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

1. Executive Summary Florida can leverage the Rural Health Transformation (RHT) Program's five-year cooperative agreement (FY26–FY30) to stabilize rural access, modernize digital infrastructure, and scale outcomes-focused care models. The NOFO (CMS-RHT-26-001) offers up to $50 billion nationally, with equal baseline distribution and a points-based workload component recalculated annually based on technical factors and initiative performance. Applications are due November 5, 2025; awards are expected December 31, 2025.

Florida's context creates a clear fit. As of the 2020 Census, 8.5% of Florida's residents live in rural areas, with rural need concentrated across north and south-central counties. Florida's Statewide Medicaid Managed Care (SMMC) "3.0" implementation (February 1, 2025) positions the state to align RHT investments with managed care incentives and reporting. Florida has extended Medicaid/CHIP postpartum coverage to 12 months (May 25, 2022 approval), which the RHT can reinforce through maternal-behavioral integration.

The Rural Health Transformation Collaborative (RHT Collaborative) can support Florida with interoperable health data platforms, tele-specialty networks, continuous remote patient monitoring, pharmacy-enabled chronic care support, analytics, and program management capacity. These capabilities align with the NOFO's allowable uses (e.g., prevention/chronic disease, remote care, IT/cybersecurity, workforce, innovative care, partnerships) and with the technical scoring factors (e.g., EMS, licensure compacts, scope of practice, data infrastructure).

Florida's broadband trajectory amplifies feasibility. FloridaCommerce's Office of Broadband reports a $1.16B BEAD allocation and an approved initial proposal, including $971M for deployment—funding that complements RHT digital health, cybersecurity, and consumer-facing technology priorities.

One-page printable summary (for distribution)

- Program fit
  - Eligible applicant: State of Florida (Governor-designated lead agency).
  - Key dates: LOI 9/30/2025 (optional), due 11/5/2025 11:59 p.m. ET, award 12/31/2025.
  - Funding model: 5 budget periods (FY26–FY30), spend-through end of following FY; 50% baseline + 50% workload points.
  - Admin and policy caps: Admin ≤10%; provider payments ≤15%; capital/infrastructure (Cat. J) ≤20%; EMR replacement ≤5% (if HITECH-certified EMR existed 9/1/2025); "tech catalyst fund" ≤ the lesser of 10% or $20M.
- Florida context anchors
  - Rural share: 8.5% (2020).
  - Medicaid structure: SMMC 3.0 live 2/1/2025; most recipients enrolled in SMMC.
  - Postpartum coverage: 12 months (approved 5/25/2022).
  - Broadband: BEAD >$1.16B allocation; deployment allocation $971M.
- Collaborative capabilities (illustrative)
  - 24/7 tele-hospitalist/ICU/ED and EMS tele-support; connected specialty clinics.
  - FDA-cleared continuous RPM and clinical intelligence for chronic and acute care.
  - Pharmacy-enabled chronic care, med reconciliation, and virtual care linkages.
  - Secure cloud, analytics, and rural cybersecurity uplift; program management.

2. Eligibility and RFP Fit 2.1 NOFO essentials (Florida-relevant)

- Applicant: Only U.S. states (50). DC and territories are ineligible. Governor designates lead; AOR must sign. One official application per state; if multiple, the latest on-time submission is reviewed. No cost-sharing.
- Timeline: LOI by 9/30/2025 (optional); application due 11/5/2025 11:59 p.m. ET; award and earliest start 12/31/2025. SF-424 Box 19c "No" (E.O. 12372 not applicable).
- Funds flow: Five budget periods; each year's funds available through end of the following FY. 50% equal baseline; remaining funding distributed by points across rural facility/population and technical factors (Table 3).
- Points methodology: Workload funding each period equals Total Available Workload Funding × (State Points / Sum of Approved States' Points). Rural factors are fixed off Q4 2025; technical factors recalculated each budget period.
- Scoring weights (Table 3): A.1–A.7 = 50% (rural facility/population); B.1–F.3 = 50% (technical).
- Required contents (examples): Application checklist; "Application contents and format"; business assessment (≤12 pages, single-spaced). Submit via Grants.gov only.
- Use-of-funds examples: Prevention/chronic disease; provider payments (cap applies); consumer-facing tech; training/TA for telehealth/RPM/AI; workforce recruitment/retention; IT/cyber; innovative care models; capital/infrastructure; partnerships.
- Funding limits and restrictions: Admin ≤10% of allotment; provider payments ≤15%; category J

capital/infrastructure ≤20%; EMR replacement ≤5% (if already HITECH-certified by 9/1/2025); “Rural Tech Catalyst Fund”-type initiatives ≤10% or $20M per period. Cosmetic/experimental “specified sex-trait modification procedures” prohibited per 45 CFR 156.400.

