Rural Health Transformation Grant Guide — North Carolina

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

North Carolina enters the CMS Rural Health Transformation (RHT) Program with a large rural population—3.47 million residents lived in rural areas in 2020 (33.3% of the state), the second-largest rural population nationally—creating both opportunity and urgency to scale sustainable access, workforce, data, and payment innovations (2020 Census/OSBM, 2023) (ncsl.org). The RHT Collaborative can support North Carolina's goals under the RHT NOFO by supplying configurable tele-specialty coverage (Avel eCare), remote physiologic monitoring (BioIntelliSense), consumer screening and navigation (Humetrix, retail partners), cybersecurity/data platforms (Microsoft), provider networks and governance (Cibolo Health), and program design/PMO support (Accenture, KPMG, PwC), all aligned to the NOFO's uses of funds and technical scoring factors (B–F) ~$50B across FY26–FY30, with funds each year split evenly between baseline and a workload component determined by state points; technical factors are re-scored annually and rural facility/population factors are set using Q4 2025 data. Applications are due November 5, 2025, with an optional LOI by September 30, 2025; only states may apply, with Governor designation and endorsement, and administrative expenses are capped at 10% (NOFO pp. 4–7, 21, 51–52, 55–56) (files.simpler.grants.gov)er payments at ≤15% and minor capital/infrastructure at ≤20% of the annual award; EMR replacement spending is ≤5% if a certified system existed as of 9/1/2025 (NOFO p. 18–19) . Th(files.simpler.grants.gov)offerings map to these parameters, supporting tele-enabled care (use-of-funds categories A, D, F, G, H, I, J, K), value-based payment enablement, workforce skilling, and statewide data architecture (Collaborative R1 portfolio) dicaid managed care transformation (July 2021), the July 2024 launch of Tailored Plans for behavioral health/I-DD populations, and robust HIE policy (NC HealthConnex) provide a platform to operationalize RHT investments at scale (ncdhhs.gov)e can support actuarial modeling/payment integrity, statewide outcome dashboards, and site-level implementation that aligns with NOFO scoring, while respecting State procurement and governance choices (Collaborative R1; NOFO) summary (for distribution)

- What RHT funds can support in NC (NOFO):
    - At least three uses among prevention/chronic disease, limited provider payments, consumer tech for chronic disease, tech TA (telehealth/AI/robotics), workforce with 5-year rural commitments, IT/cybersecurity, right-sizing services, behavioral health/OUD/SUD, innovative care/value-based models, minor capital/infrastructure, and partnerships (NOFO pp. 10–11) .
- (files.simpler.grants.gov)ructure, and caps:
    - LOI 9/30/2025; due 11/5/2025; award 12/31/2025; 10% admin cap; ≤15% for provider payments; ≤20% minor capital; ≤5% EMR replacement where certified EMR already in place (NOFO pp. 4–6, 18–21, 55–56) (files.simpler.grants.gov):
    - 3.47M rural residents (33.3%) as of 2020; strong Medicaid managed care and Tailored Plans; HIE connection mandate—positions for data-driven implementation (OSBM 2023; NCDHHS 2024; NC HIEA) (osbm.nc.gov)orative supports NC:
    - 24/7 tele-ER/ICU/hospitalist support; remote monitoring; consumer triage and multilingual tools; retail clinic integration; AI decision support and ambient documentation; cybersecurity; HVN governance; program management and analytics (Collaborative R1) r:
    - Only states apply; one application; Governor letter required; SF-424 Item 19c "No" (E.O. 12372 not applicable) (NOFO pp. 6, 25, 56) .

2(files.simpler.grants.gov)RFP Fit

2.1 Snapshot of the NOFO

- Eligibility: Only the 50 states; DC/territories ineligible. Governor designates lead agency; AOR signs forms (NOFO pp. 6–7) .
- (files.simpler.grants.gov)l LOI due 9/30/2025; applications due 11/5/2025 11:59 p.m. ET; expected award 12/31/2025; earliest start 12/31/2025; informational webinars Sept 19 & 25, 2025 (NOFO pp. 4–5, 55) .
- (files.simpler.grants.gov).gov only; Executive Order 12372 does not apply—check "No" on SF-424 item 19c (NOFO p. 56) .
- (files.simpler.grants.gov): $50B across FY26–FY30; 50% baseline equal split; 50% workload via points; rural

facility/population factors (A1–A7) set once (Q4 2025); technical factors (B–F) re-scored annually. Weighting Table 3 specifies A/B/C/D/E/F factor weights (NOFO pp. 12, 50–52) (files.simpler.grants.gov)limitations: Must address ≥3 categories; admin cap 10%; provider payments ≤15%; Category J minor renovations/equipment ≤20%; EMR replacement ≤5% if HITECH-certified EMR in place 9/1/2025; restrictions consistent with 2 CFR and HHS GPS (NOFO pp. 18–21) .

