Rural Health Transformation Grant Guide — Arkansas

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Arkansas is eligible to apply directly for CMS's Rural Health Transformation (RHT) cooperative agreement, with an application due November 5, 2025, and awards expected by December 31, 2025. The NOFO outlines five years of funding (FY26–FY30), a Baseline plus Workload funding method, and program- and policy-based scoring that together reward both near-term execution and sustained statewide impact. (files.simpler.grants.gov)

The Rural Health Transformation (RHT) Collaborative can support Arkansas in presenting a competitive, evidence-based plan and in executing complex transformation work. The Collaborative aggregates implementation capacity across: (a) clinical tele-support (e.g., Avel eCare's virtual hospitalist/ER/ICU), (b) continuous remote physiologic monitoring and exception-based care models (e.g., BioIntelliSense's FDA-cleared BioButton system), (c) statewide data and analytics platforms and TEFCA-aligned interoperability (e.g., eClinicalWorks PRISMANet QHIN), (d) consumer-facing engagement (e.g., Humetrix multilingual triage and PHR), (e) retail pharmacy access models (CVS Health, Walgreens, Walmart), (f) governance and network-building for rural providers (Cibolo Health's High Value Networks), and (g) program management and evaluation (Accenture, KPMG, PwC, AVIA). These capabilities are documented in the Collaborative catalog and appendices.

Several offerings align to high-leverage Arkansas needs and NOFO scoring factors:

- Keeping care local and reducing avoidable transfers using 24/7 tele-ER/ICU coverage, tele-hospitalist support, and tele-specialty clinics targeting high-acuity, low-occurrence events—mapping to Technical factors C.1 (strategic partnerships) and C.2 (EMS) and Use-of-Funds categories D/F/G.
- Post-discharge and chronic disease stabilization with continuous remote monitoring and exception management, paired with primary-care team workflows—mapping to B.1/B.2, F.1/F.2/F.3, and A (prevention/chronic disease).
- Statewide interoperability and security: as of January 16, 2025, eClinicalWorks was designated a TEFCA QHIN (PRISMANet), strengthening compliant data exchange and reporting; and Microsoft's rural hospital cybersecurity program has enrolled more than 550 rural hospitals by March 2025 (rising to 700+ by July 2025), directly supporting cyber-resilience expectations. (sequoiaproject.org)

The Collaborative's model is explicitly additive to State and local leadership. All implementation would be contingent on Arkansas's priorities, vendor selection, procurement, contracting, integration with existing systems (e.g., SHARE HIE and Medicaid data flows), and alignment with the NOFO's funding caps and compliance terms.

One-page printable summary (for distribution)

- Program opportunity: CMS RHT cooperative agreement; one application per state; due Nov 5, 2025; five budget periods FY26–FY30; admin ≤10%/yr; provider payments ≤15%/yr; minor capital (Cat. J) ≤20%/yr; EMR replacement ≤5%/yr if HITECH-certified EMR already installed; conditional policy points must be enacted by 12/31/2027 (12/31/2028 for B.2/B.4). (files.simpler.grants.gov)
- Arkansas context (2024–2025 data): 12 HRSA-funded health center organizations (2024); 28 designated CAHs (state ADH); ~105 RHCs (2022 HRSA allocation list); primary-care and mental-health HPSA needs persist (HRSA 3/31/2025 summaries); preliminary CDC data show Arkansas drug overdose death rate decreased from 21.7 per 100,000 (2022) to 17.7 (2023) with a further decline in 2024; BEAD planning targets >79,000 unserved locations statewide (Feb 2025). (data.hrsa.gov)
- Arkansas policy posture that can earn NOFO points: nurse licensure compact in effect; PSYPACT enacted/effective; physician IMLC enacted (effective on/after Aug 5, 2025); EMS Compact enacted in 2025; PA Compact enacted in 2025. (healthy.arkansas.gov)
- Collaborative supports (examples): Avel eCare tele-ER/ICU/tele-hospitalist; BioIntelliSense remote monitoring; eClinicalWorks QHIN/analytics; Humetrix triage/PHR; Walgreens/CVS/Walmart pharmacy-based screening/management; Cibolo Health HVN formation and shared services; Accenture/KPMG/PwC/AVIA for PMO, analytics, evaluation.