2.2 Compliance checkpoints (concise)

- Maintain current SAM/UEI; Grants.gov submission; accept HHS GPS via Notice of Award.
- Performance/risk reviews; 2 CFR 200.206 applies.

2.3 Requirement → Collaborative capability → Evidence

- Remote care services (F.1), EMS integration (C.2): Statewide tele-hospital, tele-ICU/ED, tele-EMS, specialty tele-clinics; escalation protocols and EMS tele-support. Evidence: Avel eCare profile; Viz.ai stroke detection; Teladoc scale.
- Consumer-facing tech (F.3): Retail kiosks and AI triage; multi-language intake; digital navigation; home RPM. Evidence: Humetrix; Topcon; BioIntelliSense; retail partners.
- Data/cyber (F.2): HIPAA/FHIR cloud platform; cybersecurity uplift adopted by 700+ rural hospitals; analytics and value tracking. Evidence: Microsoft and integrator descriptions.
- Workforce and licensure enablers (D.1, D.2): Compact-aware virtual care workflows; pharmacy workforce upskilling. Evidence: NLC/IMLC status for Florida; Walgreens workforce initiatives.
- Partnerships (K) and HVNs: Member-owned rural provider networks for shared services and accountability. Evidence: Cibolo Health HVN model.
- Medicaid alignment (E.1/E.2): Claims exchange, payment integrity, ACO/alternative payment design tools with actuarial analytics. Evidence: integrators’ payment modernization capabilities.

3. Florida Context Snapshot 3.1 Population and geography

- Rural share: 8.5% (2020), indicating targeted but significant rural needs in north and south-central regions.
- Broadband: Florida’s BEAD allocation exceeds $1.16B with an approved initial proposal; $971M is designated for deployment to remaining unserved/underserved areas (2023–2024 program actions; 2025 deployment window).

3.2 Rural facility mix (selected indicators)

- Critical Access Hospitals: Florida’s CAH cohort is small; for example, Calhoun-Liberty Hospital is cited among Chartis’s Top 100 CAHs (2025), underscoring the importance of virtual specialty support for geographically isolated facilities.
- Rural Health Clinics (RHCs): 158 RHCs (HRSA allocation table, March 2022).
- Federally Qualified Health Centers: FQHCs are automatic HPSAs and anchor primary care access in underserved communities statewide (policy anchor for network build-outs).

3.3 Workforce shortage indicators

- Primary care HPSAs (3/31/2025): 292 designations; estimated 1,338 PCPs needed to remove designations (HRSA data summarized).
- Mental health HPSAs (3/31/2025): 219 designations; estimated 452 providers needed (HRSA data summarized).

3.4 Medicaid and coverage

- Non-expansion state; SMMC 3.0 implemented February 1, 2025; most beneficiaries enrolled in SMMC (MMA, LTC, Dental). Postpartum coverage extended to 12 months via 1115 (approved 5/25/2022).

3.5 Licensure compacts and scope enablers

- Florida participates in the Nurse Licensure Compact (NLC) and joined the Interstate Medical Licensure Compact (IMLC) in 2024; Florida joined PSYPACT effective July 1, 2023—enablers for tele-enabled multi-state practice models.

3.6 Florida-RHT alignment table (illustrative) Metric (year) | Value | Source | Matching Collaborative capability

- Rural population share (2020) | 8.5% | NCSL/Census | Distributed retail/clinic kiosks, tele-primary care, RPM to extend reach.
- RHCs (2022) | 158 | HRSA | Tele-specialty backstop and pharmacy-managed chronic care protocols.
- PCP HPSAs (3/31/2025) | 292; need 1,338 PCPs | HRSA summary | Virtual hospitalist/ED/clinic coverage; ambient documentation to reduce burnout; compacts to speed licensure.
- BEAD allocation (2024) | >$1.16B; deployment $971M | FL Office of Broadband | Secure cloud, TEFCA-aligned exchange, cybersecurity, consumer digital tools.

