Rural Health Transformation Grant Guide — New Hampshire

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AUDIENCE: State health agencies, Medicaid, rural providers, collaboratives

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

New Hampshire can leverage the Rural Health Transformation (RHT) Program to stabilize rural access, modernize care, and advance value-based delivery while meeting all required use-of-funds and scoring criteria. The Rural Health Transformation Collaborative (the Collaborative) offers configurable capabilities across tele-emergency/tele-ICU, remote monitoring, pharmacy-enabled chronic care, analytics, cybersecurity, and program management that align directly with the RHT Program's five goals and funding guardrails. These capabilities are designed to integrate with State priorities and existing provider infrastructure, subject to contracting and systems integration. (cms.gov)

Near-term opportunities for New Hampshire include: statewide virtual specialty backstop for Critical Access Hospitals (CAHs), remote physiologic monitoring for high-risk chronic disease, pharmacist-enabled hypertension and diabetes management in rural towns, and an outcomes dashboard tied to RHT reporting. The Collaborative's partners—Avel eCare (tele-hospital services), BioIntelliSense (wearable RPM), retail pharmacy networks (CVS Health, Walgreens, Walmart), Microsoft (cloud/cybersecurity), and systems integrators (Accenture, KPMG, PwC)—can support rapid activation and statewide scale, with performance tracking aligned to CMS continuation criteria.

RHT funding totals $50B over FY26–FY30. Eligibility is limited to the 50 States; DC and territories are ineligible. Applications are due Nov 5, 2025 (11:59 p.m. ET); an optional LOI is encouraged by Sep 30, 2025. Funding is split evenly between baseline (equal shares to approved States) and workload (points-based), with program-specific caps (e.g., provider payments ≤15%, capital/infrastructure ≤20%, EMR replacement ≤5% if a HITECH-certified system existed on 9/1/2025, administrative ≤10%). New Hampshire's plan can reflect these constraints while maximizing points through credible initiatives and policy commitments. (cms.gov)

Evidence suggests New Hampshire's rural environment is well-positioned for impact: 41.7% of residents lived in rural areas in 2020; the State has 13 CAHs (of 26 acute hospitals), approximately 18 Rural Health Clinics (RHCs) and 9 FQHC awardee organizations operating statewide. Medicaid covered about 12.9% of residents in 2024, largely via three MCOs; overdose mortality fell sharply in 2024, indicating momentum for prevention and recovery models that the Collaborative's partners can support. (ncsl.org) (nhha.org) (ruralhealthinfo.org) (data.hrsa.gov) (usafacts.org) (cdc.gov)

1.1 One-page printable summary (for distribution)

- Program fit
    - Eligible applicant: State of New Hampshire (Governor-designated lead agency). Single application; optional LOI by Sep 30, 2025; application due Nov 5, 2025; awards by Dec 31, 2025. (cms.gov)
    - Funds: $10B/year FY26–FY30; 50% equal baseline, 50% points-based workload. Caps: provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5%; admin ≤10%. (cms.gov)
- NH snapshot (latest available)
    - Rural share: 41.7% (2020). CAHs: 13 of 26 acute care hospitals (2025). RHCs: ~18; FQHC awardees: 9 (2024). Medicaid enrollment: 12.9% of residents (2024). Overdose deaths: ≥35% decline in 2024 (provisional). (ncsl.org) (nhha.org) (ruralhealthinfo.org) (data.hrsa.gov) (usafacts.org) (cdc.gov)
- High-leverage options (illustrative, subject to procurement)
    - Virtual hospital services for CAHs; statewide RPM for heart failure, COPD, diabetes; pharmacy-anchored chronic care; tele-behavioral health escalation pathways; cybersecurity uplift with zero-trust patterns; outcomes dashboard tied to RHT metrics.
- Compliance checkpoints
    - 2 CFR 200/HHS Part 300; HHS GPS; program caps; cooperative-agreement reporting. (hrsa.gov) (cms.gov)