2. Eligibility and RFP Fit

2.1 Summary of NOFO requirements (selected)

- Eligible applicant: one of the 50 U.S. States; DC/territories are ineligible. Governor designates lead agency; one official application per State; AOR signature. (files.simpler.grants.gov)
- Key dates: optional LOI by Sept 30, 2025 to MAHARural@cms.hhs.gov; application by Nov 5, 2025, 11:59 p.m. ET; expected award/earliest start Dec 31, 2025; webinars Sept 19 & 25, 2025. (files.simpler.grants.gov)
- Scoring and funding: Total funding ~$50B over FY26–FY30; Baseline (equal share) + Workload (points) each period; points weight 50% "Rural facility & population factors" and 50% "Technical factors"; Table 3 lists specific sub-weights (A.1–A.7; B.1–F.3). Technical points recalc each period; rural baseline set once (Q4 2025). (files.simpler.grants.gov)
- Allowable uses: invest in at least three categories (A–K), including prevention/chronic disease; provider payments (capped); consumer-facing tech; training/TA; workforce recruitment with ≥5-year rural service; IT advances/cybersecurity; right-sizing service lines; behavioral health; innovative care models (value-based); minor renovations/equipment; partnerships. (files.simpler.grants.gov)
- Funding policies/limits: admin ≤10% of allotment; provider payments ≤15%; capital & infrastructure (Cat. J) ≤20%; EMR replacement ≤5% if a HITECH-certified EMR existed on 9/1/2025; "Rural Tech Catalyst"-like initiatives ≤ the lesser of 10% or $20M per period; Executive Order 12372 does not apply—check "No" on SF-424 box 19c. (files.simpler.grants.gov)

2.2 How Collaborative capabilities map to NOFO requirements (illustrative, not exhaustive)

- Requirement → Collaborative capability → Evidence
    - Tele-enabled access and right-sizing: statewide 24/7 tele-ER/ICU/tele-hospitalist; tele-specialty clinics; EMS tele-assist → Avel eCare; Cibolo Health HVNs coordinating shared services → aligns with Use-of-Funds D/F/G/K; Technical C.1/C.2.
    - Chronic disease prevention/management with measurable outcomes → BioIntelliSense continuous RPM; Humetrix multilingual triage/PHR; retail-based screening and care navigation via CVS/Walgreens/Walmart → Use-of-Funds A/C/F; Technical B.1/B.2/F.1/F.3.
    - Cybersecurity and data infrastructure for reporting and evaluation → eClinicalWorks PRISMANet QHIN; Microsoft rural cybersecurity program enrolled >550 rural hospitals by Mar 2025 and >700 by July 2025 → Use-of-Funds F; Technical F.2; supports HHS Cybersecurity Performance Goals. (sequoiaproject.org)
    - PMO, governance, and economic modeling → Accenture/KPMG/PwC/AVIA for program governance, outcome tracking, and value realization; Cibolo Health organizing independent rural provider HVNs → Use-of-Funds K; Technical C.1.

