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

1. Executive Summary South Carolina can use the Rural Health Transformation (RHT) Program to stabilize rural access, modernize technology, and expand value-based care. The RHT Collaborative's members—spanning virtual clinical services, consumer screening, remote monitoring, retail health, cybersecurity, analytics, and program integration—can support South Carolina's plan development and execution within the NOFO's structure (cooperative agreement; single state applicant; five budget periods) and its guardrails (e.g., provider-payment cap 15%, capital cap 20%, EMR replacement cap 5%, administrative cap 10%). (files.simpler.grants.gov)

High-leverage offerings for near-term impact include: (a) tele-emergency, tele-ICU, and specialist backup to keep care local (Avel eCare); (b) continuous remote physiologic monitoring for chronic disease and maternal health (BioIntelliSense); (c) multi-language consumer triage and patient-facing data tools (Humetrix); (d) statewide virtual/retail access for primary, urgent, behavioral health (Teladoc, CVS, Walgreens); and (e) secure cloud, interoperability, and cyber hardening at rural hospitals (Microsoft). These capabilities align with RHT priorities on prevention, workforce, innovative care, and technology and map directly to NOFO technical factors on remote care services, data infrastructure, consumer-facing tech, EMS, and strategic partnerships.

South Carolina's rural context underscores the fit. In 2020, about 1.25 million residents (24.4%) lived in rural areas; the state's rural population grew in total but declined slightly in the rural share, creating access and workforce pressures as care consolidates. (richmondfed.org) As of July 2025, RHIhub counts 3 Critical Access Hospitals (CAHs), 106 Rural Health Clinics (RHCs), and 139 FQHC delivery sites outside large urban areas; HPSA designations remain material (e.g., primary care: 93 HPSAs covering ~1.40 million residents). (ruralhealthinfo.org) Meanwhile, broadband infrastructure is approaching universality: by April 2025, only ~1.1% of residential broadband-serviceable locations remained unserved/underserved without an investment commitment, positioning the state for scaled telehealth and remote monitoring. (ors.sc.gov)

The Collaborative's role is enabling and conditional. Offerings require State sponsorship, procurement, data-use agreements, payer alignment, and local integration. Where state policy changes improve technical scoring (e.g., licensure compacts, scope of practice, EMS coordination), partners can provide analytic and implementation support; conditional points convert to full points only upon enactment by deadlines specified in the NOFO (most by December 31, 2027; certain B.2/B.4 measures by December 31, 2028). (files.simpler.grants.gov)

One-page printable summary (for distribution)

- South Carolina fit
  - Rural share: 24.4% (2020); ~1.25M rural residents. (richmondfed.org)
  - Rural facilities: 3 CAHs, 106 RHCs, 139 FQHC sites (outside >50k urban areas), July 2025. (ruralhealthinfo.org)
  - HPSAs (3/31/2025): Primary care 93 (1.40M residents, 162 practitioners needed); Dental 90; Mental health 73. (commentary.healthguideusa.org)
  - Broadband: 1.1% residential BSLs still unserved/underserved (April 2025). (ors.sc.gov)
  - Medicaid: SPA SC-24-0026 limits MCOs to 2–4 (effective 11/2/2024); high managed-care penetration historically. (medicaid.gov)
- NOFO anchors (selected)
  - Application due Nov 5, 2025, 11:59 p.m. ET; webinars Sep 19 & 25; optional LOI Sep 30; award by Dec 31, 2025. (files.simpler.grants.gov)
  - Scoring: 50% rural facility/population factors + 50% technical factors (Table 3). (files.simpler.grants.gov)
  - Funding caps: provider payments ≤15%; capital (J) ≤20%; EMR replacement ≤5% (if HITECH-certified EMR existed 9/1/2025); "rural tech catalyst" ≤ the lesser of 10% or $20M/period; admin ≤10%. (files.simpler.grants.gov)
- Collaborative support (illustrative)
  - Virtual hospital/tele-specialty (Avel eCare), RPM (BioIntelliSense), consumer triage/PHR (Humetrix), statewide virtual/retail access (Teladoc, CVS, Walgreens), cybersecurity/interoperability (Microsoft), analytics/program integration (Accenture/KPMG/PwC/AVIA).
- Compliance notes
  - Submit via Grants.gov; one application per state; check "No" on SF-424 Item 19c (EO 12372 not applicable). (files.simpler.grants.gov)

