Rural Health Transformation Grant Guide — New Jersey

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

New Jersey can leverage the Rural Health Transformation (RHT) Program to stabilize rural access points, extend specialty capacity virtually, and modernize data infrastructure while staying within the Notice of Funding Opportunity (NOFO) caps and timelines. The NOFO makes all 50 states eligible and sets an application deadline of November 5, 2025, with expected awards by December 31, 2025. It allows five budget periods, distributes funds 50% baseline and 50% via a points-based workload formula, and requires addressing at least three use-of-funds categories. The NOFO also caps administrative cost at 10%, provider payments at 15%, capital/infrastructure at 20%, and certain EHR replacements at 5%. (files.simpler.grants.gov)

Given New Jersey's relatively small rural share (6.2% of residents live in rural areas in 2020) but meaningful pockets of need, a strategy emphasizing statewide shared services, targeted virtual coverage, pharmacy-enabled chronic care, and data connectivity can reach rural residents efficiently. (ncsl.org) The Rural Health Transformation (RHT) Collaborative can support New Jersey with: tele-ER/ICU and specialist backup for rural hospitals (Avel eCare), remote physiologic monitoring for cardio-metabolic risk (BioIntelliSense), community screening and routing (AHA with Higi/Topcon), pharmacist-supported chronic disease management (Walgreens/CVS), and a governance framework (Cibolo Health High Value Networks) to align independent providers under accountable constructs—subject to State procurement and contracting.

New Jersey's statewide health information exchange (NJHIN) and 1115 demonstration approvals provide a policy and data foundation the Collaborative can work within. NJHIN, managed for NJDOH, connects hospitals and many provider types for ADT alerts, CCD exchange, and other use cases; NJII reports connectivity across all 71 hospitals. The State also launched an NJHIN-enabled birth registry feed in June 2025, illustrating production-grade exchange for maternal and infant health workflows. (nj.gov) The NJ FamilyCare 1115 Comprehensive Demonstration is approved through June 30, 2028, with CMS-approved HRSN protocols—useful for aligning RHT initiatives with Medicaid managed care incentives and data. (medicaid.gov)

The Collaborative's role is enabling, not directive. It can provide interoperable platforms (HIPAA/FHIR), cybersecurity support, analytics, and program management while New Jersey retains decision rights on scope, partners, and policy sequencing. The approach below aligns each RHT NOFO requirement with feasible, evidence-based options for New Jersey's rural communities—explicitly conditional on State priorities, provider readiness, and contracting.

One-page printable summary

• What the NOFO requires

- Eligible applicant: State government; Governor-designated lead; one official application; SF-424 19c "No"; application due Nov 5, 2025; awards by Dec 31, 2025. (files.simpler.grants.gov)
- Funds: $50B FY26–FY30; 50% baseline, 50% workload; admin cap 10%; provider-payment cap 15%; capital/infrastructure cap 20%; EMR replacement cap 5% (conditional); "Rural Tech Catalyst Fund" concept capped at lesser of 10% or $20M. (files.simpler.grants.gov)
- Technical scoring: Table 3 weights (50% rural facility/population; 50% technical factors); conditional policy points must be enacted by 12/31/2027 (12/31/2028 for two factors) or funds tied to those points are recovered. (files.simpler.grants.gov)
- Use-of-funds: Must address ≥3 categories (prevention/chronic disease, provider payments with limits, consumer tech, TA/training, workforce, IT/cyber, rightsizing care, behavioral health incl. SUD, innovative/value-based models, capital/infrastructure with limits, partnerships). (files.simpler.grants.gov)

• New Jersey context (illustrative 2024–2025 datapoints)

- Rural share 6.2% (2020). CAHs: 0. RHCs: 0. FQHC awardees: 23 (620,041 patients, 2024). Primary care HPSAs: 37; mental health HPSAs: 39 (3/31/2025). NJHIN statewide connectivity (all 71 hospitals). (ncsl.org)

• High-leverage options the Collaborative can support (subject to State direction)

- Virtual hospital support/tele-ER/ICU to cover clinical deserts; RPM for cardio-metabolic risk; pharmacist-enabled chronic disease; maternal/behavioral integration with statewide ADTs and registries; HVN governance to align independent providers.

