Rural Health Transformation Grant Guide — Indiana

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Indiana can leverage the Rural Health Transformation Program (RHT Program) to stabilize rural access, modernize care, and build durable data infrastructure while aligning Medicaid and multi-payer incentives. The CMS Notice of Funding Opportunity (NOFO) makes up to $50B available nationally over FY26–FY30 via cooperative agreements to States, with 50% of funds distributed equally among approved States and 50% distributed by a points-based workload formula; awards are expected by December 31, 2025, with applications due November 5, 2025. [1] (files.simpler.grants.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Indiana with a coherent portfolio of clinical, data, and change-enablement capabilities that align to every RHT use-of-funds category, subject to State selection, contracting, and integration. These include virtual hospitalist/ICU/ER support (Avel eCare), continuous remote monitoring (BioIntelliSense), data platforms and cybersecurity services (Microsoft), interoperability and care coordination (eClinicalWorks/PRISMA/PRISMANet), consumer screening/triage (Humetrix, Higi, Topcon), ambient documentation and analytics (Sunoh.ai/Pangaea Data), and rural provider network governance (Cibolo Health). [2–6]

Indiana's context suggests high-leverage early moves: expand rural virtual specialty coverage and tele-EMS; integrate pharmacist-enabled chronic disease care through retail health partners; scale RPM for maternal hypertension and cardiometabolic risk; and deploy statewide data and identity frameworks to support program reporting and evaluation. These directions are consistent with the NOFO's allowable uses and scoring framework (technical factors B–F) and can contribute to initiative-based points that influence workload funding over time. [1][2] (files.simpler.grants.gov)

The plan presented here is enabling and conditional. It maps Indiana's needs to NOFO requirements, illustrates program design options, and identifies risks and dependencies. It does not prescribe internal State processes.

1.1 One-page printable summary (Program-at-a-glance)

- What CMS is offering: $50B FY26–FY30; cooperative agreements to States; equal baseline + points-based workload shares; optional LOI due Sep 30, 2025; application due Nov 5, 2025; awards by Dec 31, 2025. [1] (files.simpler.grants.gov)
- What Indiana must submit: One official State application; Governor-endorsed; Project Narrative (≤60 pp), Budget Narrative (≤20 pp), attachments and required forms (SF-424, SF-424A, SF-LLL, site forms). Executive Order 12372 does not apply; check "No" on SF-424 Box 19c. [1] (files.simpler.grants.gov)
- How funding is scored: Baseline = equal split; Workload points (Table 3) from rural facility/population metrics and technical factors; initiative-based scoring considers Strategy, Workplan/monitoring, Outcomes, Projected impact, Sustainability (up to 20 points each). [1] (files.simpler.grants.gov)
- Guardrails and caps: Admin ≤10% of allotment; provider payments ≤15%; Category J capital/infra ≤20%; EMR replacement ≤5% (if HITECH-certified system in place as of 9/1/2025); "Rural Tech Catalyst Fund" ≤ the lesser of 10% or $20M per budget period. [1] (files.simpler.grants.gov)
- Indiana context signals: Rural share 28.8% (2020 Census); 33 Critical Access Hospitals (CAHs) and 150 Rural Health Clinics (RHCs); 26 FQHC awardees served 676,323 patients (2024); IDOH cites rural EMS workforce gaps; PathWays for Aging (MLTSS) launched Jul 2024. [7–11] (ncsl.org)
- Collaborative fit: Tele-specialty coverage (Avel), RPM (BioIntelliSense), data/cyber platforms (Microsoft), interoperability/QHIN (eClinicalWorks PRISMA/PRISMANet), consumer screening/triage (Humetrix/Higi/Topcon), ambient/analytics (Sunoh.ai/Pangaea), rural provider High Value Networks (Cibolo). [2–6]

