Rural Health Transformation Grant Guide — Kansas

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Kansas can leverage the CMS Rural Health Transformation (RHT) Program to stabilize rural access, modernize care, and improve outcomes, while staying within the program's strict funding rules. The RHT NOFO (CMS-RHT-26-001) makes all 50 states eligible, with a single cooperative agreement award per state, applications due November 5, 2025, and awards on December 31, 2025. Half of funding is distributed equally among awardee states and half is points-based using rural facility/population and technical factors; administrative spend is capped at 10% and certain categories (e.g., provider payments and capital) have explicit percentage limits. Executive Order 12372 does not apply; states must check "No" on SF-424 Box 19c. (files.simpler.grants.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Kansas with proven, compliant capabilities: 24/7 virtual hospital support (tele-ER/ICU, hospitalist, pharmacy), remote patient monitoring (RPM) for chronic disease, consumer screening and engagement, workforce upskilling and documentation relief via ambient AI, and program design/integration support. These map directly to RHT uses of funds (A–K) and technical scoring factors.

For Kansas, the highest-leverage near-term fit is a statewide rural network model that: (1) strengthens hospital and EMS readiness via a virtual command center; (2) expands primary and behavioral care through telehealth and retail-pharmacy partnerships in frontier and maternity-care-desert counties; (3) operationalizes RPM for cardiometabolic risk; and (4) stands up a Kansas rural provider "High Value Network" governance layer to coordinate investments, contracting, and measurement. These can be integrated with KONZA Health (a designated TEFCA QHIN) for statewide exchange, reporting, and evaluation. (globenewswire.com)

Funding and compliance considerations are manageable: provider payments ≤15% of the annual award; capital and infrastructure ≤20%; EMR replacement ≤5% if a HITECH-certified system existed as of September 1, 2025; "rural tech catalyst"-like initiatives ≤ the lesser of 10% or $20M per period; total administration (including indirects) ≤10%. Conditional technical-factor points for policy changes must be finalized by Dec 31, 2027 (Dec 31, 2028 for specified factors) to avoid point drops and potential CMS recovery. (files.simpler.grants.gov) (files.simpler.grants.gov) (files.simpler.grants.gov)

1.1 One-page printable summary (capability alignment, Kansas-specific)

- RHT fit and deadlines
    - Eligible applicant: State of Kansas (one application; Governor-designated lead). LOI optional by Sep 30, 2025; application due Nov 5, 2025; award/start Dec 31, 2025. Check "No" on SF-424 Box 19c. (files.simpler.grants.gov)
- Funding rules to observe
    - 50% equal/baseline; 50% points-based; admin ≤10%; provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% (if HITECH system pre-9/1/2025); tech catalyst ≤10% or $20M. (files.simpler.grants.gov)
- Kansas needs snapshot (latest available)
    - Nonmetro population share: 29.5% (ACS 2023). Facilities: 82 CAHs, 3 REHs, 182 RHCs, 63 rural FQHC sites (2025). Maternity-care deserts: 45.7% of counties (2023 profile). TEFCA: KONZA designated QHIN (Dec 12, 2023). (ruralhealthinfo.org) (marchofdimes.org) (globenewswire.com)
- High-leverage, compliant initiatives Kansas can consider (subject to contracting/integration)
    - Virtual hospital/ER-ICU + EMS tele-support statewide (Avel eCare).
    - RPM for cardiometabolic risk (BioIntelliSense BioButton; analytics to triage exceptions).
    - Retail-pharmacy access and screening (CVS Health, Walgreens, Walmart) with consumer tools (Higi/Topcon/Humetrix).
    - Ambient AI and workflow support; program integration by Accenture/KPMG/PwC.
    - KONZA QHIN connectivity for reporting and evaluation. (khinonline.org)