• Key compliance guardrails

- Keep admin ≤10%; track provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% (if HITECH-certified EMR existed by 9/1/2025); avoid prohibited telecom and 45 CFR 156.400 services.

(files.simpler.grants.gov)

2. Eligibility and RFP Fit

2.1 Snapshot of NOFO requirements (precise citations)

- Eligible applicants: only States; Governor designates lead; one official application; AOR signature; no cost sharing. (files.simpler.grants.gov)
- Key dates: Optional LOI (recommended); application due 11:59 p.m. ET, Nov 5, 2025; expected award and earliest start Dec 31, 2025; CMS webinars in September. (files.simpler.grants.gov)
- Submission and forms: SF-424, SF-424A, SF-LLL, Project/Performance Site; SF-424 Item 19c "No" (EO 12372 not applicable). (files.simpler.grants.gov)
- Narrative and attachments: Project summary (1 page), Project narrative (≤60 pages, format specified), Budget narrative (≤20 pages), Governor's endorsement letter (≤4 pages), Business assessment (≤12), Program duplication assessment (≤5), other support (≤35). (files.simpler.grants.gov)
- Funds distribution: 50% baseline split; 50% workload via points system and formula; rural factors set once (Q4 2025); technical score recalculated annually. (files.simpler.grants.gov)
- Scoring weights: Table 3—Rural facility/population factors sum to 50%; technical factors sum to 50%; specific factor weights listed in NOFO. (files.simpler.grants.gov)
- Caps and prohibitions: Admin ≤10%; provider payments ≤15%; category J (capital/infrastructure) ≤20%; EMR replacement ≤5% (conditions); "Rural Tech Catalyst Fund"-like initiatives ≤ lesser of 10% or $20M/budget period; restrictions per 2 CFR 200/300; 2 CFR 200.216 telecom; specified sex-trait modification procedures under 45 CFR 156.400 prohibited. (files.simpler.grants.gov)

2.2 Requirement → Collaborative capability → Evidence (examples)

- Interoperable, cyber-secure data stack to support remote care, measurement, and reporting → Microsoft Azure HIPAA/FHIR platform; data exchange and analytics; cyber program deployed to 700+ rural hospitals (supports IT advances, remote care, data infrastructure). Evidence: RHT Collaborative catalog.
- Virtual specialty coverage for rural hospitals (tele-ER/ICU/hospitalist) → Avel eCare clinical teams with Joint Commission–accredited virtual hospital model (supports F.1 remote care services; improves access/quality). Evidence: RHT Collaborative catalog.
- Remote physiologic monitoring at home for chronic disease → BioIntelliSense BioButton system with exception-based dashboards; training for digital health navigators; outcome focus aligned to NOFO technical factors. Evidence: RHT Collaborative catalog.
- Pharmacist-enabled chronic disease management and adherence → Walgreens/CVS models; telepharmacy; documented adherence and readmission impact; workforce training pathways. Evidence: RHT Collaborative catalog.
- Provider network governance and shared services → Cibolo Health High Value Networks (HVNs) to pool resources, negotiate, track outcomes and funds (aligns with partnerships and sustainability). Evidence: RHT Collaborative catalog.