- Postpartum coverage (2022) | 12 months | HHS/CMS | Tele-OB, RPM (BP, weight), behavioral health via PSYPACT.

Assumptions and Open Questions (for internal planning)

- Confirm the most recent count of hospitals receiving Medicaid DSH (latest State Plan Rate Year) for inclusion in the application.
- Compile and attach the Florida CCBHC list as of September 1, 2025 (site names/locations).
- Update facility inventories (CAH/FQHC/RHC counts) to 2025 where available; RHC figure above reflects HRSA's March 2022 table.

4. Strategy Aligned to RFP 4.1 Proposed statewide rural transformation model (Florida) A networked model that links rural hospitals, RHCs, FQHCs, EMS, and retail pharmacies to virtual specialty hubs; equips primary care with RPM and clinical AI; and stands up a state data backbone for outcomes and payment integrity. This model maps to RHT uses A, C, D, F, G, H, I, J, K and targets Table-3 technical factors (EMS, licensure compacts, data infrastructure, consumer tech).

4.2 How Collaborative offerings map to RHT pillars and scoring

- Access and right-sizing (K, G): Create rural High Value Networks (HVNs) for shared services, referral management, and capital discipline—supports partnerships and sustainability scoring.
- Clinical capacity and EMS (C.2): 24/7 virtual hospitalist/ICU/ED, tele-EMS consults, and Viz.ai stroke pathways—addresses emergency access and time-sensitive conditions.
- Prevention and chronic disease (A, C, F): Consumer screening kiosks, AI triage, RPM (BioButton), and pharmacy-supported adherence and reconciliation.
- Technology and cybersecurity (F.2): HIPAA/FHIR-based secure cloud and cybersecurity uplifts already adopted across hundreds of rural hospitals—supports F.2 technical scoring.
- Workforce (D.1, D.2, D.3): Ambient documentation; tele-mentoring; compact-aware credentialing flows; pharmacist-led chronic care where scope permits.
- Payment integrity and Medicaid alignment (E.1/E.2): Claims exchange, analytics, prior auth automation, and APM/ACO modeling integrated with SMMC reporting.

4.3 Equity strategy (rural, frontier-equivalent areas, Tribal partners) Use BEAD-supported connectivity and consumer tools to reach low-density census tracts; configure language access and mobile-first intake; and integrate Seminole and Miccosukee Tribal broadband set-asides with patient navigation and specialty tele-clinics.

4.4 Data use and privacy Adopt secure cloud governance (HIPAA, role-based access), de-identification for analytics, and TEFCA-aware exchange for cross-vendor data. The Collaborative's integrators run outcomes/value tracking and dashboards suitable for CMS monitoring.

5. Program Design Options (Florida-tuned) Option A: Rural Virtual Care and RPM Network

- Target population: Rural residents in HVN counties; high-risk chronic disease; post-discharge monitoring. Problem: PCP HPSAs and scarce specialty access lead to avoidable ED use/readmissions (2025).
- Components: Avel eCare (tele-hospital/ICU/ED), Teladoc (multi-specialty virtual), BioIntelliSense RPM, retail pharmacy engagement (adherence, BP checks).
- Payment logic: Gap-filling provider payments (≤15% cap) plus APMs tied to ED/readmission reduction.
- Policy enablers: IMLC, NLC, PSYPACT.
- Pros/risks: Rapid coverage uplift; dependency on connectivity—mitigated by BEAD deployment.

Option B: Community Paramedicine + EMS Tele-Support

- Target: Rural EMS agencies and frontier-like census tracts (low density). Problem: Long response times, hospital bypass.
- Components: Tele-EMS consults, remote triage/intake, post-event RPM; EMS-to-clinic linkages.
- Payment logic: Equipment/IT (F, J), training (D), care coordination via APMs. Caps apply.
- Pros/risks: Reduces transfers; needs EMS protocols and medical direction integration.

Option C: Maternal + Behavioral Health Integration

- Target: Pregnant/postpartum Medicaid members; co-occurring behavioral needs. Problem: Postpartum morbidity, behavioral access gaps.
- Components: Tele-OB consults; home BP/weight RPM; PSYPACT-enabled tele-psych; pharmacist-assisted adherence and screening.
- Payment logic: Case rates linked to prenatal/postpartum visit adherence; gap-filling payments for non-reimbursable services within 15% cap.