- (files.simpler.grants.gov)and page limits: Project summary (1 page); Project narrative (≤60, double-spaced main text); Budget narrative (≤20, single-spaced); Governor's endorsement (≤4); Business assessment (≤12); Program duplication assessment (≤5); other support (≤35) (NOFO pp. 25–27, 40–42) .

2(files.simpler.grants.gov)ollaborative capability → Evidence

- Required: Rural Health Plan with strategies across access/outcomes/technology/workforce/partnerships; KPIs FY26–31; state policy timelines (NOFO pp. 27–37). Collaborative: statewide tele-specialty coverage, RPM, consumer screening, AI documentation, cybersecurity, governance/HVNs, PMO and analytics. Evidence: Collaborative R1 portfolio; Microsoft rural cybersecurity; Viz.ai stroke AI use; BioIntelliSense RPM models (Collaborative R1) actors (technical B–F). Collaborative supports: B.1/B.2 via population health tech and chronic disease programs; C.1/C.2 via HVNs and EMS tele-support; D.1/D.2/D.3 via workforce skilling and compact-aligned licensure workflows; E.1/E.2/E.3 via Medicaid incentive design and analytics; F.1/F.2/F.3 via telehealth/RPM/data/consumer apps (NOFO pp. 51–52; Collaborative R1) . (files.simpler.grants.gov)t J, K map to Collaborative offerings (NOFO pp. 10–12; Collaborative R1) .
- Compliance checkpoi(files.simpler.grants.gov)1ider payment 15% cap; minor capital 20% cap; EMR 5% cap; prohibited costs; noncompliance remedies and recovery (NOFO pp. 18–21, 56) .

3. North Carolina Context Snapshot

3.1 Popu(files.simpler.grants.gov)and facilities

- Rural population: 3,474,661 residents lived in rural areas (33.3%) in 2020, second-largest rural population in the U.S. (OSBM 2023 summarizing 2020 Census) .
- Rural counties: NC Rural Center classifie(osbm.nc.gov) 2020–2023 rural growth accelerated 2.7% (NC Rural Center 2024) .
- Facility mix (state program support): NC (ncruralcenter.org)th supports 20 Critical Access Hospitals (CAHs) and 11 small rural hospitals (NCDHHS Rural Hospital Program, accessed 2025) .
- FQHCs: 38 HRSA Health Center Program awar(ncdhhs.gov)0 patients in 2024 (HRSA UDS state profile, 2024) .
- RHCs: 68 Rural Health Clinics received HR(data.hrsa.gov)ocations in 2022 (HRSA) .

3.2 Workforce and HPSA

- Shortage areas: (hrsa.gov)ties with health professional shortages, 97 with mental health shortages, and 93 with dental shortages (2025) .
- Collaborative alignment: workforce develo(ncdhhs.gov)entation and tele-mentoring (Avel eCare), retail pharmacy workforce pathways (Walgreens/CVS), and CHC training (NACHC) .

3.3 Medicaid and payment ene launch 7/1/2021 (Standard Plans); Tailored Plans launched 7/1/2024 for ~210k beneficiaries with serious behavioral health/I-DD needs (NCDHHS) .

- Expansion: Medicaid expansi(ncdhhs.gov)nsion materially increases coverage in rural areas (AP News synthesis, 2024) .
- HIE: NC HIEA requires connection to NC Hea(apnews.com)ition of receiving certain state funds; the connection mandate deadline has passed (Jan 1, 2023), with active onboarding and enforcement via good-faith participation (NC HIEA) .

3.4 Broadband, telehealth, maternal/behavi(hiea.nc.gov)ive)

- Telehealth/IT: Tailored Plans integrate physical/behavioral health with care management—positions for remote care

scaling (NCDHHS 2024) .

- Behavioral health and SUD: Tailored Plans(ncdhhs.gov)behavioral capacity needs align with RHT H/U uses of funds; Collaborative supports 24/7 tele-behavioral and crisis response (Avel eCare; Teladoc) .