3. New Jersey Context Snapshot

3.1 Highlights

- Rural population: 6.2% (2020 Census classification). (ncsl.org)
- Critical Access Hospitals (CAHs): 0; states without CAHs include NJ (population density). (definitivehc.com)
- Rural Health Clinics (RHCs): 0 (no CMS-certified RHCs). (hrsa.gov)
- FQHC/Health Center Program: 23 awardees served 620,041 patients in 2024. (data.hrsa.gov)
- HPSA indicators (3/31/2025): 37 primary care HPSAs; 39 mental health HPSAs (HRSA quarterly data as summarized). (commentary.healthguideusa.org)

- HIE/Data: NJHIN statewide HIE operated for NJDOH with hospital ADT/CCD exchange and multiple use cases; NJII reports all 71 hospitals connected; NJHIN-enabled birth registry launched June 25, 2025. (nj.gov)
- Medicaid: NJ FamilyCare 1115 Comprehensive Demonstration renewed through 6/30/2028; approvals include HRSN protocols (infrastructure/services/new initiatives). MCO delivery system statewide; plan options include five MCOs (county coverage varies for WellCare). (medicaid.gov)

3.2 Metric-to-capability table (illustrative)

- Rural share (6.2%, 2020) → Scale statewide shared services; deploy tele-specialty coverage and RPM to pockets of need. (ncsl.org)
- CAHs (0) / RHCs (0) → Compensate with virtual hospital support, community pharmacy access points, and HVN governance across independent providers. (definitivehc.com)
- HPSA (PC 37; MH 39, 2025) → Tele-behavioral, eConsults, and Avel eCare support; RPM + pharmacist outreach for hypertension/diabetes. (commentary.healthguideusa.org)
- FQHC scale (23 awardees; 620k pts in 2024) → Embed RPM, screening, consumer-facing tools (Humetrix, Higi), and ADT-driven care coordination to augment FQHC reach. (data.hrsa.gov)
- Data backbone (NJHIN; all hospitals connected; birth registry automation) → Orchestrate quality measurement, ADT-triggered outreach, maternal pathways, and statewide dashboards. (njii.com)
- Medicaid/HRSN approvals (through 2028) → Align RHT initiatives with managed care incentives, HRSN protocols, and quality reporting. (medicaid.gov)

4. Strategy Aligned to RFP

4.1 Model overview (conditional, alignable to NOFO pillars)

- Access and outcomes: Consolidate rural tele-coverage via Avel eCare for emergency, ICU, and hospitalist back-up; add tele-behavioral and virtual specialty; support transitions with ADT-driven follow-up through NJHIN.
- Prevention and chronic disease: Deploy BioIntelliSense RPM for high-risk cardio-metabolic cohorts identified through screening (AHA/Higi/Topcon) and claims/EHR analytics (Humetrix), with pharmacy-enabled titration and adherence.
- Workforce: Provide ambient documentation tools, tele-mentoring, and scope-of-practice training modules (collaborative partners) to reduce burden and expand capacity.
- Data/cyber: Utilize HIPAA/FHIR-based cloud and cybersecurity services; integrate with NJHIN feeds; build outcome dashboards tied to NOFO metrics.

4.2 Alignment to Table 3 technical factors (examples)

- F.1 Remote care services: tele-ER/ICU/consults and RPM.
- F.2 Data infrastructure: cloud-based analytics, ADT ingestion, provider-facing dashboards; use NJHIN connectivity.
- B.1 Population health clinical infrastructure: screening kiosks and mobile apps to identify and route at-risk individuals statewide.
- C.1 Strategic partnerships: Cibolo Health HVNs to share services and coordinate investment.
- D.1 Talent recruitment/training: ambient documentation, tele-mentoring, and targeted pharmacist workforce upskilling.

4.3 Equity and Tribal considerations

- Use consumer tools with multilingual interfaces (Humetrix) and pharmacy-based access points to reduce transportation and language barriers; leverage ADT-based outreach and community-partner routing for behavioral health and maternal pathways.

4.4 Data use and privacy

- Apply HIPAA/FHIR standards, role-based access, and zero-trust patterns; integrate NJHIN services and State security requirements; adhere to 2 CFR 200/300 and HHS GPS for data stewardship.