3. Arkansas Context Snapshot

3.1 Facilities and delivery system

- Critical Access Hospitals (CAHs): Arkansas Department of Health lists 28 CAHs (accessed 2025). The Collaborative's tele-hospitalist/ICU/ER model can support night/weekend coverage and specialist backups. (healthy.arkansas.gov)
- HRSA-funded health center organizations: 12 awardees reported in 2024 UDS; these are natural anchors for RPM, pharmacy partnerships, and community screening. (data.hrsa.gov)
- Rural Health Clinics (RHCs): 105 in Arkansas per HRSA's 2022 allocation list; training and workflow modernization can be extended statewide through Collaborative TA. (hrsa.gov)

3.2 Workforce and HPSA indicators (latest available)

- Primary-care HPSA: 144 HPSAs; Mental-health HPSA: 90 (HRSA Designated HPSA Quarterly Summary, 3/31/2025, as summarized by HealthGuide USA). These data indicate continued need for recruitment and tele-support in rural counties. (commentary.healthguideusa.org)
- Compacts and licensure mobility: Arkansas participates in the Nurse Licensure Compact; PSYPACT enacted/effective; the physician Interstate Medical Licensure Compact enacted with implementation on/after Aug 5, 2025; EMS Compact enacted in 2025; PA Compact enacted in 2025. These reduce barriers for cross-border practice and can earn D.2 (licensure compacts) points as enacted. (healthy.arkansas.gov)

3.3 Medicaid and payment environment

- ARHOME (1115): CMS approved Arkansas's ARHOME 1115 demonstration (effective 1/1/2022 through 12/31/2026) with amendments adding HRSN services, non-medical transportation to HRSN services, and evaluation/monitoring milestones (2022–2025). RHT initiatives can align to ARHOME financing and care management, subject to State decisions. (cms.gov)
- PASSE program: Arkansas's provider-led shared savings entities manage care for beneficiaries with complex behavioral health or IDD needs; >55,000 members (DHS); this offers a platform for BH/IDD integration with tele-behavioral supports. (humanservices.arkansas.gov)

3.4 Broadband/telehealth readiness

- Arkansas BEAD program: the State Broadband Office targets >79,000 unserved homes/businesses; Tranche-2 pricing and BEAD-eligible location lists were updated Feb 13, 2025; preliminary rounds reported extensive bidding coverage. This positions rural providers to leverage telehealth investments under RHT. (broadband.arkansas.gov)

3.5 Maternal, behavioral health, and overdose trends

- Maternal mortality (national context): U.S. maternal mortality fell to 22.3 per 100,000 in 2022 (from 32.9 in 2021); Arkansas maintains a state MMRC supported by ADH. Collaborative tele-OB, remote BP monitoring, and perinatal pathways can be targeted to high-risk rural counties. (cdc.gov)
- Drug overdose mortality: Arkansas's age-adjusted overdose death rate decreased from 21.7 per 100,000 (2022) to 17.7 (2023), with 2024 CDC provisional data indicating further decline nationally and in most states. RPM-supported OUD/SUD care and tele-behavioral programs can build on this momentum. (cdc.gov)

3.6 Metric-to-capability table (examples)

- CAHs (28; ADH, 2025) → tele-ER/ICU/tele-hospitalist coverage and workforce backup (Avel eCare). (healthy.arkansas.gov)
- HRSA health center orgs (12; 2024 UDS) → RPM plus pharmacy-based care management for diabetes/HTN (BioIntelliSense; Walgreens/CVS). (data.hrsa.gov)
- Primary-care HPSA (144; 3/31/2025) → licensure compacts and tele-support to increase supply (D.2/C.1). (commentary.healthguideusa.org)
- BEAD unserved locations (>79,000; Feb 2025) → telehealth deployment and patient engagement tools statewide (Use-of-Funds F). (broadband.arkansas.gov)
- Overdose rate 2023 (17.7/100k) → integrated tele-behavioral and OUD care pathways, naloxone distribution, remote monitoring (Humetrix + partner models). (cdc.gov)

4. Strategy Aligned to RFP

Arkansas can pursue a rural transformation strategy focused on "keep care local, coordinate regionally, measure statewide," anchored in three system pillars:

- Local access: tele-enabled emergency/ICU/consult coverage for CAHs and rural EDs; pharmacy-embedded screening/management; community-linked RPM for chronic and perinatal care.
- Regional coordination: member-owned rural High Value Networks (HVNs) for shared services, procurement, analytics, and payer contracting; aligned with C.1 and Use-of-Funds K.
- Statewide data and security: TEFCA QHIN exchange (PRISMANet) plus cyber-hardening via Microsoft/AHA program, enabling timely reporting for technical factor scoring and evaluation. (sequoiaproject.org)

Equity strategy includes multilingual triage and PHR tools (Humetrix), targeted outreach via retail locations in rural hubs, and alignment with ARHOME HRSN supports.