2. Eligibility and RFP Fit

2.1 RHT Program requirements (selected)

- Eligibility/single awardee: Only the 50 states; Governor designates the lead; one official application per state; latest timely submission counts. (files.simpler.grants.gov)
- Key dates: LOI by Sep 30, 2025; app due Nov 5, 2025 11:59 p.m. ET; awards Dec 31, 2025. Webinars Sep 19 and Sep 25, 2025. (files.simpler.grants.gov)
- Distribution and scoring: 50% equal baseline; 50% workload points. Table 3 weights split between rural facility/population and technical factors (see Table 3). (files.simpler.grants.gov)
- Conditional state-policy points: credit in Year 1 for proposed changes; must be enacted by Dec 31, 2027 (Dec 31, 2028 for two specified factors) or points drop and funds tied to those points may be recovered. (files.simpler.grants.gov)
- Uses of funds (A–K) and caps: provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% (if pre-9/1/2025 HITECH-certified system exists); "rural tech catalyst" ≤10% or $20M. Telecom restrictions per 2 CFR 200.216; prohibited specified sex-trait modification procedures per 45 CFR 156.400. Admin cap ≤10% (incl. indirect). (files.simpler.grants.gov) (files.simpler.grants.gov)
- Application content/format: project narrative (≤60 pp), budget narrative (≤20 pp), governor's endorsement (≤4 pp), business assessment (≤12 pp), program-duplication assessment (≤5 pp). Required forms: SF-424, SF-424A, SF-LLL, Project/Performance Site; SF-424 Box 19c "No" (E.O. 12372 not applicable). Submit via Grants.gov. Maintain SAM.gov/UEI. (files.simpler.grants.gov)

2.2 Requirement → Collaborative capability → Evidence (examples)

- Round-the-clock specialty backup for CAHs/REHs (Use-of-funds A, F, G; Tech factors C.1, C.2): Avel eCare virtual hospital services (tele-ER, ICU, pharmacy, hospitalist). Evidence: Collaborative catalog.
- RPM and analytics for chronic disease (A, C, F; Tech factors B.1, F.1–F.3): BioIntelliSense BioButton with exception-based triage; consumer tools (Humetrix, Higi/Topcon). Evidence: Collaborative catalog; FDA clearances (Viz.ai for adjunct analytics; BioIntelliSense resources). (viz.ai)
- Workforce support (D; Tech factors D.1–D.3): Ambient AI/documentation relief; training programs. Evidence: Collaborative catalog.
- Data exchange & privacy/security (F; Tech factors F.1–F.3): Integration with KONZA QHIN; HIPAA/FHIR-aligned platforms. Evidence: KONZA QHIN designation; Collaborative catalog. (globenewswire.com)
- Governance and program management (K; Tech factor C.1): High Value Network convening (Cibolo Health); PMO support (Accenture/KPMG/PwC). Evidence: Collaborative catalog.

3. Kansas Context Snapshot

3.1 Demography, facilities, access

- Nonmetro population: 29.5% (ACS 2023 5-year). Facilities (rural areas): 82 CAHs; 3 REHs; 182 RHCs; 63 FQHC rural sites (HRSA datasets as summarized by RHIhub; July–Sep 2025). (ruralhealthinfo.org)
- Broadband: ~96,860 Kansas broadband-serviceable locations were unserved/underserved as of Dec 2023; 133,746 Kansas households enrolled in ACP by Mar 2024 (26% of eligible). Implication: prioritize hybrid in-clinic/retail hubs and cellular RPM where fixed broadband gaps persist. (kansascommerce.gov)
- Maternity care: 45.7% of Kansas counties are maternity-care deserts; 8.4% of women had no birthing hospital within 30 minutes (2023 state profile). (marchofdimes.org)

3.2 Workforce and coverage

- HPSA context: HRSA quarterly summaries indicate substantial primary care and mental health shortfalls across Great Plains states; Kansas shows hundreds of HPSA designations with >100 additional primary-care providers needed to eliminate shortfall (3/31/2025 regional rollups). (commentary.healthguideusa.org) (commentary.healthguideusa.org)
- Licensure compacts (technical factor D.2): Kansas participates in the Interstate Medical Licensure Compact and Nurse Licensure Compact; joined the PA Licensure Compact in 2025; participates in PSYPACT. These facilitate cross-border

telehealth staffing. (ksbha.ks.gov) (ksbn.kansas.gov) (aapa.org) (psypact.gov)