2. Eligibility and RFP Fit

2.1 What the RHT NOFO requires

- Applicant: One State agency/office, designated by the Governor; letter of endorsement is required. Only the 50 States may apply. (cms.gov) (cms.gov)
- Timeline: Optional LOI by Sep 30, 2025; application by Nov 5, 2025; awards by Dec 31, 2025. Funding opportunity number CMS-RHT-26-001. (cms.gov)
- Funding/Scoring: $50B over five periods; 50% equal distribution and 50% points-based workload each year. Points blend rural facility/population and technical factors; initiative-level scoring contributes to workload in future periods. (cms.gov)
- Uses of funds (choose ≥3): prevention/chronic disease; provider payments (capped); consumer tech; tech TA (telehealth, AI, robotics); workforce recruitment/retention (≥5-yr service); IT/cybersecurity; right-sizing service lines; behavioral health/OUD; innovative models/value-based care; other CMS-defined uses. (cms.gov)
- Program caps (per period): provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% (if HITECH-certified EMR in place 9/1/2025); admin (incl. indirect) ≤10%; Technology-fund-like initiatives ≤ the lesser of 10% or $20M. (cms.gov)
- Application contents and compliance: adhere to formatting and completeness criteria; follow 2 CFR and HHS GPS; cooperative-agreement reporting and continuation. (cms.gov) (hrsa.gov)

2.2 Mapping NOFO requirements to Collaborative capabilities

Requirement → Collaborative capability → Evidence

- Telehealth/remote care and tech TA → Avel eCare virtual hospital services; Microsoft cloud/cybersecurity; systems integrators for deployment and training. Evidence: partner profiles and use cases.
- Consumer-facing tech for chronic disease → Retail kiosks/screening (Higi/Topcon), mobile triage and multilingual intake (Humetrix), patient notifications. Evidence: Collaborative catalog.
- Workforce recruitment/retention (≥5-yr commitments) → Pharmacy workforce pipelines, ambient documentation to reduce burnout, tele-mentoring for rural clinicians. Evidence: partner statements.
- Innovative/value-based models → Cibolo-enabled rural High Value Networks; payment integrity/claims modernization; analytics. Evidence: Collaborative materials.
- Data, privacy, cybersecurity → Azure-based data platform, TEFCA-oriented interoperability approaches, dashboards for KPIs and RHT reporting. Evidence: Collaborative overview.

3. New Hampshire Context Snapshot

3.1 Rural demography and geography

- Rural share: 41.7% of NH residents lived in rural areas in 2020 (Census 2020 state roll-up). (ncsl.org)
- Potential frontier designation: requires federal definitions; validation pending (see Section 3.7).
- Key rural counties: Coös, Grafton, Carroll, Sullivan; large rural land areas with dispersed populations increase time-to-care—making tele-specialty and RPM practical complements.

How Collaborative capabilities support: virtual specialty support for rural hospitals (tele-ER/ICU/hospitalist); retail pharmacy and community sites as access points; remote monitoring with escalation protocols.

3.2 Facility mix

- CAHs: 13 of 26 acute care hospitals are CAHs (NHHA, 2025). (nhha.org)
- RHCs (approximate): 18 rural health clinics (RHIhub, July 2025). (ruralhealthinfo.org)
- FQHCs: 9 awardee organizations served 92,962 patients in 2024 (HRSA UDS). (data.hrsa.gov)

Collaborative fit: Avel eCare's tele-hospital portfolio, RPM to extend observation into home, pharmacy-enabled adherence programs, and governance via member-owned HVNs (Cibolo) can enhance coverage while aligning with value-based models.

3.3 Workforce and HPSA indicators

- HPSA landscape: HRSA reports ongoing HPSA designations and quarterly updates; NH shows limited but present shortages across primary, dental, and mental health (latest state-level roll-ups reflect 2024–2025 updates). (data.hrsa.gov)
- Recruitment/retention challenge: rural sites, small panels, on-call burden.

Collaborative fit: tele-mentoring and consult-backstop (Avel eCare), ambient clinical documentation to reduce administrative time, pharmacy pipelines and technician-to-pharmacist ladders for rural communities.