2. Eligibility and RFP Fit 2.1 Program structure and requirements (selected)

- Applicant eligibility: Only the 50 U.S. states; DC/territories ineligible. Governor may designate lead agency; AOR must sign. (files.simpler.grants.gov)
- Key dates: LOI by Sep 30, 2025; application by Nov 5, 2025; award and earliest start Dec 31, 2025;

applicant webinars Sep 19 and 25, 2025. (files.simpler.grants.gov)
- Funds and distribution: ~$50B across FY26–FY30; 50% baseline equal split; 50% workload using points calculated from rural facility/population and technical factors. (files.simpler.grants.gov)
- Application contents: Project summary (1 page), Project narrative (≤60 pages, double-spaced main text), Budget narrative (≤20 pages), attachments (Governor's endorsement ≤4 pages, business assessment ≤12 pages, program duplication assessment ≤5 pages, others ≤35 pages), and standard forms (SF-424/SF-424A/SF-LLL/Project Site). (files.simpler.grants.gov)
- Intergovernmental review: EO 12372 does not apply; check "No" on SF-424 Box 19c. (files.simpler.grants.gov)
- Funding limits (selected): provider payments ≤15% of award; Category J (capital/infrastructure) ≤20%; EMR replacement ≤5% if an eligible system exists as of 9/1/2025; Rural Tech Catalyst-like initiatives ≤ the lesser of 10% or $20M per budget period; administrative expenses (including indirects) ≤10%. (files.simpler.grants.gov)

2.2 Requirement-to-Collaborative mapping (evidence-based examples)

- Rural access expansion → Tele-ER/ICU, hospitalist backup, and rural specialty clinics (Avel eCare); RPM for chronic disease and perinatal risk (BioIntelliSense); virtual visits via Teladoc and retail health partners; supports NOFO uses A, H, I and technical factors C.1, C.2, F.1.
- Consumer-facing technology → Multi-language intake/triage and PHR/Blue Button tools for beneficiaries (Humetrix); retail kiosk screening (Higi/Topcon) with routing to care. Supports NOFO uses C, F and factors F.3, B.1/B.2.
- Data and interoperability → Microsoft secure cloud/AI stack; TEFCA-aligned exchange via eClinicalWorks PRISMA/PRISMANet; analytics and program dashboards; supports F.2 and evaluation/reporting.
- Workforce enablement → On-demand clinician-to-clinician consults (Avel eCare), ambient clinical documentation, and pharmacist-led chronic care extensions with payer-aligned models; supports D.1, D.3 and C.1.
- Payment and financial sustainability → Claims modernization, payment integrity, and value-based model design (Accenture/KPMG/PwC) aligned with NOFO E.1/E.2.

Table: RFP requirement → Collaborative capability → Evidence

- Submit 60-page narrative covering needs, plan, initiatives, metrics → Advisory/system integrator templates and PMO support (Accenture/KPMG/PwC/AVIA). Evidence of program integration and analytics.
- ≥3 uses of funds; tech and remote care emphasized → RPM, tele-ER/ICU, consumer apps, cyber upgrades; documented partner deployments.
- Technical scoring on remote care, data infra, consumer tech → F.1/F.2/F.3 addressed via Microsoft cloud, Humetrix apps, BioIntelliSense RPM, Teladoc/retail virtual access.
- Admin cap ≤10% and flow-down compliance → SI partners' grants management, dashboards, subrecipient monitoring capability.