5. Program Design Options (New Jersey-tuned; conditional)

Option A: Rural Virtual Hospital Coverage + Transitions

- Target: Rural EDs, small hospitals, EMS in high-need counties; focus on nighttime/weekend coverage.
- Problem: HPSA-related clinician scarcity and transfer delays. (NJ: PC HPSAs 37; MH HPSAs 39 as of 3/31/2025.) (commentary.healthguideusa.org)
- Collaborative components: Avel eCare (tele-ER/ICU), ADT-driven follow-up via NJHIN; tele-behavioral add-on.
- Payment logic: RHT funds for remote care services and TA (F.1/F.2); Medicaid MCO quality incentives for avoidable utilization; no duplication of reimbursable services per NOFO. (files.simpler.grants.gov)
- Enablers: Hospital agreements; NJHIN interfaces; EMS protocols.
- Pros/risks: High impact on avoidable transfers; dependency on hospital readiness and credentialing.

Option B: Cardio-Metabolic Remote Care at Scale

- Target: Adults with uncontrolled hypertension/diabetes identified via kiosks/apps and claims analytics.
- Problem: Chronic disease burden and access friction in rural towns.
- Collaborative components: AHA screenings (Higi/Topcon), Humetrix outreach, BioIntelliSense RPM with exception-based clinician alerts; retail pharmacy follow-up.
- Payment logic: Prevention/chronic disease (A), consumer-facing tech (C), remote care (F.1); observe provider-payment cap (15%) and avoid duplicative reimbursement. (files.simpler.grants.gov)
- Pros/risks: Scalable statewide; requires device logistics and adherence workflows.

Option C: Pharmacy-Enabled Rural Access Hubs

- Target: Rural-adjacent communities with limited primary care.
- Problem: Timely access and medication management gaps.
- Collaborative components: Walgreens/CVS telepharmacy, medication reconciliation, adherence programs; referral routing to FQHCs and local providers.
- Payment logic: Innovative care (I), workforce (E), consumer tech (C); ensure alignment with scope-of-practice and Medicaid coverage parameters.
- Pros/risks: Rapid access point expansion; legal/regulatory dependencies on scope and payer contracts.

Option D: HVN Governance + Shared Services (Primary Care/FQHC-led)

- Target: Independent rural hospitals/clinics and FQHCs across identified rural tracts.
- Problem: Fragmented investments undermine sustainability.
- Collaborative components: Cibolo Health HVNs for pooled procurement, shared analytics, and transparent spend/outcome tracking; Microsoft cloud for dashboards.
- Payment logic: Partnerships (K), data infrastructure (F.2), innovative care (I); aligns to NOFO merit review emphasis on sustainability and statewide impact.

Primary option recommendation (conditional): Blend A + B + D to create a statewide, data-driven rural access fabric: tele-coverage for emergencies, longitudinal RPM for high-risk chronic disease, and HVN governance to coordinate spend and sustainability. Backup option: C as a rapid-access accelerator in communities lacking clinic capacity.

6. Governance and Collaborative Roles

6.1 Governance (text diagram)

- State Lead Agency (Governor-designated): Strategy, legal authority, oversight, reporting to CMS.
- Program Management Office (State): Overall management; coordination with Medicaid, NJDOH/NJHIN.
- Medicaid Agency: MCO alignment, SPA/contracting alignment (if pursued), data sharing and quality targets.

- Provider Networks (Hospitals, FQHCs, EMS, pharmacies): Service delivery, data submission.
- Collaborative Members: Technology platforms, integrators, screening/RPM vendors, virtual care providers—supporting implementation under State direction.

6.2 RACI (selected)

- Performance dashboard: Responsible—Collaborative tech lead; Accountable—State PMO; Consulted—Medicaid, NJHIN; Informed—providers/payers.
- Tele-ER roll-out: R—Avel eCare; A—Participating hospitals; C—EMS, Medicaid; I—State PMO.
- RPM program: R—BioIntelliSense; A—Participating FQHCs/clinics; C—Pharmacies; I—State PMO.
- HVN formation: R—Cibolo Health; A—Participating providers; C—State/NJHA; I—Payers.