3.5 Table: NC metrics and matching Collaborative capabilities020): 3.47M (33.3%) → statewide primary care, tele-specialty grid, RPM scaling (OSBM 2023; Collaborative R1) .

- CAHs: 20; small rural: 11 → tele-ICU/tele-hospitalist; cyber (osbm.nc.gov) ive R1) .
- FQHC awardees: 38; patients: 723,770 (2024) → chronic disease/risk stratification,(ncdhhs.gov),orative R1) .
- RHCs: 68 (2022) → RPM kits; virtual supervision; pharmacy-based monitoring (HRSA 2022; Collaborative R1(data.hrsa.gov)ry care, county count), 97 (MH), 93 (dental) → workforce skilling/ambient AI; tele-mentoring; retail health i(hrsa.gov)4. Strategy Aligned to RFP

4.1 Strategy overview

- Organizing model: State-enabled regional High Value Networks (HVNs) of independent rural provid(ncdhhs.gov) linked with tele-specialty hubs (Avel eCare), FQHCs, and retail clinics for distributed access; central data/cyber platform (Microsoft) feeding dashboards and CMS reporting; predictive analytics for clinical gaps (Pangaea/Humetrix) .
- RHT pillars mapping:
    - Make rural America healthy again: Retail kiosks/vision AI screening; RPM for high-risk cardiometabolic patie/Topcon/Humetrix; BioIntelliSense) .
    - Sustainable access: Tele-hospitalist/ICU/ER; right-sizing service lines with minor capital; EMS tele-support (Avel eCare) .
    - Workforce: Ambient documentation; tist-led chronic care (Walgreens/CVS) .
    - Innovative care: Value-based network design; sharetegrity (Accenture/Cibolo) .
    - Tech innovation: Secure cloud, TEFCA connectivity, AI triage/detecorks PRISMA/PRISMANet referenced in Collaborative) .

4.2 Scoring alignment (NOFO Table 3)

- B.1/B.2: Pol infrastructure/health & lifestyle—consumer risk stratification, RPM, CHC workflows .
- C.1/C.2/C.3: Strategic partnerships, EMS, CON—HVN governance tools; olicy analysis (Collaborative integrators) .
- D.1/D.2/D.3: Talent, licensure compacts, scope—skilling programs; compact adoption support; pharmacist models (Col1/E.2/E.3: Medicaid incentives, duals, STLDI—analytics, payment integrity, SPA support (Collaborative R1) .
- F.1/F.2/F.3: Remote care, dsumer tech—telehealth, cybersecurity, patient apps (Collaborative R1) .

4.3 Equity strategy

- Focus geographies: Counties with HPSer disease burden per Tailored Plan regions; deploy bilingual intake (Humetrix), CHC partnerships, and retail acy deserts to reduce travel burden (NCDHHS Tailored Plans; Collaborative R1) .

4.4 Data use and privac HealthConnex participation supports exchange; Collaborative platforms integrate with HIPAA/FHIR standards and TEFCA-aligned networks (NC HIEA; Collaborative R1) .

- Security: Cybersecurity planning aligned to HHS policy; cloud services with security controls; CMS evaluati(ncdhhs.gov)p; Collaborative R1) .

5. Program Design Options (NC-tuned)

Option A: Rural Acute Support Grid

- Target: CAHs/small rural hospitals; EMS; frontier-like tracts.
- Problem: Staffing variabilit(hiea.nc.gov)Eend on referrals (2025 NCDHHS) .
- Collaborative components: 24/7 tele-ER/ICU/hospitalist, ePharmacy (Avel eCare); EMS tele-consult; Viz.ai stroke triage;(files.simpler.grants.gov)ato equip tele-rooms (≤20%) .
- Payment logic: Global support grants to facilities; Medicaid ED bypass incentives; shared-savings on reduced transfers.
- Policy: EMS protocols; data-sharing through NC HealthConn(ncdhhs.gov)cts.
- Pros/risks: Improved local stabilization; cyber risk reduced; risk—vendor onboarding/bandwidth; mitigation—NC Broadband programs; SI partner PMO.

Option B: Community Cardiometabolic in rural counties and Tailored Plan members with comorbidities.

