Rural Health Transformation Grant Guide — Missouri

VERSION: 1.0

DATE: 2025-10-14

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Missouri has the infrastructure and partners to mount a competitive, high-impact Rural Health Transformation (RHT) Program application by November 5, 2025, and to translate awards into measurable rural access, outcomes, and sustainability gains starting in FY2026. CMS will award cooperative agreements by December 31, 2025; half of available funds are distributed equally across approved states, with the other half allocated by CMS using rurality and related factors described in the NOFO and program site. (cms.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Missouri's priorities across prevention and chronic disease, tele-enabled care, workforce, data/cybersecurity, value-based payment, and regional partnerships. Its members include technology platforms (e.g., Microsoft cloud and cybersecurity, FDA-cleared AI), national and regional telehealth providers (e.g., Avel eCare's tele-hospital services), consumer screening and remote monitoring (e.g., BioIntelliSense BioButton), digital advisors and system integrators (Accenture, KPMG, PwC, AVIA), retail health partners, and provider networks (Cibolo's High Value Networks). These assets map to RHT allowable uses and technical factors and are already operating at scale nationally.

Missouri's rural system needs and policy context align with the Collaborative's offerings. The state has 35 Critical Access Hospitals (CAHs), 316 Rural Health Clinics (RHCs), and 27 HRSA-funded health center organizations that served 661,041 patients in 2024—anchor sites for tele-enabled chronic care, maternal/behavioral integration, and local workforce development. Missouri also reports extensive Health Professional Shortage Areas (HPSAs) and maternal mortality challenges, while experiencing a significant decline in overdose deaths in 2023—trends that targeted RHT initiatives can address and accelerate. (health.mo.gov)

The guide summarizes RHT requirements and compliance checkpoints, profiles Missouri's current state with 2024–2025 data, and outlines policy-aware, evidence-linked program options. It remains explicitly conditional on contracting, data exchange agreements, state approvals, and CMS concurrence.

One-page printable summary (for circulation)

- What RHT funds can support in Missouri (subject to NOFO limits): evidence-based prevention/chronic care; limited provider payments; consumer-facing technology; telehealth/RPM; cybersecurity and data infrastructure; workforce recruitment/retention; care right-sizing; behavioral health; value-based models; minor renovations/equipment; regional partnerships. (cms.gov)
- Timing and eligibility: Only states may apply; DC/territories are ineligible. Application due Nov 5, 2025; awards by Dec 31, 2025; funds flow FY2026–FY2030. Equal and workload-based distributions as defined by CMS. (cms.gov)
- Missouri needs: 35 CAHs; 316 RHCs; 27 FQHC awardees (661k patients, 2024); extensive HPSA designations; maternal health disparities; drug overdose deaths declined to 1,948 in 2023 (first significant decrease since 2015). (health.mo.gov)
- Collaborative capabilities that match RHT priorities:
    - Tele-hospital/tele-ER/tele-ICU, virtual pharmacy, behavioral crisis support (Avel eCare).
    - RPM and risk stratification (BioIntelliSense; Humetrix analytics).
    - Cybersecurity, data interoperability, TEFCA-aligned exchange (Microsoft; eClinicalWorks/PRISMA/QHIN).
    - Consumer-facing screening and AI triage; retail pharmacy activation (Higi/Topcon/Humetrix; CVS/Walgreens/Walmart).
    - Value-based payment advisory and program management (Accenture/KPMG/PwC; Cibolo HVNs).

2. Eligibility and RFP Fit

- Program goals (CMS): improve rural health access, outcomes, and sustainability; accelerate innovative models and tech; strengthen workforce; and enhance data/cybersecurity. (cms.gov)
- Eligible applicants: Only the 50 states; one application per state; CMS awards cooperative agreements; awards by 12/31/2025. (cms.gov)
- Key dates: NOFO posted mid-September 2025; application closes early November (CMS press identifies Nov 5, 2025); optional webinars held Sept 19 and 25, 2025. (cms.gov)