3. South Carolina Context Snapshot 3.1 Population and geography

- Rural population: 1,249,989 of 5,118,425 (24.4%) in 2020 (Census urban-rural delineation; Richmond Fed analysis). (richmondfed.org)
- Frontier measure: Using USDA ERS FAR definitions (2010 methodology), South Carolina shows negligible/no FAR level-4 areas on the national FAR-4 map; FAR is an older but policy-relevant proxy for extreme remoteness. (ers.usda.gov)

3.2 Rural facility mix and networks

- Facilities (outside major urban areas), July 2025: 3 CAHs; 106 RHCs; 139 FQHC delivery sites. (ruralhealthinfo.org)
- EMS and small hospitals face staffing volatility; virtual backup and tele-specialty clinics can support continuity and keep patients local.

3.3 Workforce and HPSAs (as of 3/31/2025)

- Primary care HPSAs: 93; designated population ~1.40M; 162 practitioners needed to remove HPSA status. Dental HPSAs: 90 (needed 221). Mental health HPSAs: 73 (needed 99). (Derived from HRSA Quarterly Summary reported June–July 2025.) (commentary.healthguideusa.org)
- Collaborative fit: Tele-mentoring and on-demand specialist support (Avel eCare); pharmacist-enabled chronic disease programs; ambient documentation to reduce burnout.

3.4 Medicaid, managed care, and payment environment

- South Carolina Medicaid (Healthy Connections) operates comprehensive managed care statewide and (via SPA SC-24-0026) limits the number of plans to two–four (effective 11/2/2024), creating a defined environment for value-based arrangements. (medicaid.gov)
- Historically, South Carolina enrolled the vast majority of Medicaid beneficiaries in managed care (e.g., 97.9% in managed care in data summarized by CRS). Value-based models can be aligned with plan contracts. (everycrsreport.com)
- Medicaid/CHIP enrollment: April–June 2025 dashboards show ongoing coverage for ~26% of residents (2024 average), with unwinding effects in 2025. (usafacts.org)

3.5 Broadband and telehealth readiness

- As of April 2025, only ~28,724 broadband-serviceable locations remained unserved/underserved without an investment commitment—about 1.1% of residential BSLs—supporting scale for RPM and virtual care. (ors.sc.gov)

3.6 Maternal and behavioral health relevance

- South Carolina participates in CMS's Transforming Maternal Health (TMaH) Model (launched Jan 1, 2025), enabling complementary maternal health interventions (screening, remote monitoring, and social needs linkages) in rural areas. (cms.gov)

Table: Metrics → Year → Source → Collaborative capability mapped

- Rural share 24.4% → 2020 → Richmond Fed/Census → Tele-specialty, RPM, retail access. (richmondfed.org)
- CAHs=3; RHCs=106; FQHC sites=139 → 2025 → RHIhub (HRSA data) → Tele-ER/ICU, RPM, cyber upgrades for small facilities. (ruralhealthinfo.org)
- Primary care HPSAs=93 (1.40M residents; 162 needed) → 2025 → HRSA Quarterly (via HealthGuideUSA) → Tele-mentoring, pharmacist models, ambient AI. (commentary.healthguideusa.org)
- Unserved residential BSLs ~1.1% → 2025 → SCBBO/ORS press release → Statewide RPM/telehealth scale feasibility. (ors.sc.gov)
- Medicaid MCOs limited to 2–4 → 2024/2025 → medicaid.gov SPA SC-24-0026 → Contractable VB targets and provider incentives. (medicaid.gov)

4. Strategy Aligned to RFP 4.1 Transformation model (conditional)

- A phased rural network model centered on: (1) clinical access expansion (tele-ER/ICU; rural specialty clinics); (2) community prevention and chronic disease management (retail screenings + RPM + virtual coaching); (3) workforce support (tele-mentoring; ambient documentation); (4) data, interoperability, and cybersecurity uplift; and (5) value-based payment pilots for rural provider networks.
- Alignment to NOFO pillars and technical factors:
  - Make rural America healthy: consumer screening + RPM + virtual follow-up (Humetrix, Higi, Topcon, BioIntelliSense, Teladoc).
  - Sustainable access: tele-hospitalist, tele-ICU, and retail hubs to keep patients local; EMS integration.
  - Workforce development: tele-mentoring; scope-of-practice expansions (policy-contingent); ambient AI to cut documentation time.
  - Innovative care: rural HVNs and ACO-oriented models with analytics and payment integrity support.
  - Technology innovation: secure cloud, TEFCA-aligned exchange, cyber hardening, and patient-facing apps.