- APRN scope (technical factor D.3): APRNs gained full practice authority in 2022 (HB 2279; regs effective 2022), expanding rural capacity. (content.govdelivery.com)
- Medicaid program: KanCare operates via three MCOs (Healthy Blue, Sunflower Health Plan, UnitedHealthcare) under renewed 2025–2027 contracts; Kansas's 1115 "KanCare" demonstration is approved through Dec 31, 2028. (kancare.ks.gov) (medicaid.gov)
- SNAP waivers (technical factor B.3): ABAWD waiver rules and discretionary exemptions published by USDA FNS for FY2025; states may request geographic waivers; federal policy changes since 2024 restrict STLDI and adjust SNAP work-requirements timing. (fns-prod.azureedge.us) (fns.usda.gov)

3.3 Financial stability and closures

- Rural hospital stress: Kansas has among the highest shares of at-risk rural hospitals; Herington Hospital closed in Oct 2023. These trends heighten the value of virtual hospital support, right-sizing, and alternative payment models. (wibw.com) (kwch.com)

3.4 Selected Kansas metrics mapped to capabilities

- Metric (year): Nonmetro share 29.5% (2023) → Capability: multi-modal access (retail sites, telehealth, RPM) and KONZA-enabled data flow. (ruralhealthinfo.org)
- Metric: 82 CAHs, 3 REHs (2025) → Capability: tele-ER/ICU/hospitalist ladder with Avel eCare and statewide escalation protocols. (ruralhealthinfo.org)
- Metric: 45.7% maternity deserts (2023) → Capability: mobile clinics, tele-MFM consults, remote prenatal monitoring, retail-pharmacy BP/DM screening funnels. (marchofdimes.org)
- Metric: QHIN designation for KONZA (2023) → Capability: TEFCA-aligned exchange and statewide RHT reporting. (globenewswire.com)

4. Strategy Aligned to RFP

4.1 Model overview (subject to contracting and integration)

- Statewide "Virtual Rural Care Network" anchored by:
    - A tele-enabled hospital/EMS backbone (Avel eCare) for ER, ICU, hospitalist, pharmacy, behavioral crisis consults.
    - RPM and consumer engagement stack (BioIntelliSense BioButton; Higi/Topcon/Humetrix; payer integration) to reduce avoidable ED/hospital use.
    - Retail-pharmacy access nodes (CVS Health, Walgreens, Walmart) for screening, chronic care support, vaccinations in rural and frontier counties.
    - KONZA QHIN linkage to support reporting, evaluation, and ACO/APM analytics. (khinonline.org)

4.2 Alignment to RHT pillars and technical factors

- Access and outcomes (A, H, I): tele-ER/ICU and behavioral crisis support; chronic disease RPM; population screening; maternal tele-consults in desert counties.
- Workforce (D): ambient AI documentation relief; tele-mentoring; licensure compacts reduce cross-border friction. (ksbn.kansas.gov)
- Tech innovation (F): security-hardened platforms; FDA-cleared AI tools for triage (e.g., Viz.ai stroke/ICH modules). (viz.ai)
- Strategic partnerships (K/C.1): HVN formation for rural providers (Cibolo Health), aligned with payers and universities.

4.3 Equity strategy

- Focus on frontier counties and maternity-care deserts for screening and prenatal pathways; leverage mobile/retail access and multilingual intake/PHR tools (Humetrix) to address language and digital-literacy barriers.
- Use KONZA QHIN datasets, Medicaid claims, and CHC registries for disparity stratification and targeted interventions. (konza.org)

5. Program Design Options (examples; modular; subject to policy and contracting)

Option A: Rural High Value Network (HVN) + Medicaid aligned incentives

- Target: All Kansas CAHs/REHs and affiliated RHCs/FQHCs.
- Problem data: 82 CAHs; multiple facilities operating at negative margins; at-risk closures. (ruralhealthinfo.org) (wibw.com)
- Solution: Cibolo-enabled HVN for shared services, payer negotiation, care pathways; analytics and quality tracking; optional APM pilots with KanCare MCOs.
- Payment logic: Provider payments (≤15%) to catalyze care-gap services; data/IT and TA under categories D/F/K; potential Medicaid quality-withholds/shared-savings alignment (separate SPA/contracting). (files.simpler.grants.gov)
- Pros/risks: Pros—scale, governance; Risks—contracting complexity; Mitigation—phased onboarding, RACI clarity.