- Funds distribution: 50% equal share among approved states; 50% allocated by CMS using rural population, proportion of rural facilities, status of certain hospitals, and other NOFO-specified factors. (cms.gov)
- Allowable uses: States must support at least three categories spanning prevention/chronic disease, provider payments (limited), consumer-facing tech, training for advanced tech, workforce commitments (≥5 years), IT/cybersecurity, care right-sizing, behavioral health/SUD, innovative/value-based models, minor renovations/equipment, and regional partnerships. (cms.gov)
- Compliance checkpoints: prohibition on certain telecom/video surveillance equipment under 2 CFR 200.216; administrative and national policy requirements (FFATA/FSRS, etc.). (acf.gov)

RFP requirement-to-Collaborative capability mapping (illustrative)

- Data/cybersecurity uplift and interoperability → Microsoft cloud security hardening, identity, and data governance; integration to state HIE/HRSAs; analytics ops support. Evidence: Microsoft rural cybersecurity program supporting >700 rural hospitals; HIPAA/FHIR compliance.
- Tele-enabled hospital operations (tele-ER/ICU/hospitalist/pharmacy) → Avel eCare virtual hospital services with 24/7 specialist backup for rural facilities; Joint Commission–accredited model.
- Consumer screening/RPM → BioIntelliSense continuous monitoring; Humetrix multilingual triage/PHR and analytics; Topcon autonomous DR screening; retail placement.
- Value-based models and network governance → Cibolo rural High Value Networks; payer-aligned contracts; program management and economics (Accenture/KPMG/PwC).

Note: Where the NOFO specifies detailed scoring weights (e.g., technical factors), Missouri should confirm section/page references against the final PDF in Grants.gov; this guide cites the CMS program page and national notices for schedule, eligibility, and use-of-funds structure. (cms.gov)

3. Missouri Context Snapshot

Key metrics and matching capabilities

- Rural footprint (2025): 35 CAHs statewide; 67 of 161 licensed hospitals located in rural counties (31 CAHs rural; 4 CAHs in non-rural counties). Fit: tele-hospital, RPM, network governance, cyber uplift. (health.mo.gov)
- Primary care and safety-net: 316 RHCs; 27 HRSA-funded health center awardees served 661,041 patients in 2024. Fit: clinic-level RPM/tele-consults; pharmacy-linked hypertension/diabetes programs; analytics to close care gaps. (ruralhealthinfo.org)
- HPSA and workforce: HRSA dashboards show extensive primary care, dental, and mental health HPSAs; third-party summaries of HRSA data indicate 336 primary care HPSAs and 321 dental HPSAs (Mar 31, 2025). Fit: tele-specialty backstops, pharmacist-led chronic care, licensure compact tooling, recruitment pipelines. (data.hrsa.gov)
- Maternal health (2018–2022): average ~70 pregnancy-associated deaths/year; PRMR 32.3 per 100,000; 80% preventable; leading causes mental health (incl. SUD) and cardiovascular disease. Fit: perinatal RPM, tele-psychiatry, community pharmacy BP programs, referral analytics. (health.mo.gov)
- Substance use/overdose: statewide overdose deaths declined from 2,180 (2022) to 1,948 (2023); >73% opioid-involved. Fit: naloxone engagement via retail/CHC channels, SUD analytics, virtual BH, IMD coverage via SUD/SMI 1115. (health.mo.gov)
- Broadband readiness: Missouri BEAD Initial Proposal approved; Round 1 targeted 192k+ locations (~90% of eligible) and final proposal posted Sept 19, 2025; >200k un/underserved locations identified for investment. Fit: telehealth site enablement, RPM connectivity, secure data transport. (ded.mo.gov)
- Medicaid context: MO HealthNet managed care is statewide for most populations via Healthy Blue, UnitedHealthcare, and Home State Health; SUD/SMI 1115 demonstration (approved 12/6/2023) expands residential SUD and IMD acute inpatient coverage through 2028. Fit: value-based contracts, behavioral integration, prior auth streamlining. (oembed-mydss.mo.gov)
- Telehealth policy (2025): Medicaid reimburses live video, some store-and-forward/teledentistry, RPM for specified conditions; private payer service parity (not universal payment parity). Fit: RPM programs coded to state rules; interprofessional consult workflows. (cchpca.org)
- Certificate of Need (CON): Missouri maintains an active CON process via the Health Facilities Review Committee (rules amended Nov 30, 2024). Fit: capital projects sized to demand; minor renovations/equipment under NOFO limits. (health.mo.gov)

