM for CKD/CVD/COPD/Diabetes. Use-of-funds: prevention, consumer tech, workforce. Outcomes: CHF readmissions ↓10%, hypertension control ↑10 pp at participating FQHCs by Q4-2026.
- Initiative 3: Behavioral Crisis & 988 Integration. Use-of-funds: behavioral health, IT/cyber. Outcomes: BH ED boarding hours ↓15%; 24/7 tele-psychiatry coverage for ≥8 rural facilities by Q4-2026; align with 1115 metrics. (medicaid.gov)

11.4 Implementation plan & timeline (abbrev.)

See Section 9 workplan. The State PMO (with integrator support) will manage milestones, reporting, and risk, with monthly governance meetings and quarterly performance reviews with CMS.

11.5 Stakeholder engagement

HVNs convene CAHs, FQHCs, rural clinics, EMS, retail partners, and payers with community input. The State will conduct Tribal consultation and include representatives on regional governance where appropriate.

11.6 Metrics & evaluation

Core measures address access (response/transfer times), quality (chronic disease control, readmissions), behavioral health (crisis response/boarding), workforce (vacancy/turnover), financial (avoidable transfers), cyber posture, and program implementation (on-time/within-budget).

12. References

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13. Nevada Interstate Medical Licensure Compact (NRS 629A), Nevada Legislature; ASLP-IC enactment (2025 Statutes of Nevada); reporting on Nurse Licensure Compact status (2025), accessed 2025-10-14. (leg.state.nv.us)
14. Rural Health Transformation Collaborative — Consensus Catalog (uploaded, R1, dated 10-11-25), internal reference; capabilities cited throughout (tele-specialty, RPM, consumer triage, cybersecurity/data, HVNs, integrators).

13. AI Generation Notice

This guide was generated with the gpt-5 model on 2025-10-14. The content is AI-generated. All facts, figures, program terms, and citations—especially NOFO-specific scoring weights and caps—must be independently validated against the final CMS RHT NOFO and current State/Federal policy before use or submission.