title: Rural Health Transformation Grant Guide — West Virginia version: 1.0 date: 2025-10-14 audience: State health agencies, Medicaid, rural providers, collaboratives

1. Executive Summary West Virginia enters the CMS Rural Health Transformation (RHT) Program with structural strengths (extensive critical access hospital and health center presence; a functioning statewide HIE) and urgent needs (workforce shortages, behavioral health and substance use burdens, aging infrastructure). The Rural Health Transformation Collaborative (the Collaborative) can support a State-led plan that is compliant with the CMS-RHT-26-001 Notice of Funding Opportunity (NOFO) and oriented to measurable outcomes in access, quality, and sustainability. The NOFO provides up to $50B nationally over FY26–FY30 via cooperative agreements to States; awards are determined once, with annual funding determined by a baseline-allotment plus a points-based workload methodology and strict programmatic limits (e.g., provider payments ≤15% of a period's award; capital/infrastructure ≤20%; EMR replacement ≤5% under defined conditions; administrative expenses ≤10%). (files.simpler.grants.gov)

The Collaborative brings provider networks (independent rural hospitals, clinics, FQHCs), retail health access points, national telehealth resources, remote monitoring, AI/analytics, cybersecurity, and experienced systems integrators to accelerate safe adoption of technology-enabled care, care model redesign, and value-aligned payment pilots—mapped to the NOFO's allowable use categories and technical scoring factors. Examples include Avel eCare's virtual hospital and EMS support; BioIntelliSense's FDA-cleared continuous physiological monitoring and reporting; Viz.ai's AI-enabled stroke pathways; Microsoft's cloud/cyber platform; NACHC's training/TA; and Cibolo Health's rural provider High Value Network (HVN) construct.

Three near-term, high-leverage opportunities for West Virginia:

- State-facilitated rural HVNs with payer engagement to stabilize rural facilities and expand primary/behavioral capacity; enabled by analytics, WVHIN connectivity, and retail/community partners.
- Remote care-at-home for chronic disease and post-acute transitions using continuous monitoring plus regional tele-specialty backup, tied to hospital quality and avoidable utilization metrics.
- Consumer-facing prevention and behavioral health engagement across pharmacies, clinics, and community sites, integrated with multilingual triage and care navigation tools.

The plan is explicitly conditional on State direction, procurement, and data-sharing agreements; deliveries depend on integration with State policy choices, Medicaid alignment, and local provider governance.

One-page printable summary (next page)

— One-Page Summary —

- What CMS is offering: One award per State; $10B/year nationally FY26–FY30; awards determined by Dec 31, 2025; application due Nov 5, 2025; optional LOI by Sep 30, 2025. (files.simpler.grants.gov)
- Funding mechanics: 50% baseline + 50% points-based workload; workload formula uses Total Available Workload Funding × (State's total points ÷ sum of all approved States' points); rural facility/population factors fixed from Q4 2025; technical factors recalculated annually. (files.simpler.grants.gov)
- Caps and limits that drive design: Provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% if a HITECH-certified EMR is already in place (as of 9/1/2025); "rural tech catalyst" initiative ≤ the lesser of 10% or $20M per period; admin (incl. indirects) ≤10%. (files.simpler.grants.gov) (files.simpler.grants.gov)
- WV readiness signals: 21 CAHs; 66 RHCs; 309 FQHC sites in rural areas; statewide HIE (WVHIN) connecting hospitals and ambulatory providers; Medicaid enrollment ~30% of residents in 2024; specialized managed care (Mountain Health Promise) and mainstream MCO program (Mountain Health Trust). (ruralhealthinfo.org) (wvhin.org) (usafacts.org) (bms.wv.gov) (bms.wv.gov)
- WV priority needs and signals: large rural population share (54% in 2020); overdose mortality declining sharply in 2024–2025 (≥35% decrease) but still high need; workforce shortages (HPSA designations); broadband expansion plans to connect ~74,000 locations (BEAD proposal). (ncsl.org) (cdc.gov) (commentary.healthguideusa.org) (broadband.wv.gov)
- What the Collaborative can support (examples): statewide remote monitoring and tele-ICU/ER; pharmacy-enabled chronic care; AI documentation and risk identification; payer-aligned payment models; secure data platform and analytics; EMS/paramedicine enablement; workforce training and licensing-compact navigation; HVN governance and reporting.