2. Eligibility and RFP Fit

2.1 Snapshot of NOFO requirements

- Eligible applicants: Only the 50 U.S. States; DC and territories are ineligible. Governor designates lead agency/office; one official application per State; most recent on-time submission counts. [1] (files.simpler.grants.gov)
- Key dates: Optional LOI by Sep 30, 2025; application due Nov 5, 2025, 11:59 p.m. ET; expected award/earliest start Dec 31, 2025; CMS webinars Sept 19 and 25, 2025. [1] (files.simpler.grants.gov)

- Distribution: $50B over five budget periods (FY26–FY30). 50% equal baseline; 50% points-based workload recalculated annually for technical factors; rural facility/population factors set using Q4 2025 data. [1] (files.simpler.grants.gov)
- Scoring: Table 3 weights A.1–A.7 (50%) and B.1–F.3 (50%); initiative-based scoring matrix (Table 2) across Strategy, Workplan & monitoring, Outcomes, Projected impact, Sustainability (each 0–20). [1] (files.simpler.grants.gov)
- Application components: Project Summary (1 page), Project Narrative (≤60 pp), Budget Narrative (≤20 pp), required forms (SF-424, SF-424A, SF-LLL, site forms), Governor's endorsement (≤4 pp), Business assessment (≤12 pp), Program duplication assessment (≤5 pp), Other supporting docs (≤35 pp). Box 19c "No" (EO 12372 does not apply). [1] (files.simpler.grants.gov)
- Allowable uses of funds: Multiple categories spanning prevention/chronic disease; provider payments (capped); consumer-facing tech; training/TA for tech-enabled care; workforce recruitment/retention; IT and cybersecurity; right-sizing service lines; behavioral health (including OUD/SUD); innovative care/payment models; minor renovations/equipment; regional partnerships. [1] (cms.gov)
- Funding limits: Admin ≤10% total; provider payments ≤15%; Category J capital/infra ≤20%; EMR replacement ≤5% (if prior HITECH-certified EMR in place 9/1/2025); Rural Tech Catalyst Fund ≤ the lesser of 10% or $20M/budget period. [1] (files.simpler.grants.gov)
- Compliance and reporting: 2 CFR Part 200 and applicable 2 CFR Part 300; HHS GPS; reporting includes progress, FFR, FFATA, SAM responsibility/qualification, PMS, audit, workplan updates, debarment/suspension; annual NCC applications (~60 days before period end); cybersecurity plan if accessing HHS systems and PII/PHI. [1] (files.simpler.grants.gov)

2.2 Requirement-to-Collaborative mapping (illustrative)

- Requirement: Tech innovation, remote care, cybersecurity; Evidence: NOFO "Uses of Funds" and technical factors F.1–F.3. Collaborative capabilities: Microsoft cloud security services for rural hospitals; TEFCA-aligned interoperability via eClinicalWorks PRISMA/PRISMANet; RPM via BioIntelliSense; tele-specialty via Avel eCare. [1][2–4] (cms.gov)
- Requirement: Workforce recruitment/retention; Evidence: NOFO workforce use-of-funds; Technical factor D.1. Collaborative: Avel provider-to-provider tele-mentoring; ambient documentation to reduce burden; CHC training via NACHC; pharmacist-enabled models in retail settings. [1][2] (cms.gov)
- Requirement: Innovative care/payment models; Evidence: NOFO I. Innovative care models; Technical factors C.1/E.1/E.2. Collaborative: Cibolo Health to convene rural High Value Networks (HVNs); integrator support (Accenture/KPMG/PwC) for APM design and tracking. [1][2] (files.simpler.grants.gov)
- Requirement: Minor capital/right-sizing; Evidence: Category J; ≤20% cap. Collaborative: Advisory and engineering support to align renovations/equipment with volumes and digital care models. [1][2] (files.simpler.grants.gov)