Option D: Rural Data and Cyber Modernization

- Target: Rural hospitals, RHCs, FQHCs. Problem: Fragmented data/cyber risk.
- Components: HIPAA/FHIR cloud, identity and endpoint hardening, dashboards for RHT metrics, TEFCA-aware exchange.
- Funding: Category F (IT/cyber), Category J (equipment/retrofits) under 20% cap.

6. Governance and Collaborative Roles 6.1 Partner map (simplified)

- State lead (Governor-designated): overall accountability; policy levers; SMMC coordination; RHT reporting.
- Medicaid (AHCA): benefits alignment, APM design, SPA/contract updates.
- Provider networks/HVNs (Cibolo Health-enabled): funds stewardship, shared services, initiative oversight.
- Tele-care/RPM vendors: clinical services and monitoring with Florida credentialing.
- Retail pharmacies: adherence, screenings, med reconciliation, digital engagement.
- Integrators (Accenture/AVIA/KPMG/PwC): PMO, procurement support, analytics, outcomes tracking and value realization.

6.2 RACI (selected) Task | State lead | Medicaid | HVN | Providers | Collaborative

- Program governance, reporting | R | C | A | C | C
- APM design and SMMC alignment | C | R | C | C | C
- Tele-specialty/RPM deployment | C | C | A | R | R
- Pharmacy-enabled chronic care | C | C | C | R | R
- Data/cyber platform & dashboards | C | C | C | C | R

7. Payment and Funding

- Within-NOFO caps: Admin ≤10%; provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5%; “tech catalyst” ≤10% or $20M.
- Medicaid alignment: Integrate with SMMC 3.0 quality incentives and reporting; leverage analytics for payment integrity and ACO readiness.

Illustrative budget structure (rough order of magnitude; subject to award) Cost category | ROM share | Source window | Collaborative deliverables

- Tele-care contracts (Avel/Teladoc) | 25–35% | Y1–Y5 | 24/7 coverage, metrics feeds.
- RPM devices/services (BioIntelliSense) | 10–15% | Y1–Y5 | Continuous vitals, alerting, training.
- Pharmacy-enabled chronic care | 8–12% | Y1–Y5 | Adherence, reconciliation programs.
- Data/cyber platform + analytics | 15–20% | Y1–Y5 | Cloud, security hardening, dashboards.
- Capital/equipment (Cat. J) | ≤20% | Y1–Y3 | Telehealth rooms, secure networking (≤ cap).
- Program management/TA | ≤10% admin | Y1–Y5 | PMO, procurement, training; admin cap respected.

8. Data, Measurement, and Evaluation

- Core outcomes: avoidable ED visits/readmissions; chronic disease control; specialty access; maternal metrics; workforce/IT resilience. The NOFO Appendix lists outcome examples used for initiative scoring in later periods.
- Data sources: SMMC claims, EHRs, HIE/TEFCA frameworks, EMS, consumer apps, RPM streams. Cloud analytics and dashboards provide quarterly updates and “initiative-level” scorecards for workload points.
- Evaluation: State-led with Collaborative analytics support; methods include difference-in-differences at county level and patient-level risk adjustment; cooperate with CMS/third-party evaluations as required.

9. Implementation Plan (12–24 months) Gantt-style table (months from award) Workstream | Start | End | Owner | Outputs

- Governance/PMO mobilization | M0 | M2 | State + Integrator | Charter, RACI, reporting plan.
- Data/cyber platform stand-up | M1 | M6 | State + Tech | Tenant, identity, baseline dashboards.
- Tele-hospital/ICU/ED hubs | M2 | M8 | HVN + Avel | SLA, clinical protocols, EMS links.
- RPM cohort launch | M3 | M9 | HVN + BioIntelliSense | 2–3 condition pathways, training.
- Pharmacy-enabled chronic care pilots | M3 | M10 | Retail + FQHC/RHC | Adherence and med rec workflows.
- Behavioral/PSYPACT tele-psych | M4 | M10 | Providers | Intake triage, referral grid.
- Maternal RPM + tele-OB | M4 | M10 | Providers | BP/weight RPM, visit adherence.
- Outcome dashboard v1 | M5 | M8 | State + Integrator | KPI baselines and targets.
- APM alignment with SMMC | M6 | M12 | Medicaid + Plans | Measure set and payment rules.
- Expansion waves (county cohorts) | M9 | M24 | HVN + State | Coverage to ≥80% rural residents (phased).