- Problem: Chronic disease prevalence and access barriers.
- Components: Retail screening (Higi/Topcon); multilingual triage (Humetrix); RPM (BioIntelliSense); pharmacist-led titration via standing orders with virtual physician backup; CHC care management .
- Payment logic: Medicaid incentive pools (E.1), medication therapy management, shared savings on avoidable ED/hospitalizations.
- Policy: Pharmacist scope protocols; Medicaid coverage for RPM/telepharmacy.
- Pros/risks: Population-level impact; risk—adherence; mitigation—pharmacy follow-ups, SMS nudges.

Option C: Behavioral Health and Crisis Integration

- Target: Tailored Plan enrollees and rural EDs/law enforcement.
- Proychiatry; ED boarding.
- Components: 24/7 tele-behavioral; mobile crisis tele-support; 988 integration; virtual IOP pilots (Avel eCare; Teladoc; Accenture crisis platforms) .
- Payment logic: Tailored Plan PMPMs and value-based metrics; state performance incentives.
- Policy: Data-sharing with NC HIEA; consent management; parity compliance.
- Pros/risks: Reduced ED boarding; risk—workforce burnout; mitigation—ambient documentation.

Option D: Rural Data and Cyber Resilience

- Target: All state-funded rural providers.
- Problem: Fragmented data; cyber exposure.
- Components: Azure-based data lakehouse; connectors to Hft assessments; statewide dashboards; grant PMO (Accenture/KPMG/PwC; Microsoft) .
- Payment logic: State-level shared services; allocate ≤10% admin; category F uses.
- Pros/risks: Reporting readiness; risk—change management; mitigation—training, CHC champions.

Recommended primary: Option A + B statewide; backup: Option C regionally.

6. Governance and Collaborative Roles

6.1 Structure (illustrative)

- State Lead Agency (Governor-designated): convening authority; NOFO compliance; funds flow; CMS liaison (NOFO p. 6–7) .
- Rural ealth): member-owned networks for investment governance and transparency .
- PMO/Systems Integrator (Accenture/KPMG/PwC): workplan, procurement support, vendor orchestration, evaluation and reporting .
- Clinical delivery: CAHs, small rural hospitals, FQHCs, RHCs, retail clinics; Tele-specialty hubs (Avel eCare); RPM (BioIntelliSense); behavioral health (Avel/Teladoc) .
- Data & cyber: Microsoft platform;(files.simpler.grants.gov)onnectivity; consent tools (Humetrix) .

6.2 RACI (high-level)

- Responsible: PMO (SI partners) for inteeporting; Avel eCare for tele-clinical SLAs; BioIntelliSense for RPM logistics.
- Accountable: State Lead Agency for NOFO complive oversight (NOFO p. 15–16) .
- Consulted: NC HIEA; Hospital Association; FQHC association; payers; universities.
- Informed: County health departmentseening campaigns) .

7. Payment and Funding

- Within NOFO caps: ≤10% admin; provider paymen≤20%; EMR replacement ≤5% where applicable (NOFO pp. 18–21) .
- Medicaid alignment: Use Standard and Tailored Plan quality incentives; SPAs for telepharmacy/RPM where needed; actuarial modeling for shared savings (Collaborative R1) .

Illustrative co(files.simpler.grants.gov)ble (planning placeholder $200M/year per NOFO guidance)

- Tele-acute grid (A): $60–80M/yr; RHT categories F,G,K; deliverables: tele-ER/ICU SLAs, EMS tele-support, reduction in .
- Community cardiometabolic (B): $40–60M/yr; categories A,C,D,F; deliverables: screenings, RPM enrollments, pharmacist metrics .
- Data/cyber (D): (files.simpler.grants.gov)ry F; deliverables: data lake, dashboards, cyber uplift plans .
- Behavioral health integration (C): $20–40M/yr; categories H,I,F; deliverables: tele-BH coverage, crisis min/PMO: ≤10% (cap) with reporting stack and NCC submissions (NOFO p. 39) .

8. Data, Measurement, and Evaluation

- Core measures: transfers avoided; ED LOS; 30-day readmissions; RPM engagement and alert-(files.simpler.grants.gov)T resolution times; workforce retention; cyber incidents averted.
- Data sources: claims (Medicaid/Medicare), NC HealthConnex clintate profile), EMS CAD data, pharmacy dispensing, consumer app events (NC HIEA; HRSA UDS) .
- Cadence: quarterly dashboards; annual NCC package aligned to NOFO reporting (NOFO pp. 58–60) ners provide quasi-experimental designs; CHC/CAH site comparisons; CMS/third-party coope(files.simpler.grants.gov)tive agreement terms (NOFO pp. 15–16) .