Option B: Statewide Virtual ER/ICU and EMS modernization

- Target: CAHs/REHs and rural EMS.
- Problem data: Long transports, staffing gaps; mortality risk in time-sensitive cases. (ruralhealthinfo.org)
- Solution: Avel eCare tele-ER/ICU and pharmacy; EMS tele-consult and documentation; remote triage/AI intake.
- Payment logic: Capital ≤20% for carts/ICU endpoints; TA/training under D/F; provider payments ≤15% for specified gap services. (files.simpler.grants.gov)
- Pros/risks: Pros—time-critical capabilities statewide; Risks—network reliability; Mitigation—cellular failover and store-and-forward workflows.

Option C: Maternal access network in deserts

- Target: High-risk counties lacking OB units.
- Problem data: 45.7% counties are maternity deserts; travel/time barriers. (marchofdimes.org)
- Solution: Retail-pharmacy screening (BP, DM), mobile clinics, tele-MFM; RPM in prenatal/postpartum; KONZA-enabled perinatal dashboard. (khinonline.org)
- Payment logic: Category A (prevention), F (tech), J (minor renovations), K (partnerships); MCO incentives for timely prenatal and postpartum visits. (files.simpler.grants.gov)

Option D: Chronic disease RPM and pharmacy-enabled management

- Target: Medicaid and duals with HTN/DM/HF in rural areas.
- Problem data: Chronic disease burden and access gaps; overdose trends improving but vigilance needed. (blogs.cdc.gov)
- Solution: BioButton RPM, pharmacist-supported titration and adherence programs, tele-primary care; ambient AI to reduce clinician burden.
- Payment logic: Provider payments ≤15% for gap-filling services; D/F investments for training and data. (files.simpler.grants.gov)

6. Governance and Collaborative Roles

6.1 Structure (illustrative)

- Lead agency (Governor-designated): KDHE (with DHCF/Medicaid, KDADS for BH/LTSS).
- Program Steering Group: KDHE, Medicaid MCOs (Healthy Blue, Sunflower, UHC), KHA, KRHA, FQHCs, KONZA, universities (KUMC), EMS Board, Tribal/IHS.

- Collaborative role: technical and clinical enablement; HVN formation; PMO support; data/evaluation support; workforce training (subject to state procurement).

6.2 RACI (selected deliverables)

- Program workplan and metrics: R—KDHE PMO; A—KDHE; C—MCOs/KONZA/Collaborative; I—KHA/FQHCs/EMS.
- Virtual ER/ICU rollout: R—Avel eCare; A—Participating hospitals; C—EMS/KDHE; I—MCOs/KHA.
- RPM deployment: R—BioIntelliSense + providers; A—Participating systems; C—MCOs; I—KDHE.
- Retail screening network: R—CVS/Walgreens/Walmart; A—Local sites; C—FQHCs; I—KDHE/KONZA.
- Data integration/reporting: R—KONZA; A—KDHE; C—Collaborative; I—MCOs/providers. (khinonline.org)

7. Payment and Funding

- RHT distribution: 50% equal/baseline; 50% points-based across rural and technical factors (Table 3). (files.simpler.grants.gov)
- Funding caps to observe: provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% (pre-9/1/2025 HITECH systems); tech catalyst ≤10% or $20M; admin (incl. indirects) ≤10%. (files.simpler.grants.gov) (files.simpler.grants.gov)

Indicative budget mapping (planning placeholder ~$200M/year; subject to CMS award and Kansas allocations)