2. Eligibility and RFP Fit 2.1 What CMS requires (selected elements; see NOFO)

- Eligible applicant: Only a U.S. State; DC and territories ineligible; Governor designates lead agency; one official application per State. (files.simpler.grants.gov)
- Key dates: LOI by Sep 30, 2025; application due Nov 5, 2025 11:59 p.m. ET; awards by Dec 31, 2025; earliest start Dec 31, 2025. (files.simpler.grants.gov)
- Submission and forms: Grants.gov; SF-424 (check "No" on Item 19c, EO 12372); SF-424A; Performance Site; SF-LLL; attachments include Governor's endorsement letter. (files.simpler.grants.gov)

(files.simpler.grants.gov)
- Funding and scoring: Five budget periods (FY26–FY30 funds); workload allocation weighted across factors A.1–A.7 and B–F (Table 3); initiative-based scoring matrix used to set potential points; data-driven metrics scored relative to peer States. (files.simpler.grants.gov)
- Limits: Admin ≤10% of period award; Provider payments ≤15%; Capital/Infrastructure ≤20%; EMR replacement ≤5% (if prior HITECH-certified EMR existed as of 9/1/2025); "Rural Tech Catalyst" ≤ the lesser of 10% or $20M. (files.simpler.grants.gov) (files.simpler.grants.gov)
- Prohibitions (selected): Construction/expansion as a direct cost; supplanting; purchase of covered telecom/video surveillance equipment (2 CFR 200.216); funding certain procedures defined at 45 CFR 156.400; salary cap per current HHS limits. (files.simpler.grants.gov)

2.2 Mapping NOFO requirements to Collaborative capabilities

- The table below is illustrative and conditional; it references representative offerings and evidence from the Collaborative document.

Requirement → Collaborative capability → Evidence

- "Use at least three approved uses of funds" → Remote care-at-home (F.1), consumer-facing screening and chronic disease tools (C), training/TA for technology (D) → Partner portfolio spanning telehealth (Avel eCare), RPM (BioIntelliSense), AI/analytics and patient engagement (Humetrix, Pangaea), and systems integration/training (Accenture, KPMG, PwC).
- "Data and interoperability" → HIPAA/FHIR-aligned cloud platform; TEFCA connectivity via QHINs; WVHIN integration approach → Microsoft secure cloud/cyber; eClinicalWorks/PRISMA/QHIN; WVHIN connection for statewide exchange. (wvhin.org)
- "Rural provider partnerships and EMS" → Rural HVNs with Cibolo Health; 24/7 tele-ER/ICU/back-up; EMS tele-support → Cibolo HVNs; Avel eCare EMS/ER services.
- "Workforce development and burnout reduction" → Ambient clinical AI, multilingual intake, tele-mentoring, pharmacist-top-of-license programs → Microsoft DAX/Dragon Copilot; Humetrix intake; Avel provider-to-provider telemedicine; retail pharmacy workforce pathways.
- "Payment and sustainability" → Claims data exchange, payment integrity, value-based design, actuarial modeling → Accenture claims/payment integrity tools and value-based program design.

3. West Virginia Context Snapshot 3.1 Population and geography

- Rural population share: 54% (2020 Census; among the highest nationwide). This supports emphasis on rural access, EMS coverage, and telehealth. (ncsl.org)
- Broadband: State BEAD final proposal aims to connect approximately 74,000 unserved/underserved locations (2025), positioning rural telehealth and RPM if local last-mile buildouts proceed. (broadband.wv.gov)

3.2 Rural facility mix and networks

- Facilities (rural): 21 Critical Access Hospitals (CAHs), 66 Rural Health Clinics (RHCs), and 309 FQHC sites in rural areas (as cataloged by RHIhub/HRSA data). These assets align to Collaborative telehealth, RPM, and pharmacy-based access models. (ruralhealthinfo.org)
- State HIE: WVHIN provides secure exchange and encounter notifications; WVU Medicine publicly notes participation and cross-border CRISP connectivity—important for stroke, transfers, and transitions. (wvhin.org) (wvumedicine.org)

3.3 Workforce shortage indicators

- Primary Care HPSAs: 121 West Virginia HPSAs; 748,303 residents in HPSAs; estimated shortfall 123 primary care practitioners (3/31/2025, HRSA-derived summary). These shortages reinforce licensure-compact strategies and tele-consult augmentation. (commentary.healthguideusa.org)
- Nursing/multistate licensure: West Virginia participates in the Nurse Licensure Compact (NLC), supporting multistate practice. (wvrnboard.wv.gov)
- Behavioral health HPSAs: 115 mental health HPSAs; 766,433 residents; estimated shortfall 89 practitioners (3/31/2025, HRSA-derived summary). (commentary.healthguideusa.org)