3.4 Coverage and financing

- Medicaid enrollment: avg. 182,100 residents (12.9%) in FY2024. (usafacts.org)
- Medicaid managed care: three MCOs operate statewide (AmeriHealth Caritas NH, NH Healthy Families/Centene, and Well Sense), with renewed contracts through 2029. (amerihealthcaritasnh.com) (nhfv.org)
- Marketplace coverage: 70,337 plan selections for 2025 OEP (CMS snapshot). (cms.gov)

Collaborative fit: claims data exchange and payment integrity analytics; actuarial and model design support via integrators; pharmacy-aligned adherence programs that reduce avoidable utilization.

3.5 Broadband and telehealth

- Broadband adoption: 93.9% of NH households reported broadband subscriptions in 2023 ACS; wireline broadband ~82.9%. (broadbandexpanded.com)
- Telehealth policy: NH law provides coverage/reimbursement parity for telemedicine and broad modality/site flexibility for Medicaid and commercial plans (RSA 415-J; HB1623-FN, 2020). (gc.nh.gov) (gc.nh.gov)

Collaborative fit: statewide tele-enabled models can operate within existing parity frameworks; Microsoft cybersecurity patterns mitigate rural hospital ransomware risk as systems expand connectivity.

3.6 Maternal and behavioral health

- Infant mortality (comparative): NH had the lowest infant mortality rate among states in 2023 (3.1 per 1,000 live births) in a national comparative analysis. (commonwealthfund.org)
- Overdose mortality: provisional federal data indicate NH overdose deaths declined ≥35% in 2024 versus 2023. (cdc.gov)

Collaborative fit: community screening (AHA/ASA with kiosk partners), tele-behavioral escalation via tele-ER/psychiatry, medication reconciliation and adherence programs in pharmacies, and RPM-supported step-down care after overdose.

3.7 Prior reforms and policy context (select)

- Certificate of Need (CON): NH repealed CON effective June 30, 2016—relevant to NOFO factor on CON policy context. (ncsl.org)
- Medicaid expansion ("Granite Advantage"): permanently extended (2023 legislation) and operating via MCOs. (nhpr.org)

3.8 Metrics-to-capability table (illustrative)

Metric (latest) | Year | Source | Matching Collaborative capability

- Rural share 41.7% | 2020 | NCSL (Census 2020) | Tele-specialty for distance, RPM for chronic care. (ncsl.org)
- CAHs 13 of 26 | 2025 | NHHA | Virtual hospital services; cyber uplift. (nhha.org)
- RHCs ≈18 | 2025 | RHIhub | RPM kits via RHCs with escalation to tele-ER. (ruralhealthinfo.org)
- FQHC awardees 9; 92,962 pts | 2024 | HRSA UDS | Care-gap analytics and pharmacist-supported adherence. (data.hrsa.gov)
- Medicaid 12.9% enrolled | 2024 | USAFacts (CMS) | Payment integrity analytics; SPA drafting support (if pursued). (usafacts.org)

- Overdose deaths −35% | 2024 | CDC NCHS provisional | Recovery care pathways; tele-behavioral consults. (cdc.gov)

Assumptions and Open Questions (for validation)

- Latest NOFO PDF text on Grants.gov is referenced by CMS, but this guide cites the CMS webinar deck and program page where the PDF is not directly reproduced here; citations reflect those official pages. (cms.gov) (cms.gov)
- Count of hospitals receiving Medicaid DSH for the most recent State Plan Rate Year (SPRY): requires confirmation with NH Medicaid finance.
- CCBHC list as of Sep 1, 2025 (sites/locations): verify from SAMHSA's directory.
- Licensure compact participation status (IMLC, NLC, PSYPACT) and STLDI policy posture: confirm current statutes/regulatory rules for NOFO technical factors.

4. Strategy Aligned to RFP

Proposed model (configurable): a "Rural Access and Outcomes Platform" anchored by (a) a 24/7 virtual hospital backstop for CAHs/EDs; (b) pharmacy-enabled primary-care extension for hypertension/diabetes; (c) statewide RPM for high-risk chronic disease and post-discharge; (d) a secure analytics layer and outcomes dashboard for RHT reporting; and (e) workforce support (ambient documentation; tele-mentoring). This structure aligns to each RHT goal and the required use-of-funds categories; costs are planned within NOFO caps. (cms.gov) (cms.gov)

- Make rural America healthy again: community screening via AHA/ASA with Higi/Topcon; RPM for high-risk patients; pharmacist protocols for titration and adherence.
- Sustainable access: tele-ER/ICU/hospitalist coverage; right-sizing service lines with escalation pathways and fewer transfers.
- Workforce development: ambient documentation and AI-assisted intake reduce burnout; structured upskilling and tele-mentoring.
- Innovative care/payment: Cibolo-enabled HVNs for joint purchasing/shared services; payment integrity and value models supported by integrators.
- Tech innovation/cybersecurity: Azure-based data and identity controls; device-to-cloud security baselines; telemetry for risk management.