Table—Selected Missouri metrics (latest) and matching capabilities

- CAHs: 35 (MO DHSS, 2025). Capability: Avel tele-hospital support; BioIntelliSense inpatient→home RPM; Microsoft cyber hardening. (health.mo.gov)
- RHCs: 316 (RHIhub, updated 9/11/2025). Capability: pharmacist-enabled chronic care; Humetrix multilingual triage; value tracking. (ruralhealthinfo.org)
- FQHC awardees: 27; 661,041 patients (UDS 2024). Capability: care-gap analytics; TEFCA/QHIN exchange; ambient AI documentation. (data.hrsa.gov)
- Overdose deaths: 1,948 (2023) (DHSS). Capability: virtual BH; naloxone distribution analytics; SUD 1115 alignment. (health.mo.gov)
- Maternal PRMR: 32.3 (2018–2022) (DHSS PAMR). Capability: perinatal RPM; home BP; tele-psychiatry. (health.mo.gov)
- Broadband: BEAD final proposal posted 9/19/2025; >200k eligible locations. Capability: telehealth/RPM footprint expansion; device procurement with 2 CFR 200.216 compliance. (ded.mo.gov)

4. Strategy Aligned to RFP

Missouri can position a statewide Rural Care Connectivity and Outcomes Model built on three reinforcing layers:

- Connected rural facilities: deploy 24/7 tele-ER/ICU/hospitalist, tele-pharmacy, and BH crisis services across CAHs and rural PPS hospitals; stand up perinatal and stroke escalation pathways; integrate community paramedicine. Evidence and fit: Avel eCare's virtual hospital model; Viz.ai stroke AI alerts in 400+ rural hospitals.
- Community-anchored chronic and maternal care: equip FQHCs/RHCs/retail sites with screening, multilingual triage, and RPM for hypertension, diabetes, COPD, CHF, and perinatal risk; use pharmacist-enabled management and referral to tele-specialists; drive closing of care gaps via analytics.
- Data, cybersecurity, and payment: consolidate claims/EHR/RPM feeds into a secure, HIPAA/FHIR-aligned lakehouse; harden identity, endpoint, and backup; model ROI and value-based incentives; use High Value Networks for local governance and payer contracting.

Equity strategy: prioritize micropolitan/rural-minority communities with higher PRMR and HPSA scores; deploy multilingual tools and community pharmacy access points; use dashboards to stratify outcomes by geography, race/ethnicity, payer, and SDOH. (health.mo.gov)

Privacy/security: follow 2 CFR 200.216/200.471 and HIPAA; exclude covered telecom/video surveillance vendors from any procurement; implement zero-trust controls and continuous monitoring. (acf.gov)

5. Program Design Options

Option A. Rural High Value Network (HVN) + Tele-Hospital Backbone (primary)

- Target population: patients served by Missouri CAHs and rural PPS hospitals in high-HPSA counties; initial cohort ~20–25 hospitals. (commentary.healthguideusa.org)
- Problem: staffing shortages, off-hour coverage gaps, transfer leakage. Evidence: high HPSA counts; CAH footprint. (commentary.healthguideusa.org)
- Solution set: HVN governance (Cibolo); Avel tele-ER/ICU/hospitalist; Viz.ai stroke/aneurysm AI; shared virtual pharmacy; RPM for high-risk discharges; payer engagement for global or episodic guarantees (subject to actuarial work).
- Payment logic: shared-savings or global budgets at network level with quality/transfer/readmission metrics; Medicaid SPA/amendments for tele-hospital and RPM coverage as needed. (Collaborative supports actuarial and SPA drafting.)
- Pros/risks: rapid coverage lift; measurable ED boarding/transfer reductions; risk—staff adoption and contracting timeline; mitigation—embedded change management and monthly governance.