3.4 Medicaid and coverage environment

- Enrollment: ~534,800 (30.2% of population) covered by Medicaid in 2024; enrollment ~516,500 as of Apr 1, 2024 post-unwinding (State report). This scale pressures rural provider solvency and supports value-aligned reimbursements. (usafacts.org) (dhhr.wv.gov)
- Managed care: Mountain Health Trust (Aetna Better Health of WV, The Health Plan of WV, Highmark Health Options, Wellpoint WV) and specialized Mountain Health Promise (Aetna; foster/kin/adoptive youth). Integration of managed care care-management data with WVHIN and State dashboards can

enhance impact tracking. (bms.wv.gov) (bms.wv.gov)

3.5 Behavioral health, maternal health and overdose trends

- Overdose: CDC reports a ≥35% decline in West Virginia overdose deaths in 2024; State data indicated an 18.5% year-over-year decline for the 12 months ending June 2024 and a 36% Jan–May 2024 decline vs 2023, suggesting momentum to build on with monitoring, virtual BH, and pharmacy support. (cdc.gov) (dhhr.wv.gov)
- Maternal/child health: WV WIC is piloting in-hospital certification and postpartum breastfeeding support expansion, indicating system capacity for hospital-public health integration that can be paired with screening and RPM for perinatal risk. (dhhr.wv.gov)

3.6 Telehealth and licensure compacts

- Interstate medical licensure: West Virginia is a member of the Interstate Medical Licensure Compact; psychologist interjurisdictional practice via PSYPACT is enacted/effective (WV SB 668; effective 11/18/2021). EMS licensure compact is enacted in WV Code Ch.16, Art.60. These enable scale for rural tele-consults. (law.justia.com) (psypact.gov) (code.wvlegislature.gov)

3.7 Summary metric-to-capability table

- Rural population share (54%, 2020) → Prioritize remote care and local access points; Collaborative telehealth/RPM, retail health integration, and EMS support. (ncsl.org)
- CAHs 21 / RHCs 66 / rural FQHC sites 309 (2025) → Facility grid for RPM kits, AI documentation, transitions-of-care pathways. (ruralhealthinfo.org)
- Primary Care HPSA shortfall (123 clinicians; 3/31/2025) → Leverage NLC, AI documentation, tele-mentoring, pharmacist-led chronic care. (commentary.healthguideusa.org)
- WVHIN connectivity → Unified data layer with TEFCA/QHIN and secure cloud for dashboards and evaluation. (wvhin.org)

4. Strategy Aligned to RFP 4.1 Overall model for West Virginia

- A State-facilitated rural transformation anchored in regional HVNs, WVHIN-enabled data flows, and county-level prevention/monitoring nodes (clinics, pharmacies, EMS). The Collaborative can support a HIPAA/FHIR-aligned data platform, governance toolkits, outcome analytics, payment integrity, and TA to meet NOFO pillars and technical factors (B–F).

4.2 How solutions map to NOFO pillars and scoring

- Prevention and chronic disease (Use A; Factors B.1, F.3): Screening kiosks, multilingual triage, RPM, community pharmacy management programs; evidence includes partner deployments and AI-enabled gap closure.
- Sustainable access/partnerships (C.1–C.2): HVNs, tele-ER/ICU, EMS tele-support, and regional system partnerships.
- Workforce (D.1–D.3): AI scribing, tele-mentoring, pharmacist top-of-license pathways; licensure compacts utilized under State policy discretion. (wvrnboard.wv.gov)
- Payment and duals (E.1–E.2): Claims modernization, payment integrity, and value-based design; integration with MCO data feeds.
- Tech innovation/data (F.1–F.3): Secure cloud, cyber-hardening, TEFCA/QHIN exchange, consumer tools; aligns with NOFO's tech initiatives and limits. (files.simpler.grants.gov)

4.3 Equity approach

- Rural and frontier-proximate areas in WV (few if any counties meet <6 persons/mi²; confirm during application) will receive targeted screening and BH support using community channels (retail sites, CHCs) and language-accessible apps, with metrics disaggregated by county and HPSA status.

4.4 Data privacy and governance

- HIPAA/FHIR alignment with auditable access logs; WVHIN policies and opt-out model; State ownership of program data; federal rights for intangible property where applicable under 2 CFR 200.315. (bms.wv.gov) (files.simpler.grants.gov)

5. Program Design Options (WV-tuned; non-prescriptive) Option A. Rural chronic care and transitions network

- Target: Adults with CHF/COPD/diabetes recently discharged from rural/CAH settings; aim to reduce readmissions and ED revisits. WV's CAH footprint and WVHIN alerts enable targeting.