Equity and Tribal strategy: multilingual intake and triage, pharmacy access in rural communities, and community-based screenings; analytics to stratify results by geography, race/ethnicity, and payer; support for culturally appropriate navigation.

Data use and privacy: HIPAA-aligned architecture with role-based access; support for TEFCA connectivity through participating networks; dashboards for RHT KPIs and CMS continuation applications. (cms.gov)

5. Program Design Options (tailored to NH; all subject to contracting and integration)

Option A. Rural Virtual Specialty Network + CAH Backstop

- Target population/problem: Rural ED/ICU cases and after-hours inpatient consults; CAH staffing gaps. NH has 13 CAHs; distances add delay/risk. (nhha.org)
- Services: 24/7 tele-ER/ICU/hospitalist; pharmacy consults; e-ICU monitoring; stroke AI alerting to expedite transfers.
- Payment logic: care-coordination and standby availability payments within provider-payment cap (≤15%); savings via avoided transfers/readmissions. (cms.gov)
- Enablers: hospital association partnerships; credentialing; cross-facility governance; cyber hardening.
- Pros/risks: Pros—rapid coverage, measurable access; Risks—credentialing latency, bandwidth at small sites.

Option B. Pharmacy-Enabled Chronic Care Extension

- Target: Rural adults with hypertension/diabetes; leverage high pharmacy reach.
- Services: kiosk screening; pharmacist BP/diabetes management protocols; e-consults; refill adherence and RPM for uncontrolled patients.
- Payment logic: combination of training/TA (tech), consumer tech, and limited provider payments (≤15%); aligned with Medicaid quality incentives where feasible. (cms.gov)

- Pros/risks: Pros—low barrier access; Risks—scope-of-practice constraints (policy factor for scoring).

Option C. Statewide RPM + Transitional Care

- Target: CHF/COPD/diabetes/high-risk discharge cohorts; reduce 30-day readmissions and ED revisits.
- Services: FDA-cleared wearable RPM (BioButton) with dashboards and exception-based workflows; multilingual outreach; pharmacist titration support.
- Payment logic: tech/care-model under prevention/consumer tech/IT categories; admin share ≤10%. (cms.gov)
- Pros/risks: Pros—scalable; Risks—device logistics and cellular coverage.

Option D. Rural Behavioral Health Escalation

- Target: patients with SUD/OUD and crisis presentations; overdose declines present opportunity to lock in gains. (cdc.gov)
- Services: tele-psychiatry on-demand; e-consults to primary care; pharmacy-based MAT navigation; post-overdose RPM check-ins.
- Payment logic: behavioral health category; prevention/chronic care; limited provider payments (≤15%). (cms.gov)

6. Governance and Collaborative Roles

6.1 Conceptual structure (overview)

- State lead agency (Governor-designated): strategy/oversight; grants management; continuation applications.
- Rural Provider HVN (Cibolo) as member-owned vehicle (subject to State decision): shared purchasing, standards, and accountability for rural participants.
- Systems integrator (Accenture/KPMG/PwC): PMO, procurement support, interoperability, value tracking.
- Technology/clinical partners (Avel, Microsoft, BioIntelliSense, retail pharmacies, AHA/ASA): implementation and outcomes reporting.

6.2 RACI (illustrative)

Task	State lead	Medicaid	Hospital Assoc./CAHs	FQHCs	HVN (Cibolo)	Integrator	Tech/Clinical partners
Strategy & NOFO compliance	R	C	C	C	C	C	C
PMO & reporting dashboard	A	C	C	C	C	R	C
Tele-ER/ICU rollout	C	C	R	C	A	C	R (Avel)
RPM program	C	C	C	R	A	C	R (BioIntelliSense)
Pharmacy chronic care	C	C	C	C	A	C	R (Retail)
Cybersecurity uplift	C	C	C	C	C	C	R (Microsoft)
R=Responsible; A=Accountable; C=Consulted.							