Option B. Maternal and Behavioral Health Integration via CHCs/RHCs + Retail Health

- Target: rural birthing people and postpartum up to 12 months; rural adults with SUD/BH needs. Missouri PAMR shows 80% preventability and leading mental health/cardiovascular causes; SUD/SMI 1115 expands benefit flexibility. (health.mo.gov)

- Solution set: perinatal RPM (BP/weight/tele-coaching); virtual psychiatry; pharmacy BP checks and MAT navigation; multilingual triage and home safety planning; warm handoffs to CHCs.
- Payment logic: per-episode maternal bundles with RPM add-on; Medicaid behavioral integration codes; managed care pay-for-performance. (oembed-mydss.mo.gov)
- Pros/risks: strong alignment to PRMR drivers; risk—digital divide; mitigation—BEAD-enabled connectivity plus loaner devices. (ded.mo.gov)

Option C. Hypertension/Diabetes at Scale (Clinic + Pharmacy + Home)

- Target: adults with uncontrolled HTN/DM in RHCs/FQHCs.
- Solution: consumer screening (kiosks/retail), pharmacist titration protocols, RPM with escalation to tele-cardiology/endocrinology; AI to surface non-adherent patients.
- Payment: primary care capitation with quality bonuses; Medicaid MCO P4P. (oembed-mydss.mo.gov)

Option D. Community Paramedicine + Tele-EMS

- Target: frequent ED users and post-discharge patients in frontier counties.
- Solution: Avel tele-EMS backup, remote monitoring kits, and risk-triggered visits; link to HVN hospitals for rapid escalation.

6. Governance and Collaborative Roles

- Structure: State lead agency (recipient) retains decision rights; MO HealthNet, DHSS, and stakeholder councils provide direction; HVN(s) act as regional stewards; Collaborative members operate under subawards/subcontracts with federal flow-downs.
- RACI (abbrev):
    - State lead: R/A for compliance, budgets, reporting.
    - MO HealthNet: A for Medicaid alignment and SPAs; C/I on value-based pilots.
    - Hospital association/CAHs: R for facility onboarding; C on network design.
    - FQHCs/RHCs: R for clinic workflows, RPM enrollment.
    - Payers: C for incentive alignment.
    - HIE/IT: R for interfaces, privacy/security compliance.
    - Collaborative: R for tele-services, analytics, cybersecurity, PMO, training; C for policy/legal.

7. Payment and Funding

- Funding paths consistent with NOFO and 2 CFR: no new construction; avoid duplication; adhere to telecom restrictions. (hcpf.colorado.gov)
- Medicaid alignment: use existing telehealth/RPM coverage; consider SPA for enhanced RPM/tele-hospital codes; align managed care P4P with outcome dashboards; leverage SUD/SMI 1115 authorities. (cchpca.org)

Illustrative budget categories and deliverables (subject to NOFO caps)

- Tele-hospital services (contracts, licensing, 24/7 coverage); deliverables: activation at X hospitals; quality/reporting feeds.
- RPM kits and services; deliverables: Y patients enrolled with 90-day adherence tracking.
- Data/cybersecurity uplift; deliverables: zero-trust baseline, incident response plan, backup/restore tests.
- Training/workforce; deliverables: clinician onboarding, tele-readiness, preceptor/tele-consult schedules.
- Minor equipment/renovations; deliverables: tele-rooms, peripherals. All procurements to comply with 2 CFR 200.216 and related guidance. (acf.gov)

8. Data, Measurement, and Evaluation

- Core measures: access (tele-response times, transfer rates), quality (HTN control, A1c, perinatal BP control, 7-/30-day

follow-ups), utilization (ED revisits, admissions), financial (avoidance, net cost), workforce (vacancy/retention), tech (uptime, cyber incidents).

- Data sources: MO HealthNet claims; CHC UDS; hospital EHRs; EMS; HIE; RPM platforms; pharmacy systems; overdose dashboards; PAMR dashboards. (data.hrsa.gov)
- Evaluation: pre/post and matched-cohort designs; Collaborative analytics teams support dashboards, ROI modeling, and CMS reporting.

9. Implementation Plan (12–24 months; Gantt-style)

Workstream | Start | End | Owner | Outputs —|—|—|—|— Program mobilization & governance | Jan 2026 | Mar 2026 | State + PMO | Charter; roles; reporting calendar Security & data readiness | Jan 2026 | Jun 2026 | State IT + Microsoft/Cyber partner | Zero-trust baseline; data lakehouse; 2 CFR 200.216 attestation Tele-hospital pilots (5–8 sites) | Mar 2026 | Sep 2026 | HVN + Avel | 24/7 tele-ER/ICU in pilots; SOPs; metrics RPM maternal/HTN cohorts | Apr 2026 | Sep 2026 | CHCs/RHCs + RPM vendor | 1,500 enrollees; adherence ≥70% Retail screening roll-out | May 2026 | Nov 2026 | Retail + CHCs | 50 sites; referral conversion rates Scale-up (Phase 2 hospitals/clinics) | Oct 2026 | Sep 2027 | HVN + providers | 20 hospitals; 100 clinics online Value-based pilot contracting | Jan 2026 | Sep 2026 | MO HealthNet + MCOs + HVN | P4P measures; shared-savings model External evaluation & mid-course corrections | Jul 2026 | Nov 2026 | State + evaluator | Interim report; plan update