4.2 Equity strategy

- Combine retail locations, FQHCs, and community events for outreach; use multi-language digital intake and culturally tailored guidance; apply analytics to identify untreated/under-treated patients and route to local care teams.

4.3 Data use and privacy

- Architecture uses HIPAA-aligned cloud controls, TEFCA-enabled exchange, and role-based access; patient-facing consent tools support data-sharing preferences.

5. Program Design Options (tuned to South Carolina) Option A. Rural Chronic Disease and Hypertension Collaborative

- Target: Adults in rural counties with uncontrolled hypertension/diabetes (align with HPSAs and high-risk ZIPs).
- Problem: High chronic disease burden with limited local specialty access; frequent ED use.

- Collaborative services: Retail BP/retinopathy screening (Higi/Topcon), RPM (BioIntelliSense), tele-coaching/visits (Teladoc), pharmacist-enabled management (CVS/Walgreens) connected to local FQHC/PCP.
- Payment logic: MCO-contracted pay-for-performance for BP control/A1c reduction; shared savings at network level; provider payments within 15% cap. (files.simpler.grants.gov)
- Enablers: Cloud analytics dashboards; TEFCA exchange; ambient AI for documentation.
- Pros/risks: Rapid scale via retail footprint; risk of digital divide mitigated by SC's high coverage and device support; governance through rural HVN. (ors.sc.gov)

Option B. Rural Maternal Safety Net (complements CMS TMaH)

- Target: Medicaid/CHIP pregnant/postpartum individuals in rural SC.
- Problem: Access gaps in prenatal/postpartum care and behavioral health.
- Collaborative services: RPM for BP/weight/temp (BioIntelliSense), multi-language intake and social needs routing (Humetrix), tele-MFM consults and ED escalation via Avel eCare; integration with local OB/FQHCs and community events.
- Payment logic: Episode-based incentives for prenatal visit adherence and postpartum BP control; linkage to TMaH technical assistance. (cms.gov)
- Pros/risks: Strong CMS model complement; requires contracting and care-path alignment with hospital affiliates.

Option C. Rural Behavioral Health and Crisis Linkage

- Target: Rural adults/adolescents with OUD/SUD and co-occurring mental health needs.
- Problem: Limited psychiatric access and crisis stabilization; high EMS transports.
- Collaborative services: 24/7 tele-behavioral consults; pharmacy-based OUD risk alerts and adherence services; 988 crisis integration and virtual crisis care support; referral tracking via analytics.
- Payment logic: Case rates with quality gates (follow-up within 7 days, reduced ED revisits).

Option D. Cybersecurity and Data Modernization for Rural Facilities

- Target: CAHs, rural PPS hospitals, RHCs, FQHCs.
- Problem: Cyber risk and interoperability gaps.
- Collaborative services: Microsoft cyber program for rural hospitals; identity and device hardening; TEFCA-aligned exchange; eCW PRISMA/PRISMANet integration.
- Payment logic: Capital/infrastructure Category J (≤20%); non-capital IT services under F and K; admin ≤10%. (files.simpler.grants.gov)

6. Governance and Collaborative Roles 6.1 Structure (illustrative)

- State lead agency (Governor-designated) holds the award, sets statewide targets, and oversees subrecipients.
- Rural High Value Network (HVN) convened with provider ownership for shared services and value-based contracting; Collaborative members support network design and operations.

6.2 RACI (summary)

- Accountable (A): State lead agency (program oversight, reporting); HVN board (initiative approvals, network policies).
- Responsible (R): SI partners for PMO, dashboards, economic modeling; clinical partners (Avel, Teladoc) for service delivery; tech partners (Microsoft, Humetrix, BioIntelliSense) for platforms/devices; retail providers (CVS/Walgreens) for community access points.
- Consulted (C): Medicaid agency (payment alignment, SPA support); Hospital association; FQHC PCA; EMS Office; universities.
- Informed (I): Community organizations, AHA/ASA, county leadership.