- Virtual ER/ICU/EMS stack (A, F, G): ~25–35%; deliverables: 24/7 coverage, equipment, EMS tele-consult.
- Chronic disease RPM (A, C, F): ~15–20%; deliverables: devices, dashboards, navigator training.
- Retail & mobile access (A, C, K): ~10–15%; deliverables: screening stations, referral pathways.
- Data, cybersecurity, and analytics (F): ~10–15%; deliverables: TEFCA connectivity, dashboards, evaluations. (khinonline.org)
- Provider payments (B): ≤15% aggregate. (files.simpler.grants.gov)
- Capital/renovations (J): ≤20% aggregate. (files.simpler.grants.gov)
- Admin/PMO (≤10% total, incl. indirect): program office, subrecipient monitoring, audit readiness. (files.simpler.grants.gov)

Medicaid alignment opportunities (separate authorities)

- Value-based incentives for rural network performance via MCO contracts; targeted SPA for chronic-care management or telehealth service definitions; leverage 1115 authorities for care transformation pilots. (medicaid.gov) (kancare.ks.gov)

8. Data, Measurement, and Evaluation

- Core measures (examples): avoidable ED visits, unplanned admissions, 30-day readmissions, BP/A1c control, prenatal and postpartum visit rates, EMS response/transfer times, total cost of care for target cohorts, RPM adherence, tele-consult turnaround, SUD/MH engagement.
- Data sources: KONZA QHIN clinical exchange, Medicaid claims (MCO feeds), CHC EHRs, EMS ePCR, consumer apps/kiosks, RPM telemetry. (khinonline.org)
- Reporting cadence: quarterly dashboards; annual continuation submissions; FFATA/SAM/PMS/audit reporting per NOFO. (files.simpler.grants.gov)
- Evaluation: collaborative analytics partners support baseline/target setting and contribution analysis; use TEFCA exchange to track longitudinal outcomes statewide. (konza.org)

9. Implementation Plan (12–24 months; subject to procurement)

Gantt-style overview

- Workstream | Start | End | Owner | Outputs

- Program initiation & governance | Jan 2026 | Mar 2026 | KDHE PMO | Charter; RACI; risk & compliance plan. (files.simpler.grants.gov)
- KONZA data & reporting setup | Jan 2026 | Jun 2026 | KONZA/KDHE | Data use agreements; TEFCA onboarding; dashboards. (konza.org)
- Virtual ER/ICU/EMS pilot (Phase 1: 15–20 sites) | Mar 2026 | Sep 2026 | Avel eCare + hospitals | SLA; equipment install; go-live.
- RPM cohort launch (HTN/DM/HF) | Apr 2026 | Dec 2026 | BioIntelliSense + providers | 2,000–5,000 enrollees; navigator training.
- Retail screening network (10–20 counties) | May 2026 | Dec 2026 | CVS/Walgreens/Walmart + FQHCs | Screening sites; referral pathways.
- Maternal access bundle pilots | Jul 2026 | Jun 2027 | Providers + mobile partners | Tele-MFM, RPM prenatal, mobile clinics.
- HVN legal & operations stand-up | Feb 2026 | Oct 2026 | Cibolo Health + providers | Bylaws; shared-services portfolio; payer dialogues.
- Scale-up (Phase 2: +40–60 sites) | Oct 2026 | Sep 2027 | KDHE + partners | Coverage expansion; outcome targets.