(ruralhealthinfo.org) (wvhin.org)
- Problem statement: High rural prevalence of chronic disease and travel burdens; workforce shortages limit frequent follow-up. HPSA data indicates significant primary care shortfall. (commentary.healthguideusa.org)
- Collaborative components: BioIntelliSense continuous monitoring; Avel virtual hospitalist/tele-ICU/ER backup; AI documentation; pharmacy-based blood pressure and A1c checks; WVHIN notifications for post-discharge outreach.
- Payment logic: Categorize under Use A and F; limited gap-filling service payments (≤15%); capital ≤20% for devices/telehealth rooms; admin ≤10%. (files.simpler.grants.gov) (files.simpler.grants.gov)
- Enabling policy: Scope-of-practice flex; licensure compacts; MCO care management alignment. (wvrnboard.wv.gov) (bms.wv.gov)
- Pros/risks: Pros—measurable utilization reductions; Risks—RPM adoption variance; require training and broadband buildouts. Mitigation: TA and device logistics; leverage BEAD build. (broadband.wv.gov)

Option B. State-supported Rural High Value Networks (HVNs)

- Target: Independent rural hospitals/clinics across WV regions; goal to stabilize access and coordinate investments.
- Problem: Fragmentation and limited negotiating scale hinder sustainability.
- Collaborative components: Cibolo HVN governance toolkit, shared services, value-aligned payer discussions; analytics and reporting; retail health as spoke access.
- Payment logic: Uses K (partnerships), F (data/cyber), I (innovative care), with admin ≤10%. (files.simpler.grants.gov)
- Pros/risks: Pros—coordinated spend and outcomes; Risks—provider alignment time; Mitigation—neutral convening and clear transparency rules.

Option C. Community paramedicine and EMS tele-support

- Target: Rural 9-1-1 “frequent utilizers,” post-overdose, and homebound chronically ill; integrate with ED diversion pathways.
- Problem: EMS staffing strain, long transports.
- Collaborative components: Avel EMS tele-support; multilingual intake; naloxone/BH linkage; remote monitoring kits; MCO medical management alignment.
- Policy: EMS compact provisions; data-sharing via WVHIN; consumer apps for triage. (code.wvlegislature.gov) (wvhin.org)
- Metrics: Non-transport treat-in-place, repeat 9-1-1, 30-day ED revisits.

Option D. Maternal and perinatal risk mitigation via community and retail access

- Target: Rural pregnant/postpartum persons; integrate WIC hospital certification pilot expansion with pharmacy screening. (dhhr.wv.gov)
- Components: BP/diabetes screening at pharmacies; multilingual triage; remote BP monitoring; obstetric tele-consults; perinatal safety bundles.
- Payment: Use A/C/D/F; device costs under capital cap; service payments within 15% cap. (files.simpler.grants.gov)

6. Governance and Collaborative Roles 6.1 Diagram (textual)

- State Lead Agency (Governor-designated): program owner; sets priorities; signs award; oversees subawards; approves data-sharing.
- WV Medicaid (BMS): payment alignment; data feeds; MCO oversight; evaluation co-lead.
- Hospital Association / SORH: provider engagement; CAH/RHC/EMS support; flex/SHIP coordination. (dhhr.wv.gov)
- WVHIN: interoperability services; encounter alerts; opt-out administration; TEFCA/QHIN integration. (wvhin.org)
- Collaborative members (examples):
  - Technology/cyber/cloud (Microsoft), AI/analytics (Pangaea), RPM (BioIntelliSense), telehealth (Avel), retail health (CVS, Walgreens, Walmart), systems integrators (Accenture, KPMG, PwC), HVN convener (Cibolo), NACHC (TA).

6.2 RACI (selected)

- Rural HVN formation: Responsible—Cibolo Health; Accountable—State lead; Consult—WVHA/SORH, WV Medicaid, payers; Informed—WVHIN.
- RPM roll-out: Responsible—BioIntelliSense/hospital sites; Accountable—State PMO; Consult—Avel eCare (tele-ICU/ER), WVHIN; Informed—BMS/MCOs.
- Pharmacy-enabled prevention: Responsible—retail health partners; Accountable—State PMO; Consult—NACHC/FQHCs; Informed—BMS/MCOs.