7. Payment and Funding

- Allowable uses and caps (selected): provider payments ≤15%; capital/infrastructure (J) ≤20%; EMR replacement ≤5% (if prior HITECH-certified EMR in place 9/1/2025); Rural Tech Catalyst-type initiatives ≤ the lesser of 10% or $20M; administrative (incl. indirect) ≤10%. (files.simpler.grants.gov)
- Medicaid alignment: With SPA SC-24-0026 constraining MCO count, the state can negotiate quality-linked payments for hypertension control, postpartum engagement, SUD follow-up, tele-emergency performance, and eConsults; actuarial modeling and contract drafting can be supported by Collaborative advisors. (medicaid.gov)

Table: Cost categories (ROM), funding source, timing, Collaborative deliverables (conditional)

- Clinical services (tele-ER/ICU, tele-behavioral): RHT Program (A/H/I), Years 1–5; deliverables: coverage footprint, SLAs, quarterly outcome reports.
- Remote monitoring (RPM devices and services): RHT (A/F/I), Years 1–3 scale then sustain; deliverables: panels onboarded, alert-to-intervention metrics.
- Consumer engagement (kiosks/apps): RHT (C/F), Years 1–2 pilots then expand; deliverables: screenings completed, routing yield.
- Cyber/data infra (cloud, HIE connectors): RHT (F/J/K), Years 1–3 foundation; deliverables: cyber posture baselines, TEFCA transactions.
- Program management and analytics: Admin ≤10% of award; deliverables: dashboards, FFATA/SF-425/FFR support. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Core measures: Access (tele-ER response, time-to-consult), quality (BP control, A1c, prenatal/postpartum visit adherence), utilization (ED revisits, avoidable admissions), financial (total cost of care for attributed rural populations), workforce (vacancy/turnover, documentation time), technology (uptime, cyber events).
- Data sources: Medicaid claims and encounter (via MCOs); FQHC and hospital EHRs; patient-facing app data; EMS run data; HIE/TEFCA queries; program dashboards. Collaborative stack supports ingestion, identity resolution, and privacy controls.
- Evaluation: Annual performance reviews (per NOFO reporting), independent assessments, and learning collaboratives; incorporate conditional-to-full technical points evidence. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months) Gantt-style table (illustrative; dates conditional on award and contracting)

- Workstream: Program mobilization; Start: Jan 2026; End: Mar 2026; Owner: State PMO/SI; Outputs: governance charter, risk plan, stakeholder map.
- Clinical virtual access (tele-ER/ICU/behavioral): Feb 2026–Dec 2026 (phase 1 sites), Owner: Avel/Teladoc + hospital partners; Outputs: live go-lives, monthly KPIs.
- RPM chronic/maternal cohorts: Mar 2026–Nov 2026 (pilot) → 2027 expansion; Owner: BioIntelliSense + FQHCs; Outputs: enrolled panels, alert-to-intervention reports.
- Consumer apps/kiosks: Apr 2026–Oct 2026; Owner: Humetrix/Higi/retail; Outputs: screenings, closed-loop referrals.
- Data/cyber uplift: Feb 2026–Dec 2026; Owner: Microsoft + facility CIOs; Outputs: identity hardening, log baselines, TEFCA connectors.
- VBP contracting (MCOs/HVNs): Feb 2026–Aug 2026; Owner: Medicaid + HVN + SI; Outputs: addenda, performance dashboards.

Checklist (compliance-focused)

- Grants.gov registration active; SF-424 Box 19c “No”; Governor’s endorsement ≤4 pages with required certifications; narrative/budget within page limits and spacing; admin ≤10% documented; caps (15/20/5/10%) met in budget; stakeholder engagement evidenced; CCBHC list and Medicaid DSH counts included; duplication assessment completed. (files.simpler.grants.gov)