9. Implementation Plan

Gantt-style workplan (12–24 months; contingent on award and procurement)

Workstream	Start	End	Owner	Outputs
Governance/PMO setup	M1	M3	State + SI	PMO charter; RACI; risk plan.
Data & cyber platform	M1	M12	Microsoft + SI	Data lake; connectors to HealthConnex; security plan.
Tele-acute grid rollout (waves of CAHs and hospitals)	M2	M18	State + Avel + hospital partners	Tele-ER/ICU SLAs; site go-lives. (hiea.nc.gov)
Community cardiometabolic program	M3	M18	FQHCs/Retail partners + RPM vendor	Screening events; RPM cohorts. (files.simpler.grants.gov)
Behavioral health integration	M4	M20	Avel/Teladoc + Tailored Plans	Tele-BH coverage; crisis metrics.

Workstream	Start	End	Owner	Outputs
Evaluation & reporting	M1	Ongoing	State PMO + Evaluator	Dashboards; quarterly reports; NCC packet.

Procurement/legal gating

- Master enabling agreements with SI and clinical tech; HealthConnex data use alignment; retailer MOUs; Tailored Plan quality metric alignment (NC HIEA; NCDHHS) .

10. Risk Register (selected)

Risk	Mitigation	Owner
Broadband constraints in last-mile sites	Conduct site surveys, deploy offline-capable RPM, and use phased activation.	SI/Data team
Workforce burnout	Provide ambient AI documentation support and tele-mentoring.	Clinical leads
Cyber incidents	Perform security assessments, enforce MFA/monitoring, and maintain incident playbooks.	State CISO + Microsoft team
Data-sharing gaps	Execute HealthConnex participation agreements and consent workflows.	NC HIEA liaison
Policy dependencies (scope, compacts)	Maintain policy roadmap and conditional points with 2027/2028 checkpoints per NOFO. (hiea.nc.gov)	State policy office
Provider payment cap exceedance	Track Category B spend ≤15%. (NOFO p. 18)	Finance
Capital cap exceedance	Gate projects and monitor Category J ≤20%.	Finance
EMR replacement cap misinterpretation	Inventory certified systems as of 9/1/2025; limit spend to ≤5%.	PMO IT
Subrecipient monitoring	Implement PMO subaward SOPs. (NOFO pp. 58–60) (hiea.nc.gov)	Grants management
Noncompliance with reporting	Calendarize NCC/FFR/FFATA submissions. (NOFO pp. 59–60)	PMO

11. Draft RFP Response Language (paste-ready excerpts)

11.1 Proj(files.simpler.grants.gov)e)

North Carolina proposes a Rural Health Transformation Plan focused on: (1) stabilizing rural acute and (files.simpler.grants.gov) via a statewide tele-specialty grid; (2) improving cardiometabolic outcomes through retail/community scree(files.simpler.grants.gov) navigation, and remote monitoring; (3) integrating behavioral health crisis and outpatient services; and (4) establishing a secure, interoperab(files.simpler.grants.gov)ecurity platform connected to NC HealthConnex. The Plan addresses at least three uses of funds and adh(files.simpler.grants.gov)tions (admin ≤10%; provider payments ≤15%; Category J ≤20%; EMR replacement ≤5% where applicable) and(files.simpler.grants.gov)uirements (NOFO pp. 10–12, 18–21) .

11.2 Rural Health Needs & Target Population (narrative excerpt)

As of 2020, 3.47 million North Carolinians (33.3%) lived in rural areas, the nation's second-largest rural population; rural growth accelerated 2020–2023 (OSBM; NC Rural Center) . The state supports 20 CAHs and 11 small rural hospitals, 38 HRSA-funded health center awardees (723,770 patients in 2024), and 68 RHCs (NCDHHS; HRSA) . Workforce shortages persist across 90+ counties (NCDHHS 2025) .

11.3 Goals, Strategies, and Policy Actions (excerpt)

We will deploy: (A) statewide tele-ER/ICU/hospitalist and EMS tele-support; (B) cardiometabolic con(files.simpler.grants.gov)ning, RPM, and pharmacist-enabled protocols; (C) 24/7 tele-behavioral care integrated with Tailored Plans; and (D) a secure data/cyber platform integrated with NC HealthConnex. We will pursue conditional policy points with timelines consistent w(osbm.nc.gov)rotocols, compact participation where applicable) (NOFO pp. 51–52) .