7. Payment and Funding

7.1 Funding alignment (within caps)

- Mix funding across prevention, consumer tech, IT/cyber, workforce TA; limit direct provider payments ≤15%; capital

≤20%; admin ≤10%; EMR replacement ≤5% (if applicable). (cms.gov)

7.2 Medicaid alignment (illustrative)

- Use actuarial and analytics support to design SPA or value-based arrangements tied to rural outcomes (e.g., avoidable transfers, chronic disease control), subject to State policy. The Collaborative's integrators have claims modernization and payment integrity experience to support this.

7.3 Cost categories and rough order of magnitude (ROM) (illustrative)

Category	ROM	Funding source(s)	Timing	Deliverable
Tele-hospital services	Programmatic	RHT (uses: tech TA/innovative care)	Yr 1–2	24/7 coverage + KPIs. (cms.gov)
RPM devices/licenses	Programmatic	RHT (prevention/consumer tech)	Yr 1–2	1–2k patients on RPM.
Pharmacy chronic care	Programmatic	RHT (prevention/innovative care)	Yr 1	50+ rural towns engaged.
Cybersecurity uplift	Programmatic	RHT (IT/cyber)	Yr 1	Hardening baselines and monitoring.
PMO/data platform	Admin/programmatic	RHT (admin ≤10%)	Yr 1	Dashboard; continuation packet. (cms.gov)

8. Data, Measurement, and Evaluation

- Core measures: access (tele-response times; transfer rates), quality (BP control, A1c <8%), utilization (ED revisits, readmissions), behavioral health engagement, cybersecurity events mitigated, implementation milestones.
- Data sources: Medicaid claims; EHRs; pharmacy systems; RPM feeds; EMS data; public health datasets; HRSA UDS; program dashboards.
- Reporting cadence: Quarterly internal; annual CMS continuation with initiative scoring updates (NOFO emphasizes continuation criteria). (cms.gov)

9. Implementation Plan

9.1 12–24-month Gantt-style plan (illustrative; subject to procurement)

Workstream	Start	End	Owner	Outputs
Program mobilization/PMO	Jan 2026	Mar 2026	Integrator	Charter; governance; dashboard spec.
Tele-hospital coverage (pilot 5 CAHs)	Feb 2026	Jun 2026	Avel/CAHs	Coverage live; KPI baseline.
RPM cohort 1 (CHF/COPD 1,000 pts)	Mar 2026	Oct 2026	BioIntelliSense/FQHCs	Enrollment; adherence reports.
Pharmacy chronic care launch	Apr 2026	Dec 2026	Retail pharmacies	Protocols; BP control rates.

Workstream	Start	End	Owner	Outputs
Cybersecurity uplift L1	Feb 2026	Sep 2026	Microsoft	Identity, endpoint, backup hardening.
Data platform & KPI dashboard	Feb 2026	Sep 2026	Integrator/Microsoft	RHT dashboard v1; training.
Expansion (tele-hospital to 10+ CAHs)	Jul 2026	Mar 2027	Avel/CAHs	Coverage scale; report.
RPM cohort 2 (+1,500 pts)	Sep 2026	Mar 2027	BioIntelliSense	Outcomes report; sustain plan.

Milestones/gates: contracting complete; site readiness; cyber baseline; clinical protocols; data-use agreements; quarterly reviews aligned to continuation application timelines. (cms.gov)