7. Payment and Funding 7.1 Alignment with NOFO limits

- Budget design demonstrates: admin ≤10% (incl. indirects), provider service payments ≤15%, capital/infrastructure ≤20%, EMR replacement ≤5% when applicable. (files.simpler.grants.gov) (files.simpler.grants.gov)

7.2 Medicaid integration opportunities

- Value-aligned add-ons or shared-savings constructs in managed care (MHT; MHP) with actuarial and program integrity support; analytics to identify high-value interventions for rural cohorts and dually eligible members. (bms.wv.gov) (bms.wv.gov)

7.3 Illustrative cost table (rough order of magnitude; subject to State budgeting)

- Categories:
  - Remote monitoring kits/services (Use A/F) → $XX–$XXXM/yr (devices, monitoring, dashboards).
  - Tele-specialty/virtual hospital services (Use F/I) → $XXM/yr (availability fees, staffing).
  - Consumer screening and engagement (Use C) → $X–$XXM/yr (kiosks, multilingual apps).
  - Data platform/cyber/TEFCA connectivity (Use F) → $X–$XXM/yr (cloud, security, interfaces).
  - Workforce training and tele-mentoring (Use D) → $X–$XXM/yr.
  - Limited provider payments (Use B) → ≤15% cap; gap-filling, non-duplicative services.
  - Capital/renovations (Use J) → ≤20% cap (e.g., telehealth rooms, network upgrades). (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation 8.1 Core measures and cadence

- Access/Utilization: avoidable ED visits; 30-day readmissions; time-to-tele-consult; EMS non-transport rates.
- Quality/Safety: stroke door-to-decision intervals with AI notification; chronic disease control rates (BP <140/90; A1c levels).
- Workforce: documentation time per visit (AI scribe), vacancy/turnover in rural sites.
- Financial: cost per beneficiary; operating margins for rural hospitals; payment integrity flags.
- Reporting: Quarterly dashboards; annual updates per NOFO; cooperation with CMS/third-party evaluations. (files.simpler.grants.gov)

8.2 Data sources and integrations

- Claims (BMS/MCOs), WVHIN HIE, EHRs, EMS run data, public health (ODCP/WIC), device feeds; governed under State agreements, HIPAA, and 2 CFR requirements on intangible property and program income. (wvhin.org) (files.simpler.grants.gov)

9. Implementation Plan 9.1 18-month Gantt (illustrative; calendar dates approximate)

- Workstream | Start | End | Owner | Outputs
- PMO and governance stand-up | Jan 2026 | Mar 2026 | State lead | Program charter, RACI, risk log.
- Data platform & cyber hardening | Jan 2026 | Jun 2026 | Tech partners | Cloud tenancy, security plan, HIE interfaces.
- HVN convening and bylaws | Feb 2026 | Sep 2026 | Cibolo + State | HVN agreements, shared services plan.
- RPM pilots (3 regions) | Mar 2026 | Dec 2026 | BioIntelliSense + hospitals | Enrolled cohorts, baseline/outcome reports.
- Tele-ER/ICU expansion | Apr 2026 | Jan 2027 | Avel eCare | Coverage roster, protocols, QA metrics.
- Pharmacy chronic care nodes | Apr 2026 | Dec 2026 | Retail partners | Screening volume, referrals closed.
- EMS tele-support & community paramedicine | May 2026 | Jan 2027 | Avel + EMS agencies | Non-transport/TIP metrics.
- Evaluation & scale decision | Nov 2026 | Jan 2027 | State + evaluation team | Year-1 evaluation, FY27 scale plan.

9.2 Milestones and gates

- Security ATO for data platform; first TEFCA exchange validated; HVN legal formation; RPM cohort outcomes reaching predefined thresholds; MCO data-sharing live; compliance attestation to NOFO limits. (files.simpler.grants.gov)

10. Risk Register (top 10; examples)

- Broadband gaps delay RPM scaling. Mitigation: prioritize counties in BEAD build plan; include LTE/5G