7. Payment and Funding

7.1 NOFO-consistent payment paths (examples)

- RHT cooperative funds for: prevention/chronic care (A), consumer tech (C), training/TA (D), workforce with 5-year rural commitments (E), IT/cyber (F), right-sizing services (G), behavioral health/OUD (H), innovative care/value-based (I), capital/infrastructure ≤20% (J), and partnerships (K). Observe provider-payment ≤15% and admin ≤10%. (files.simpler.grants.gov)
- Medicaid alignment: Leverage 1115 approvals (e.g., HRSN protocols) and MCO quality levers where appropriate. (medicaid.gov)

7.2 Illustrative cost/deliverable table

- Tele-ER/ICU coverage: deliver 24/7 consult coverage, transfer protocols, metrics integration; Funding: RHT F.1; Timing: Year 1–2; Owner: Hospitals + Avel eCare.
- RPM kits + monitoring: devices, triage workflows, training; Funding: A/F/D; Timing: Year 1–2; Owner: Clinics/FQHCs + BioIntelliSense.
- Pharmacy hubs: adherence programs, vitals/POCT, referral routing; Funding: A/C/I; Timing: Year 1–2; Owner: Retail pharmacies + FQHCs.
- Data platform/dashboards: cloud tenancy, ADT interfaces, security hardening; Funding: F.2; Timing: Year 1; Owner: State/NJHIN + Collaborative tech.
- HVN governance: bylaws, participation agreements, pooled procurements; Funding: K; Timing: Year 1; Owner: Providers + Cibolo Health.

8. Data, Measurement, and Evaluation

8.1 Core measures (examples aligned to NOFO)

- Access: avoidable ED visits; time-to-consult; ADT-confirmed post-discharge follow-up.
- Quality/outcomes: BP control, A1c, readmissions; behavioral crisis response metrics.
- Financial: total cost of care proxies; transfer avoidance; capital utilization.
- Workforce: staffing stability, tele-mentoring participation, documentation time saved.

8.2 Data sources and integrations

- Claims (Medicaid/MCO), EHRs, NJHIN ADT/CCD, EMS ePCR, pharmacy systems, screening kiosks/mobile apps; cloud analytics for secure linkage and dashboards.

8.3 Evaluation plan

- Annual updates per NOFO; initiative-based scoring tied to milestones and outcomes; technical score recalculated each period; collaborate with CMS and third-party evaluators. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; indicative)

Gantt-style table (quarters)

Workstream	Start	End	Owner	Outputs
Program governance	Q1 2026	Q2 2026	State PMO	Charter; RACI; reporting calendar.
HIE/analytics set-up	Q1 2026	Q3 2026	State + NJHIN + Collaborative	Cloud tenancy; ADT/CCD pipelines; dashboards.
Tele-ER/ICU pilots	Q2 2026	Q4 2026	Hospitals + Avel eCare	Sites live; SLA metrics.
RPM cohort wave 1	Q2 2026	Q1 2027	FQHCs + BioIntelliSense	2–3k patients onboarded; outcomes tracking.
Pharmacy access hubs	Q3 2026	Q2 2027	Pharmacies + FQHCs	Sites active; adherence KPIs.
HVN formation	Q1 2026	Q3 2026	Providers + Cibolo	Agreements; pooled procurements.
Maternal/behavioral integration	Q3 2026	Q4 2027	NJDOH/NJHIN + partners	Birth registry/988 linkages live. (nj.gov)

Gating decisions: hospital participation MOUs; data-sharing agreements; Medicaid alignment; procurement awards; cybersecurity ATOs.