Data use and privacy rely on HIPAA-compliant platforms, TEFCA exchange for treatment, and role-based access with audit trails; collaborative partners operate within federal rules (2 CFR Part 200/300; HHS GPS) and State requirements.

(files.simpler.grants.gov)

5. Program Design Options (Arkansas-tuned)

Option A. Rural stabilization via HVN + tele-acute network

- Target: CAHs, small rural PPS, rural EDs in high-transfer corridors.
- Problem: Night/weekend staffing, specialist scarcity, and transfer-driven costs. Evidence: statewide CAH footprint; HPSA burden. (healthy.arkansas.gov)
- Collaborative components: Avel eCare (tele-ER/ICU/tele-hospitalist), Cibolo Health HVN formation, PMO analytics (Accenture/KPMG/PwC), PRISMANet connectivity.
- Payment logic: within NOFO caps—limited stabilization and on-call coverage supports (≤15% provider payments) tied to avoided transfers, LOS, and quality metrics; capital (e.g., carts/monitors) within Cat. J ≤20%. (files.simpler.grants.gov)
- Policy enablers: EMS Compact for cross-border coverage; licensure compacts to widen clinician pools. (emscompact.gov)
- Pros/risks: Faster impact on access; risk is adoption variance; mitigated via PMO, local champions.

Option B. Chronic disease + perinatal home-to-clinic monitoring

- Target: adults with HTN/diabetes/HF; high-risk pregnancies (rural counties).
- Problem: high readmissions/utilization; maternal morbidity concerns. (cdc.gov)
- Components: BioIntelliSense RPM; pharmacy hypertension/diabetes management (Walgreens/CVS/Walmart); Humetrix multilingual triage; eClinicalWorks for care gap closure.
- Payment: RPM and coaching under Use-of-Funds A/C/F; provider payments as gap-fill within 15% cap; leverage ARHOME HRSN supports where applicable. (files.simpler.grants.gov)
- Pros/risks: Measurable outcomes; ensure data governance and device logistics.

Option C. Behavioral health and crisis integration

- Target: rural EDs/EMS, PASSE populations, counties with high SUD burden.
- Problem: limited BH coverage, ED boarding, overdose risk.
- Components: 24/7 tele-behavioral consults and crisis response (Avel eCare), PASSE coordination, Humetrix risk alerts, 988 integration.
- Payment: Use-of-Funds H/I; EMS support (C.2) and training (D).
- Pros/risks: Strong alignment to NOFO goals; workforce availability risk mitigated by compacts. (imlcc.com)

Option D. EMS-led community paramedicine and tele-triage (complementary)

- Target: frontier/remote counties and frequent 911 users.
- Problem: long response times, avoidable transports.
- Components: tele-triage, post-discharge check-ins, remote diagnostics; EMS Compact eases cross-jurisdiction operations. (emscompact.gov)

6. Governance and Collaborative Roles

6.1 Oversight structure (text diagram)

- Governor-designated Lead Agency (prime recipient)—sets priorities; holds cooperative agreement; oversees PMO.
- State Medicaid—alignment with ARHOME and payment levers.
- State Rural Health/ADH—clinical integration, AMMRC insights, EMS linkages.
- Provider networks (CAHs, FQHCs, RHCs), HVN(s) (Cibolo convening).
- Collaborative PMO (Accenture/KPMG/PwC/AVIA)—program control, economic modeling, compliance tracking.
- Technical stack (eClinicalWorks QHIN, Microsoft security/identity, partner AI) and tele-services (Avel eCare). (sequoiaproject.org)