fallbacks; Owner: State PMO + tech partner. (broadband.wv.gov)
- Workforce burnout impedes adoption. Mitigation: AI scribe and tele-mentoring; Owner: Provider sites + Microsoft/Avel.
- Data-sharing hesitancy. Mitigation: WVHIN agreements and provider education; Owner: WVHIN + State. (wvhin.org)
- Duplicate payments risk. Mitigation: Payment integrity analytics; Owner: BMS + Accenture.
- Noncompliance with limits (15%, 20%, 10%). Mitigation: Budget controls and quarterly checks; Owner: PMO/Finance. (files.simpler.grants.gov) (files.simpler.grants.gov)
- Cyber incidents. Mitigation: Cloud cyber stack and incident playbooks; Owner: Tech partner CISO.
- EMS coverage variability. Mitigation: staged rollout and tele-support; Owner: Avel + EMS.
- Pharmacy program uptake uneven. Mitigation: align with MCO incentives; Owner: Retail partners + BMS.
- Licensure/compact misunderstandings. Mitigation: compact education; Owner: State boards + PMO. (wvrnboard.wv.gov) (law.justia.com)
- Evaluation burden. Mitigation: shared analytic workspace; Owner: State + evaluators; leverage WVHIN. (wvhin.org)

11. Draft RFP Response Language (boilerplate, to be adapted by the State) 11.1 Rural Health Needs and Target Population (excerpt) “West Virginia’s rural population is among the nation’s highest (54% in 2020), with significant primary care and behavioral health shortages documented in HPSA designations. Our plan focuses on rural counties with elevated HPSA shortfalls (121 primary care HPSAs; estimated 123 provider shortfall as of 3/31/2025). We will prioritize cohorts with chronic cardiometabolic conditions and behavioral health needs, integrate EMS/community paramedicine for high-risk utilizers, and coordinate transitions of care using WVHIN data exchange.” (ncsl.org) (commentary.healthguideusa.org) (wvhin.org)

11.2 Strategies and Key Performance Objectives (excerpt) “Our Rural Health Transformation Plan deploys remote monitoring and regional tele-specialty support to reduce 30-day readmissions and avoidable ED visits, with year-over-year targets at the county level. Pharmacy-enabled screening and multilingual triage will expand prevention access points, with documented referral closure rates. Data will be integrated via WVHIN and a HIPAA/FHIR-aligned cloud, with dashboards tracking program KPIs per CMS requirements.”

11.3 Use of Funds and Limits (excerpt) “We commit to: administrative costs ≤10% of each budget period; provider payments ≤15%; capital/infrastructure ≤20%; and EMR replacement ≤5% if applicable. We will avoid unallowable costs (e.g., construction as a direct cost) and comply with 2 CFR Part 200/Part 300 and the HHS Grants Policy Statement.” (files.simpler.grants.gov) (files.simpler.grants.gov)

11.4 Implementation and Governance (excerpt) “The Governor-designated lead agency will oversee program implementation, with WV Medicaid, WVHIN, WV Hospital Association/SORH, and other stakeholders. The State will charter regional High Value Networks (HVNs) to coordinate investments and monitor performance. The Collaborative can support data platform configuration, tele-services, analytics, and workforce training, subject to State procurement.”

11.5 Evaluation and Sustainability (excerpt) “We will participate in CMS-directed evaluations and publish annual county-level results. Sustainability pathways include payer-aligned reimbursement for remote care, shared-savings for rural networks, and ongoing public-health partnerships (e.g., WIC hospital-based certification expansion).” (dhhr.wv.gov)

Assumptions and Open Questions

- Frontier classification: We assume WV has few or no counties meeting ultra-low-density “frontier” thresholds; confirm CMS’s accepted metric and WV’s status before finalizing factor A.5 narrative.
- WV CON policy detail: This guide references the NOFO’s CON factor and legislative materials; confirm current WV CON statutes/regulations for the technical factor narrative and any proposed changes by end of 2027/2028 timelines. (blog.wvlegislature.gov)
- WVHIN participation rates: Use latest WVHIN “Connected Providers” list to quantify hospital and clinic penetration in the final application. (wvhin.org)
- Medicaid program data feeds: Confirm technical specifications and cadence for claims/encounter data from each MCO (MHT/MHP) into the State data environment. (bms.wv.gov) (bms.wv.gov)

12. References

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13. WV WIC in-hospital certification pilot (2025). WV DoH News. https://dhhr.wv.gov/... (dhhr.wv.gov)
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15. PSYPACT participation – WV SB 668 (enacted; effective 11/18/2021). https://psypact.gov/page/psypactmap (psypact.gov)
16. EMS Licensure Compact (REPLICA) – WV Code Ch.16, Art.60. https://code.wvlegislature.gov/16-60-4/ (code.wvlegislature.gov)

13. AI Generation Notice This guide was generated with the gpt-5 model on 2025-10-14. It is provided for planning support. All facts, figures, and citations must be independently validated against primary sources and current State policies and processes before inclusion in any official submission.