11.4 Proposed Initiatives & Use of Funds (excerpt)

Each initiati(ncdhhs.gov)selines/targets, statewide county FIPS coverage, and funding est(ncdhhs.gov)caps (NOFO pp. 25–27, 39) .

11.5 Implementation, Stakeholder Engagement, and Metrics (excerpt)

We will leverage NC HealthConnex participation, Medicaid managed care/Tailored Plans, and collaborative partners for timely onboarding, with quarterly dashboards and annual NCC submissions per NOFO (NOFO pp. 55–60; NC HIEA) .

Assumptions and Open Questions

- The NOFO (CMS-RHT-26-001) as posted 9/15/2025 governs requirements, caps, scoring, and timelines cited here; if (files.simpler.grants.gov)ded NOFO, State will reconcile differences (assumption) .
- SNAP waiver status, licensure compacts, and pharmacist scope changes in NC require confirmation to claim conditional technical points by 12/31/2027(files.simpler.grants.gov).2/B.4) per NOFO (open items) .
- Final counts of CCBHCs and hospitals receiving Medicaid DSH (most recent SPRY) to be confirmed for the application (open items; NOFO asks to include) .

Checklists (NOFO-compliant)

- Eligibility and submissions
    - Governor(files.simpler.grants.gov)ement (≤4 pages). ✔ (NOFO pp. 6, 40–41)
    - AOR authorized, SAM.gov active UEI, Grants.gov registered. ✔ (NOFO p. 2, 23–24)
    - SF-424: Check "No" on item 19c (E.O. 12372). (files.simpler.grants.gov)
- Page-limited documents
    - Project summary (1); Project narrative (≤60, double-spaced); Budget narrative (≤20, single) (NOFO pp. 25–27, 39–40)
    - Business assess(files.simpler.grants.gov)m duplication assessment (≤5); other support (≤35) (NOFO pp. 40–42)
- Budget guardrails
    - Admin ≤10% (total, incl. indirects); Provid(files.simpler.grants.gov)Category J ≤20%; EMR replacement ≤5% (NOFO pp. 18–21, 39)
- Uses of funds
    - Address ≥3 categories; document prohi(files.simpler.grants.gov)ce (NOFO pp. 10–12, 17–21)

12. References

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3. Rural Health Transformation – Frequently Asked Questions, CMS PDF, 2025. https://www.c(files.simpler.grants.gov)alth-transformation-frequently-asked-questions.pdf (accessed 2025-10-14).
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10. HRSA UDS — North Carolina State Profile (2024 reporting)(osbm.nc.gov)gov/tools/data-reporting/program-data/state/NC (accessed 2025-10-14).
11. HRSA — Allocation to Rural Health Clinics for COVID-19 Testing (state count(ncsl.org)w.hrsa.gov/rural-health/topics/coronavirus/testing-allocation (accessed 2025-10-14).
12. NCDHHS Press Release — Tailored Plans launch July 1, 2024. https://www.ncdhhs.gov/news/press-releases(ncruralcenter.org)aid-launches-behavioral-health-and-intellectualdevelopmental-disabilities-tailored-plans (accessed 2025-10-14).
13. NCDHHS Press Release — NC Medicaid Managed Care launch July 1, 2021. http(ncdhhs.gov)ews/press-releases/2021/06/30/nc-medicaid-managed-care-launch-statewide-july-1 (accessed 2025-10-14).
14. NC HIEA — What Does the (data.hrsa.gov)lthConnex), accessed 2025. https://hiea.nc.gov/providers/what-does-law-mandate (accessed 2025-10-14).
15. NC HIEA — For Providers (NC HealthConnex connection), acce(hrsa.gov)iea.nc.gov/providers (accessed 2025-10-14).
16. Rural Health Transformation Collaborative. R1. 10-11-25 (internal coalition catalog), 2025. [Internal source provided by user]. (ncdhhs.gov)are, BioIntelliSense, Humetrix, Viz.ai, Walgreens, Microsoft, Accenture entries in Collaborative R1 (internal).

13. AI Generation Notice

This guide was(ncdhhs.gov)0-14 using the gpt-5 model. It draws on the CMS RHT NOFO, CMS program pages, HRSA data, NCDHHS/NC HIEA sources, and the Rural Health Transformation Coll(hiea.nc.gov) All facts, figures, and citations must be independently validated against source documents, current statutes/regulations, and o(hiea.nc.gov)ore use in any submission or public communication.