10. Risk Register (selected)

Risk	Mitigation	Owner
Procurements delayed	Use existing State vehicles where applicable; finalize SOWs early.	State PMO
Provider-payment cap breaches	Budget controls and tagging; trigger monthly spend tests. (files.simpler.grants.gov)	PMO finance
Capital cap over-allocation (20%)	Track category J separately; apply pre-submission cap review. (files.simpler.grants.gov)	PMO finance
Policy commitments not enacted by deadlines (2027/2028)	Stage commitments and assign policy owner checkpoints. (files.simpler.grants.gov)	State policy lead
Data protection/cyber incidents	Harden cloud controls and enable continuous monitoring.	State CISO + vendor
Rural uptake/adherence to RPM	Deploy CHW/digital navigator support; align incentives.	FQHCs + vendor

Risk	Mitigation	Owner
Tele-credentialing/privileging lag	Standardize credentialing packets; start early with hospitals.	Hospitals + Avel eCare
NJHIN interface latency	Test feeds ahead of launch; prioritize ADT use cases. (nj.gov)	NJHIN + State
Pharmacy scope variability	Align to current State rules; use incremental pilots.	Pharmacies + State
Duplication with existing funding streams	Maintain program duplication assessment SOP. (files.simpler.grants.gov)	PMO compliance

11. Draft RFP Response Language (paste-ready, to be tailored)

11.1 Project Summary (excerpt)

"The State of New Jersey, through the Governor-designated lead agency, proposes a rural access and outcomes program that addresses at least three NOFO use-of-funds categories, including prevention/chronic disease management, remote care services, and data infrastructure. The program combines virtual specialty coverage, remote physiologic monitoring, pharmacy-enabled chronic care, and data-driven coordination leveraging NJHIN. The approach conforms to NOFO administrative and category caps, uses allowable activities only, and supports statewide rural residents while avoiding duplication of other funding. Application due Nov 5, 2025; anticipated start Dec 31, 2025." (files.simpler.grants.gov)

11.2 Rural Health Transformation Plan (excerpt)

"Our plan advances the NOFO's strategic goals by: (1) deploying tele-ER/ICU and specialty consults for rural hospitals; (2) implementing population screening and RPM for cardio-metabolic disease; (3) forming provider High Value Networks (HVNs) to coordinate investments. We will report program-level KPIs and comply with annual technical score updates. Policy commitments, if any, will be finalized by Dec 31, 2027 (and by Dec 31, 2028 for B.2 and B.4), consistent with NOFO conditions." (files.simpler.grants.gov)

11.3 Use of Funds and Caps (excerpt)

"Administrative costs do not exceed 10% of allotment. Provider payments are ≤15% with justifications for non-reimbursable services. Capital/infrastructure (Category J) remains ≤20%. Any EMR replacement is ≤5% and only where an eligible HITECH-certified system was in place as of September 1, 2025. No funds address prohibited telecom/video surveillance equipment or specified procedures under 45 CFR 156.400." (files.simpler.grants.gov)

11.4 Attachments (excerpt)

"Governor's endorsement letter (≤4 pages) certifies collaboration with State health, Medicaid, rural health offices, tribal/IHS as applicable, and compliance with 42 U.S.C. 1397ee(h)(2)(A)(ii), as required in the NOFO." (files.simpler.grants.gov)

12. References

1. Rural Health Transformation Program – Notice of Funding Opportunity (CMS-RHT-26-001), Centers for Medicare & Medicaid Services, https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf, accessed 2025-10-14. (files.simpler.grants.gov)
2. Rural Health Transformation Program overview page, CMS, https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview, accessed 2025-10-14. (cms.gov)
3. CMS Grants Program Funding Opportunities (CMS-RHT-26-001), CMS, https://www.cms.gov/about-cms/grants-cooperative-agreements/currentnts-funding-opportunities, accessed 2025-10-14. (cms.gov)