6.2 RACI (selected)

- Rural tele-acute rollout: R—Avel eCare; A—Lead Agency; C—Hospital Association/FQHCs; I—Medicaid.
- HVN creation and shared services: R—Cibolo Health; A—Lead Agency; C—payers/hospitals; I—Medicaid/ADH.
- Cybersecurity upgrades: R—Microsoft + facility IT; A—Lead Agency CIO; C—AHA/Microsoft program; I—CMS. (aha.org)
- Data integration/Evaluation: R—eClinicalWorks/PMO; A—Lead Agency; C—HIE/Medicaid; I—CMS evaluator. (sequoiaproject.org)

7. Payment and Funding

- Allowable pathways within NOFO caps: targeted provider payments (≤15%) linked to outcomes (e.g., avoided transfers, BP control); minor capital (≤20%) for carts, cameras, RPM kits; EMR replacement only if within ≤5% and meets prior HITECH condition; admin ≤10% including indirects. (files.simpler.grants.gov)
- Medicaid alignment opportunities: ARHOME HRSN services and NMT to HRSN; PASSE for BH/IDD populations; SPA/State Plan coding for tele-services as applicable (subject to State decision and CMS approvals). (cms.gov)

Illustrative funding table (planning placeholder $200M/yr)

- Workstream: Tele-acute network; ROM: $40–60M; Source: RHT (Cats. D/F/G/J); Deliverables: tele-ER/ICU units, SOPs, metrics. (files.simpler.grants.gov)
- RPM + pharmacy care: $25–40M; RHT (A/C/F); device pools, coaching, pharmacy collaborations.
- Cybersecurity & data: $20–30M; RHT (F) + Microsoft discounts; hardening plan, dashboards, reporting. (aha.org)
- HVN/shared services: $10–20M; RHT (K); governance, analytics, payer engagement.
- PMO & evaluation: $10–15M; RHT (admin ≤10% applies overall); program control, independent evaluation liaison. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Core measures: access (ED transfer rates, time-to-consult), quality (30-day readmissions for HF/COPD; BP control), maternal outcomes (postpartum follow-up, remote BP engagement), BH (ED boarding hours), workforce (vacancy/retention), cyber maturity (CPGs adherence). (files.simpler.grants.gov)
- Data sources: Medicaid claims; QHIN exchange/EHR (eClinicalWorks PRISMANet); HIE feeds; EMS runs; pharmacy data; evaluation data mart managed by PMO with role-based access and 2 CFR compliance. (sequoiaproject.org)
- Evaluation: cooperate with CMS/third-party evaluators; publish time-series dashboards; attribute changes to specific initiatives using difference-in-differences or stepped-wedge designs as feasible. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; subject to procurement/contracting)

Gantt-style table (example)

- Workstream | Start | End | Owner | Outputs
- PMO stand-up, governance | Jan 2026 | Mar 2026 | Lead Agency + PMO | Charter, RAID log, reporting plan.
- Cybersecurity baseline + quick wins | Jan 2026 | Jun 2026 | Facilities + Microsoft | Assessments, MFA/endpoint hardening, CPG scorelines. (aha.org)
- Tele-acute phases (pilot → scale) | Feb 2026 | Dec 2026 | Avel eCare + hospitals | Go-lives, coverage hours, transfer KPIs.
- RPM cohorts (HTN/DM; perinatal) | Mar 2026 | Dec 2026 | FQHCs/RHCs + BioIntelliSense | Enrollments, exception mgmt SLA, outcome reports.
- HVN(s) formation | Apr 2026 | Nov 2026 | Cibolo Health + providers | JV docs, shared services catalog, payer MOUs.
- Data integration/TEFCA connections | Mar 2026 | Oct 2026 | eClinicalWorks | Encounter/claims feeds, KPI dashboards. (sequoiaproject.org)