10. Risk Register (top items)

- Procurement delays (Owner: KDHE PMO). Mitigation: cooperative purchasing, pre-negotiated master service terms.
- Broadband gaps (Owner: KDHE + KOBD). Mitigation: cellular-enabled RPM; retail hubs; BEAD coordination. (kansascommerce.gov)
- Workforce adoption/burnout (Owner: Providers). Mitigation: ambient AI, tele-mentoring, phased ramp.
- Data-sharing agreements lag (Owner: KDHE/KONZA). Mitigation: standardized DUAs; TEFCA participation. (konza.org)
- Policy timing risk for conditional points (Owner: KDHE/Legislature). Mitigation: legislative calendar alignment; interim administrative actions. (files.simpler.grants.gov)
- Provider payments cap breach (Owner: KDHE finance). Mitigation: category tracking; pre-award budget controls. (files.simpler.grants.gov)
- Capital cap breach (Owner: KDHE finance). Mitigation: cap ledger; stage equipment buys. (files.simpler.grants.gov)
- Privacy/cyber events (Owner: Vendors/KDHE). Mitigation: vendor attestations; zero-trust patterns; incident playbooks.
- MCO contract misalignment (Owner: KDHE-DHCF/MCOs). Mitigation: quality-withhold tie-ins; SPA if needed. (medicaid.gov)
- Sustainability post-FY31 (Owner: HVN/Providers/MCOs). Mitigation: APMs; network shared-services ROI tracking.

11. Draft RFP Response Language (paste-ready; adapt as needed)

11.1 Rural health needs and target population (excerpt)

"Kansas serves a nonmetro population of 29.5% (ACS 2023). Rural facilities include 82 Critical Access Hospitals, 3 Rural Emergency Hospitals, 182 Rural Health Clinics, and 63 rural FQHC sites (HRSA/RHIhub, 2025). Persistent access barriers include 45.7% of counties classified as maternity care deserts (March of Dimes 2023) and broadband gaps totaling ~96,860 un/underserved locations as of December 2023 (KOBD). These needs inform our proposed focus on emergency readiness, chronic disease control, maternal access, and data-driven care coordination." (ruralhealthinfo.org) (marchofdimes.org) (kansascommerce.gov)

11.2 Goals & strategies (excerpt)

"Kansas will establish a Virtual Rural Care Network to improve emergency readiness and chronic care outcomes through integrated tele-ER/ICU services, remote patient monitoring for cardiometabolic risk, and retail-pharmacy screening in rural and frontier areas. We will coordinate investments through a rural provider High Value Network, supported by a statewide QHIN-connected data backbone (KONZA). These strategies align with RHT uses of funds A, D, F, G, H, I, J, K and technical

factors C.1, C.2, F.1–F.3." (khinonline.org)

11.3 Uses of funds and caps (paste-ready)

"We will maintain total administrative costs ≤10% (includes indirect). Provider payments for items/services will be ≤15% of the total award per budget period. Capital and infrastructure (Category J) will be ≤20%; any EMR replacement will be ≤5% if a HITECH-certified system existed on or before Sept 1, 2025. Any 'rural tech catalyst' activity will be ≤ the lesser of 10% or $20M. We will avoid unallowable costs (e.g., lobbying); we will comply with 2 CFR 200.216 telecom restrictions and 45 CFR 156.400 prohibitions." (files.simpler.grants.gov) (files.simpler.grants.gov)

11.4 Implementation & timeline (paste-ready)

"Within 6 months, we will launch Phase 1 tele-ER/ICU in 15–20 rural facilities, enroll 2,000–5,000 high-risk patients in RPM, and activate retail-pharmacy screening lanes in 10–20 counties. By 12 months, we will expand to ≥40 facilities and integrate KONZA-enabled dashboards to report RHT metrics quarterly. By 18–24 months, we will complete Phase 2 facility onboarding, scale maternal access bundles in priority deserts, and document outcome deltas vs. baseline." (khinonline.org)

11.5 Compliance statements (paste-ready)

"Kansas confirms submission via Grants.gov, maintenance of SAM.gov/UEI, and that Executive Order 12372 does not apply; we will check 'No' on SF-424 Box 19c. We will cooperate with CMS evaluation, submit required financial and performance reports, and implement subrecipient monitoring consistent with 2 CFR 200." (files.simpler.grants.gov)