Procurement/legal enablers (conditional):

- State contracts for tele-specialty, RPM, analytics, and PMO; subaward flow-downs to rural providers; compact-aware credentialing.

10. Risk Register (selected) Risk | Likelihood/Impact | Mitigation | Owner

- Policy points not finalized by 12/31/2027 (12/31/2028 for B.2/B.4): points drop to zero; funds recoverable. | M/H | Early legislative calendar mapping; fallback initiatives not dependent on law changes. | State/Medicaid
- Admin cap breach (>10%). | L/H | Admin tracking in budget dashboards; PMO guardrails. | State/Integrator
- Provider payment cap breach (>15%). | L/H | Periodic cap checks; use in-kind/operations instead. | State/HVN
- Capital (J) overrun (>20%). | M/M | Phase procurements; prioritize high-yield retrofits. | State/HVN
- Cyber incident. | M/H | Zero-trust, hardening, MDR/SOC; tabletop exercises. | State/Tech
- Broadband shortfalls delay telehealth. | M/M | Align site sequencing with BEAD rollouts; hotspot contingencies. | State/HVN
- Licensure/credentialing delays. | M/M | Utilize IMLC/NLC/PSYPACT pathways; pre-credential pools. | Providers
- Data-sharing barriers. | M/M | TEFCA-aware agreements; minimum necessary access. | State/Tech
- SMMC misalignment. | M/H | Joint steering with plans; APM pilots in select regions. | Medicaid/Plans
- Measurement drift vs NOFO expectations. | M/M | Quarterly scorecards; initiative rebalancing. | State/Integrator

11. Draft RFP Response Language (Florida-ready; pasteable) 11.1 Project summary (abstract) Florida proposes a statewide rural transformation that links rural hospitals, RHCs, and FQHCs with tele-specialty hubs; equips primary care with continuous remote monitoring and pharmacy-enabled chronic care; and modernizes data/cyber infrastructure. The state will use RHT funding across at least three eligible categories—including prevention/chronic disease, remote care, IT/cybersecurity, innovative care models, workforce, capital/infrastructure, and partnerships—subject to program limitations and caps. Activities align with SMMC 3.0 incentives and Florida's 12-month postpartum coverage policy, with quarterly dashboards tracking access, outcomes, technology adoption, and financial sustainability.

11.2 Rural Health Transformation Plan (excerpt) Florida's plan addresses access, outcomes, technology, partnerships, workforce, data-driven solutions, and financial solvency. We will:

- Deploy tele-hospitalist/ICU/ED, EMS tele-support, and specialty e-clinics across rural facilities.
- Scale consumer screening/triage and home RPM with clinical intelligence for chronic disease and maternal care.
- Stand up a secure, HIPAA/FHIR data platform with dashboards for program reporting and payment integrity.
- Foster rural provider High Value Networks to coordinate capital, workforce, and shared services statewide. Legislative/regulatory commitments (technical factors) will be detailed with timelines to meet the NOFO's 2027/2028 checkpoints.

11.3 Proposed initiatives and uses of funds (examples)

- "Rural Virtual Specialty and RPM Network": Uses A, C, D, F; technical factors C.2, F.1–F.3; outcomes include reductions in avoidable ED and readmissions; county-level access metrics.
- "Maternal-Behavioral Integration": Uses A, H, F; postpartum RPM and tele-psych per PSYPACT; outcomes include postpartum visit adherence and BP control.
- "Rural Data & Cyber Uplift": Use F (and J for equipment); outcomes include system uptime, incident-free quarters, and increased data completeness for quality reporting.

11.4 Compliance statements (concise)

- Florida acknowledges caps and restrictions (admin ≤10%; provider payments ≤15%; capital ≤20%; EMR replacement ≤5%; "tech catalyst" ≤10% or $20M), LOI/application deadlines, SAM/UEI maintenance, Grants.gov submission, and SF-424 19c "No."

12. References

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