10. Risk Register (selected)

- Adoption variability among facilities → Mitigation: phased pilots, clinical champions; Owner: PMO.
- Cyber incidents during rollout → Accelerate security controls; Owner: facility CIO + Microsoft. (aha.org)
- Workforce burnout → Ambient documentation/tele-mentoring; Owner: facilities + vendors.
- Data-sharing lags → TEFCA QHIN onboarding, SLA-backed interfaces; Owner: eClinicalWorks. (sequoiaproject.org)
- Policy points not enacted by deadlines → Track legislative milestones; Owner: Lead Agency. (files.simpler.grants.gov)
- Procurement delays → Pre-procurement market research and template scopes; Owner: PMO.
- Broadband gaps → Sequence deployments with BEAD projects; Owner: PMO + ABO. (broadband.arkansas.gov)
- Medicaid alignment complexity → ARHOME/HRSN change management; Owner: Medicaid. (cms.gov)
- Privacy/security compliance → 2 CFR/HHS GPS controls; Owner: PMO + counsel. (files.simpler.grants.gov)
- Reporting burden → Centralized data mart and automation; Owner: PMO.

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

11.1 Rural Needs and Target Population (excerpt)

"Arkansas will target CAHs and rural PPS hospitals in Regions X/Y, FQHCs/RHCs in medically underserved counties, and perinatal high-risk cohorts identified via Medicaid claims and public health registries. We will prioritize counties with primary-care HPSA and mental-health HPSA designations as of March 31, 2025. Interventions include tele-acute coverage, remote monitoring, and pharmacy-enabled chronic disease management, paired with licensure compacts to improve clinician supply." (commentary.healthguideusa.org)

11.2 Goals, Strategies, and State Policy Actions (excerpt)

"Over FY26–FY31 we will: (1) reduce interfacility transfers from CAHs by 15%; (2) improve BP control among enrolled hypertensive adults by 10 percentage points; (3) decrease ED BH boarding hours at pilot sites by 20%; (4) reduce 30-day readmissions for HF by 10%. Arkansas has enacted nurse, physician, PA, and EMS compacts (with IMLC go-live after Aug 5, 2025) and will align credentialing to maximize licensure mobility (Technical D.2)." (healthy.arkansas.gov)

11.3 Proposed Initiatives and Use of Funds (excerpt)

"Tele-Acute & Transfer Avoidance Initiative (Use-of-Funds D/F/G/J; Technical C.1/C.2): deploy 24/7 tele-ER/ICU coverage at CAHs in three waves, with performance-based support (≤15% provider payments). Minor renovations and equipment (≤20%) enable tele-zones and monitoring rooms." (files.simpler.grants.gov)

11.4 Implementation, Stakeholders, and Governance (excerpt)

"Arkansas will stand up a PMO with monthly CMS engagement per cooperative agreement norms, supported by systems integrators for program control and evaluation. Provider-owned HVN(s) will steward shared investments and track value realization."

11.5 Metrics and Evaluation (excerpt)

"We will report quarterly on access, quality, cost, workforce, technology, and implementation milestones; leverage TEFCA QHIN exchange (PRISMANet) and HHS CPGs for cyber to underpin data validity and security." (sequoiaproject.org)

Assumptions and Open Questions (to be validated before submission)

- Arkansas rural population share and county-level "frontier" status: will confirm final A.4/A.5 values from 2020 Decennial Census rural definitions and any CMS-specified frontier metric. (Planning placeholder only; not used in calculations herein.)
- Final lists of participating facilities, HIE integration specifics, and payer partners to be confirmed during readiness

assessment.

- Any ARHOME amendments submitted in 2025/2026 (e.g., work/community engagement "Pathway to Prosperity") may affect alignment timelines; coordination with CMS will be required. (content.govdelivery.com)

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13. AI Generation Notice

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