10. Risk Register (selected)

- Cyber incident at rural facility disrupts services: Mitigation—Microsoft cyber program; 24/7 SOC integration; Owner: Facility CIO + Microsoft partner.
- RPM adoption lag: Mitigation—digital navigator training; simple escalation workflows; Owner: FQHC/clinic leads + BioIntelliSense.
- MCO alignment delays: Mitigation—use SPA framework and quality addenda; phased pilots; Owner: Medicaid + HVN. (medicaid.gov)
- Workforce burnout persists: Mitigation—ambient documentation and tele-mentoring; Owner: clinical partners.
- Broadband pockets remain: Mitigation—patient hotspots/offline pathways; focus on nearly-unserved BSLs; Owner: PMO + retail partners. (ors.sc.gov)
- Data-sharing barriers: Mitigation—TEFCA connectors, legal templates; Owner: SI/legal + HIE.
- Capital cap exceedance: Mitigation—phase Category J; monitor 20% cap; Owner: PMO/Budget. (files.simpler.grants.gov)
- Provider-payment cap exceedance: Mitigation—track ≤15% in budget tools; Owner: PMO/Finance. (files.simpler.grants.gov)
- Conditional policy points not enacted by deadlines: Mitigation—legislative tracker; escalate 2027/2028 checkpoints; Owner: State policy lead. (files.simpler.grants.gov)
- Duplication risk with existing funding: Mitigation—duplication assessment SOPs; Owner: PMO/Compliance. (files.simpler.grants.gov)

11. Draft RFP Response Language (paste-ready; adapt as needed) 11.1 Goals and strategies “South Carolina proposes a rural transformation model that advances access, outcomes, workforce sustainability, innovative care, and technology. The plan uses scalable virtual clinical services, remote physiologic monitoring, consumer-facing engagement, and cybersecurity/data modernization to improve prevention and chronic care while keeping patients local. We will leverage Medicaid managed care to align incentives with quality and total cost of care, subject to contracting and integration with participating MCOs. This model addresses NOFO uses of funds A, C, F, H, I, and J and the technical factors for remote care services, data infrastructure, consumer-facing technology, EMS, and rural strategic partnerships.”

11.2 Initiatives and outcomes (example) “Rural Hypertension & Diabetes Initiative will combine retail screenings with RPM and tele-coaching to improve BP control and A1c. Outcomes include: (1) ≥10-point absolute increase in BP control at 12 months; (2) ≥15% reduction in diabetes-related ED visits; (3) ≥20% increase in completed follow-up within 14 days of abnormal screening; (4) county-level reduction in potentially avoidable hospitalizations. Data sources include Medicaid encounters, EHRs, and device-generated data with privacy-preserving exchange. Implementation is conditional on subrecipient contracting and site readiness.”

11.3 Workforce approach “We will support clinicians with on-demand specialist consultation and ambient documentation tools to reduce administrative burden, supplemented by pharmacist-enabled chronic disease management in rural communities, consistent with state policy. Training will include tele-mentoring and digital navigator programs to sustain adoption.”

11.4 Governance and compliance “The Governor has designated [Lead Agency] as the applicant. The State will convene a provider-owned rural High Value Network to steward subawards, ensure transparency, and track outcomes. The State will adhere to NOFO caps (≤15% provider payments; ≤20% Category J; EMR replacement ≤5%; admin ≤10%) and prohibit unallowable costs per 2 CFR Part 200 and HHS GPS. We certify EO 12372 does not apply and will check ‘No’ on SF-424 Item 19c.” (files.simpler.grants.gov)

12. Assumptions and Open Questions

- Frontier metric: We used USDA ERS FAR maps (2010 method) as a proxy for frontier status; if the State maintains a newer ZIP-level analysis, we will update. (ers.usda.gov)
- Medicaid managed care share: We cite historical managed-care penetration from federal summaries; current plan-level shares will be confirmed with 2024–2025 MCO enrollment files. (everycrsreport.com)
- State policy levers (e.g., certificate-of-need changes, licensure compacts, pharmacist scope): scoring impacts depend on enacted language and timing; we assume policy feasibility by the NOFO deadlines where points are claimed. (files.simpler.grants.gov)
- CCBHC list and Medicaid DSH hospital counts: will be appended from the most current State data as required by the NOFO. (files.simpler.grants.gov)

13. References

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