Procurement/legal prerequisites (illustrative): master service agreements with tele-hospital and RPM vendors; BAAs and DPIAs; data-sharing with HIE; subaward T&Cs with 2 CFR flow-downs; telecom/video-surveillance compliance. (acf.gov)

10. Risk Register (selected)

Risk | Likelihood/Impact | Mitigation | Owner —|—|—|— Data/cyber incident | Med/High | Zero-trust, MFA, backup, tabletop drills | State CIO + Microsoft/Audit partner Workforce adoption | Med/Med | Bedside change mgmt; tele-mentoring; ambient documentation | HVN + SI partners Broadband gaps | Med/Med | BEAD-aligned site selection; LTE/5G failover; device subsidies | State Broadband Office (ded.mo.gov) SUD demand fluctuation | Low/Med | Flexible virtual BH capacity; referral routing; naloxone distribution | DHSS + CHCs (health.mo.gov) Maternal RPM adherence | Med/Med | CHW support; pharmacy touchpoints; multilingual UX | CHCs + Retail Procurement delays | Med/Med | Pre-negotiated templates; parallel reviews | State PMO Policy misalignment | Low/High | SPA/contract addenda; legal review cadence | MO HealthNet CON timing | Low/Med | Plan minor renovations/equipment within thresholds; early engagement | DHSS CON (health.mo.gov) Telecom restricted vendors | Low/High | 2 CFR 200.216 screening in all procurements | State procurement (acf.gov) Evaluation/data quality | Med/Med | Common data model; validation routines | State + evaluator

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

Program purpose and alignment “Missouri proposes a statewide Rural Care Connectivity and Outcomes Model to improve rural access, outcomes, and sustainability through tele-enabled hospital services, community-anchored chronic and maternal care, and secure data/cyber infrastructure. The model advances CMS RHT strategic goals on access, workforce, innovative care, and technology, and will adhere to cooperative-agreement terms and federal administrative requirements, including 2 CFR 200.216.” (cms.gov)

Use of funds and allowable activities “Funds will support at least three allowable categories: (1) evidence-based prevention and chronic disease management with consumer-facing technology and RPM; (2) training and technical assistance for adoption of tele-ER/ICU and advanced analytics; and (3) significant information technology advances including cybersecurity and interoperability. Limited provider payments may be used consistent with NOFO limits.” (cms.gov)

Stakeholder engagement and governance “Missouri will convene rural hospitals/CAHs, FQHCs/RHCs, EMS, retail pharmacies, payers, and community groups under a state-led governance structure. High Value Networks will provide regional stewardship. Subrecipients and vendors will operate under contracts incorporating federal flow-downs.”

Data, privacy, and evaluation “Missouri will integrate Medicaid claims, HIE, EHR, RPM, EMS, and public health feeds into a secure, HIPAA/FHIR-aligned platform with independent evaluation. All procurements will meet 2 CFR 200.216 restrictions on covered telecommunications/video surveillance equipment.” (acf.gov)

Workforce and licensure compacts “The plan expands rural clinical capacity through tele-consultation, training, pharmacist-enabled chronic care, and licensure compact participation, paired with technology that reduces administrative

burden." (cchpca.org)

12. References

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13. Assumptions and Open Questions

- The final CMS-RHT-26-001 NOFO PDF (sections/pages) could not be retrieved directly from Grants.gov in this environment; schedule/eligibility/uses are cited from CMS's program page and federal/association notices. Missouri should confirm detailed scoring weights, category caps (e.g., provider payment and capital caps), and form-level instructions (e.g., SF-424 item 19c) against the final posted NOFO. (cms.gov)
- Facility- and county-level implementation depends on willing providers, broadband buildout schedules, data-sharing agreements, and procurement timelines; sequence and coverage are conditional on contracting and integration with state systems.

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