10. Risk Register (top 10)

Risk	Likelihood/Impact	Mitigation	Owner
Bandwidth constraints at rural sites	Med/Med	Site surveys; LTE failover; asynchronous workflows.	Integrator/Microsoft
Credentialing delays	Med/Med	Batch privileging; early credentialing packets.	Avel/CAHs
Device logistics (RPM)	Med/Med	Centralized kitting; patient tech support; inventory buffer.	BioIntelliSense
Workforce adoption	Med/Med	Super-user model; ambient documentation; CME/CE.	Integrator/Providers
Data-sharing friction	Med/Med	Standard DUAs; TEFCA-aligned exchange.	Integrator/State
Cyber incidents	Low/High	Zero-trust baselines; backup/restore drills; monitoring.	Microsoft/Providers
Payment cap overrun (≤15%)	Low/High	Track spend categories; mid-year rebalancing. (cms.gov)	PMO
Scope drift	Med/Med	Quarterly steering; change control.	PMO
Policy dependencies (e.g., pharmacist scope)	Med/Med	Legal review; phased protocols.	State/Boards
Continuation risk if outcomes lag	Med/High	Early KPI alerts; remediation sprints; technical factor updates.	PMO/State

11. Draft RFP Response Language (paste-ready; adapt as needed)

11.1 Project Summary (≤1 page)

The State of New Hampshire proposes to implement a Rural Access and Outcomes Platform to improve rural access, quality, and sustainability. The Platform combines (1) a statewide virtual specialty backstop for rural hospitals, (2) pharmacy-enabled chronic disease management, (3) remote physiologic monitoring for high-risk populations, (4) a secure analytics layer and

performance dashboard, and (5) workforce support. Activities are organized under RHT Program uses of funds including prevention/chronic disease, consumer-facing technology, technology TA, workforce, IT/cybersecurity, behavioral health, and innovative care models, with direct provider payments remaining below 15% of annual awards, capital/infrastructure below 20%, EMR replacement (if applicable) below 5%, and administrative costs at or below 10%. The strategy aligns with the RHT goals and funds-distribution methodology, positions NH to demonstrate measurable outcomes for continuation, and is supported by experienced partners. (cms.gov) (cms.gov)

11.2 Rural Health Needs & Target Population (excerpt)

As of 2020, 41.7% of New Hampshire's population lived in rural areas. The State has 13 CAHs among 26 acute care hospitals, approximately 18 Rural Health Clinics, and 9 FQHC awardees serving 92,962 patients in 2024. Medicaid covers 12.9% of residents (FY2024). Provisional data indicate a ≥35% decline in drug overdose deaths in 2024. These data justify statewide initiatives that reinforce emergency/critical care backstops, expand chronic disease control capacity, and sustain behavioral health improvements. (ncsl.org) (nhha.org) (ruralhealthinfo.org) (data.hrsa.gov) (usafacts.org) (cdc.gov)

11.3 Goals, Strategies, and Policy Actions (excerpt)

NH will pursue measurable improvements in: (a) avoided transfers from CAHs, (b) BP control and A1c control rates, (c) 30-day readmission reduction, (d) time-to-psychiatric consult in rural EDs, (e) critical cyber incident rate. The State may consider policy actions that strengthen scoring (e.g., pharmacist scope adjustments consistent with safety and training requirements) subject to legislative processes and stakeholder input. (cms.gov)

11.4 Proposed Initiatives & Use of Funds (excerpt)

Initiative 1: Virtual Hospital Backstop for CAHs (Use-of-funds: tech TA; innovative care)

- Services: tele-ER/ICU/hospitalist; specialist e-consults; stroke AI facilitation.
- Outcomes: reduced transfers; sepsis bundle adherence; door-to-needle time.
- Counties: prioritized by CAH location.

Initiative 2: Pharmacy-Enabled Hypertension & Diabetes Control (Use-of-funds: prevention; consumer tech)

- Services: kiosk screening, pharmacist-led management under protocols, RPM escalation for uncontrolled patients.
- Outcomes: % patients with BP <140/90; A1c <8%; therapy adherence.

Initiative 3: Statewide RPM Transitional Care (Use-of-funds: prevention; IT)

- Services: FDA-cleared wearable monitoring; exception-based workflows; multilingual patient outreach.
- Outcomes: 30-day readmissions; ED revisits; patient experience.

11.5 Implementation, Stakeholder Engagement, Evaluation (excerpt)

Implementation follows a phased plan beginning with PMO mobilization, site readiness, and early pilots in high-need regions, with outreach through hospital and primary care associations. The State will cooperate with CMS evaluations and report annually on workplan progress, budgets, and outcomes per the NOFO. (cms.gov) (cms.gov)

12. References

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13. AI Generation Notice

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