4. NCSL – Rural Population by State (2020 Census), National Conference of State Legislatures, https://www.ncsl.org/.../voting-for-all-americans-rural-voters, accessed 2025-10-14. (ncsl.org)
5. Definitive Healthcare – CAHs by State (Nov 2023), https://www.definitivehc.com/resources/healthcare-insights/us-critical-access-hospitals, accessed 2025-10-14. (definitivehc.com)
6. HRSA UDS – New Jersey Health Center Program Data (2024), https://data.hrsa.gov/tools/data-reporting/program-data/state/NJ, accessed 2025-10-14. (data.hrsa.gov)
7. HRSA – RHC Vaccine Confidence (note: NJ has no CMS-certified RHCs), https://www.hrsa.gov/coronavirus/rural-health-clinics/confidence/funding, accessed 2025-10-14. (hrsa.gov)
8. HRSA – Health Workforce Shortage Areas Dashboard (as of 10/12/2025), https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard, accessed 2025-10-14. (data.hrsa.gov)
9. Health Guide USA (summarizing HRSA 3/31/2025 HPSA data) – Mid-Eastern US primary care and mental health shortfalls, https://commentary.healthguideusa.org/2025/06/the-primary-care-shortfall-in-mid-eastern-US.html and https://commentary.healthguideusa.org/2025/06/, accessed 2025-10-14. (commentary.healthguideusa.org)
10. NJHIN (NJDOH), https://www.nj.gov/health/njhin/, accessed 2025-10-14. (nj.gov)
11. NJII – NJHIN participants and metrics, https://www.njii.com/njhin, accessed 2025-10-14. (njii.com)
12. NJDOH press release – NJHIN birth record data exchange (June 25, 2025), https://www.nj.gov/health/news/2025/approved/20250625b.shtml, accessed 2025-10-14. (nj.gov)
13. CMS Medicaid – NJ FamilyCare 1115 Comprehensive Demonstration (effective through 6/30/2028), https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82571, accessed 2025-10-14. (medicaid.gov)
14. NJ DHS – NJ FamilyCare 1115 renewal and materials, https://www.nj.gov/humanservices/dmahs/home/waiver.html, accessed 2025-10-14. (nj.gov)
15. NJ DHS – NJ FamilyCare Medicaid MCOs (plan list), https://www.nj.gov/humanservices/dmahs/home/mltss_choose_plan.html, accessed 2025-10-14. (nj.gov)
16. Rural Health Transformation Collaborative catalog (internal consensus document), Rural Health Transformation Collaborative. R1. 10-11-25.pdf, on file with the State (internal reference), accessed 2025-10-14.

Assumptions and Open Questions

- The Collaborative catalog is treated as internal market information; final partner lists and scopes are subject to State procurement and due diligence.
- New Jersey's current participation status in interstate licensure compacts (IMLC, NLC, PSYPACT) should be confirmed to maximize workforce factors under the NOFO's technical score. (Policy status subject to change.)
- County-level rural targeting will be refined with NJHIN, Medicaid, and Census/RUCA data extracts during application drafting.
- If the Grants.gov system attachments differ from the NOFO PDF cited here, the Grants.gov package controls; reconcile any changes during red-team review. (cms.gov)

Compliance checklist (abbreviated)

- Required forms: SF-424; SF-424A; SF-LLL; Project/Performance Site. SF-424 19c "No." (files.simpler.grants.gov)
- Narratives: Summary (1 page); Project narrative (≤60 pages, double-spaced main text); Budget narrative (≤20 pages, single-spaced). (files.simpler.grants.gov)
- Attachments: Governor's endorsement (≤4); Business assessment (≤12); Program duplication assessment (≤5); indirect cost agreement (if applicable); other support (≤35). (files.simpler.grants.gov)
- Caps observed: Admin ≤10%; provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5%; prohibited 2 CFR 200.216 purchases; 45 CFR 156.400 restriction. (files.simpler.grants.gov)

Gantt-style Implementation (illustrative)

- Q1 2026: PMO mobilization; governance; data governance charter; procurement awards.
- Q1–Q2 2026: Cloud/data platform stood up; NJHIN interfaces finalized; hospital and FQHC onboarding waves.
- Q2–Q4 2026: Tele-ER/ICU go-lives; RPM cohort wave 1; pharmacy hubs phase-in.
- 2027: Scale to additional cohorts; policy milestones; evaluation/reporting cadence established (technical score refresh).

AI Generation Notice