12. Checklists and Implementation Tables

12.1 Compliance checklist (extract)

- Eligibility: single state application; Governor endorsement letter attached. (files.simpler.grants.gov)
- Key dates met: LOI (optional) by Sep 30, 2025; application by Nov 5, 2025. (files.simpler.grants.gov)
- Forms: SF-424 (Box 19c "No"), SF-424A, SF-LLL, Project/Performance Site. (files.simpler.grants.gov)
- Admin ≤10%; provider payments ≤15%; capital ≤20%; EMR replacement ≤5%; catalyst ≤10% or $20M. (files.simpler.grants.gov)
- 2 CFR compliance (incl. 200.216 telecom), 45 CFR 156.400 prohibition. (files.simpler.grants.gov)

12.2 24-month Gantt (high-level; see Section 9 for details)

- Q1–Q2 2026: PMO set-up; KONZA agreements; pilot sites prepared; device procurement.
- Q3 2026: Phase-1 go-lives (tele-ER/ICU, RPM, retail screening).
- Q4 2026–Q2 2027: Scale-up; maternal bundle pilots; HVN operations.
- Q3 2027: Full reporting cycle; evaluation deliverables; Year-2 budget true-up.

13. Assumptions and Open Questions

- Assumption: The Kansas lead agency will confirm final initiative phasing and sites during contracting; this guide is non-prescriptive and capability-oriented.
- Open question: Final list of Kansas Certified Community Behavioral Health Clinics (as of Sep 1, 2025) to be compiled in the application annex per NOFO instructions. (files.simpler.grants.gov)
- Open question: Which RHT technical factors Kansas elects to claim as conditional policy changes for Year 1 scoring and their 2027/2028 enactment schedule. (files.simpler.grants.gov)

14. References

1. Rural Health Transformation Program – Notice of Funding Opportunity (CMS-RHT-26-001), Centers for Medicare & Medicaid Services, Simpler.Grants.gov (pdf), posted Sep 15, 2025. Accessed Oct 14, 2025. (files.simpler.grants.gov)
2. Rural Health Transformation (RHT) Program overview page, CMS. Accessed Oct 14, 2025. (cms.gov)
3. Rural Health Information Hub: Kansas – State Guide (facilities and nonmetro population), last updated Sep 11, 2025. Accessed Oct 14, 2025. (ruralhealthinfo.org)
4. Kansas Office of Broadband Development – Digital Opportunity Strategic Plan (2024). Accessed Oct 14, 2025. (kansascommerce.gov)
5. March of Dimes – Maternity Care Deserts: Kansas state profile (2023). Accessed Oct 14, 2025. (marchofdimes.org)
6. KanCare – Providers: MCOs (Healthy Blue, Sunflower, UHC). Accessed Oct 14, 2025. (kancare.ks.gov)
7. CMS Medicaid 1115 Demonstrations – KanCare (approval through 12/31/2028). Accessed Oct 14, 2025. (medicaid.gov)
8. KONZA Health – QHIN designation (Dec 12, 2023); The Sequoia Project press notice. Accessed Oct 14, 2025. (globenewswire.com)
9. CDC/NCHS – U.S. Overdose Deaths Decrease in 2023 (with Kansas ≥15% decline among states). Accessed Oct 14, 2025. (blogs.cdc.gov)
10. Kansas APRN independent practice (HB 2279; Governor news release and KMS/AANP summaries). Accessed Oct 14, 2025. (content.govdelivery.com)
11. Kansas Insurance Department – STLDI guidance (3-month initial term + one-month extension for policies issued on/after Sep 1, 2024). Accessed Oct 14, 2025. (insurance.kansas.gov)
12. USDA FNS – SNAP ABAWD Discretionary Exemptions FY2025; ABAWD Waivers (FY2025-2029). Accessed Oct 14, 2025. (fns-prod.azureedge.us) (fns.usda.gov)
13. Viz.ai FDA clearances (ICH/SDH quantification; AAA). Accessed Oct 14, 2025. (viz.ai) (viz.ai)
14. BioIntelliSense product resources (BioButton; NOFO kit notice). Accessed Oct 14, 2025. (biointellisense.com)
15. Rural Health Transformation Collaborative – Consensus Catalog (R1, dated 10-11-25). Internal partner document provided by user.

AI Generation Notice

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