3. Indiana Context Snapshot

- Rural population share: 28.8% of Hoosiers lived in rural areas in 2020 (Census). [7] (ncsl.org)
- Nonmetro population: 21.8% per ACS 2019–2023 (RHIhub). [8] (ruralhealthinfo.org)
- Facility mix: 33 Critical Access Hospitals (CAHs) and 150 Rural Health Clinics (RHCs) (RHIhub, updated 2025); IDOH map confirms CAHs statewide. [8][9] (ruralhealthinfo.org)
- FQHCs: 26 Health Center Program awardees served 676,323 patients in 2024 (HRSA UDS). [10] (data.hrsa.gov)
- EMS/trauma: IDOH notes rural EMS workforce shortages; 21 adult and 5 pediatric ACS-verified trauma centers. [11] (in.gov)
- Medicaid delivery: Indiana Medicaid operates large managed care programs (HIP, Hoosier Healthwise, Hoosier Care Connect) and launched Indiana PathWays for Aging (MLTSS) July 1, 2024 (Anthem, Humana, UnitedHealthcare). [12–14] (in.gov)
- Maternal health: Indiana MMRC publishes annual reports; 2024 report (2018–2022 data) available; stakeholders note preventability of many maternal deaths and rural access gaps. [15–17] (in.gov)

3.1 Metrics-to-capability table (selected)

- Metric (year; source): Rural share 28.8% (2020; Census via NCSL). Collaborative capability: retail/clinic screenings +

RPM to reach dispersed residents (Humetrix/Higi/Topcon; BioIntelliSense). [7][2] (ncsl.org)

- CAHs 33; RHCs 150 (2025; RHIhub). Capability: tele-ICU/ER/Pharmacy to support low volume sites (Avel); data platform + cyber uplift (Microsoft). [8] (ruralhealthinfo.org)
- FQHC awardees 26; patients 676,323 (2024; HRSA UDS). Capability: PRISMA/PRISMANet for cross-network records; ambient documentation to reduce burden. [10][2] (data.hrsa.gov)
- Rural EMS need (2025; IDOH). Capability: tele-EMS consults, e-triage intake (Humetrix), and trauma transfer decision support. [11][2] (in.gov)
- PathWays MLTSS go-live Jul 2024; ~120,000 eligible seniors (FSSA). Capability: home-based RPM + virtual care bundles for frail elders; analytics for plan quality metrics. [13][14][2] (in.gov)

4. Strategy Aligned to RFP

- Prevention and chronic disease (Use A; Technical B.1/B.2/F.3): Deploy consumer screening (Higi/Topcon), multilingual intake/triage (Humetrix), pharmacist-enabled BP/diabetes management with retail partners, and RPM for high-risk cohorts (BioIntelliSense). Evidence base and components are detailed by Collaborative members. [2–6]
- Sustainable access and right-sizing (Use G/J; Technical C.1/C.2): Expand tele-ICU/ER and virtual hospitalist coverage (Avel), align service lines using analytics, and invest in minor renovations/equipment within the 20% capital cap. [1] [2] (files.simpler.grants.gov)
- Workforce (Use E/D; Technical D.1): Reduce burden through ambient documentation and prior-auth assistance; create training pathways via NACHC and system integrators; consider pharmacist scope pilots where permissible. [2]
- Innovative care/payment (Use I; Technical C.1/E.1/E.2): Convene rural HVNs for shared services and APMs; integrate duals and Medicare alignment opportunities with PathWays and MA D-SNPs. [1][2] (files.simpler.grants.gov)
- Tech innovation, cyber, data (Use F; Technical F.1–F.3): State-level secure cloud tenancy, identity/access controls, TEFCA-aware exchange, and longitudinal analytics to meet initiative monitoring, Table 2 scoring, and annual reporting. [1][2–4] (files.simpler.grants.gov)

Equity approach: prioritize rural and frontier-adjacent ZIP codes with low broadband and maternal care access; use multilingual tools, community screening with AHA/ASA; apply risk-stratification to reach Medicaid/duals and behavioral health needs. [2]

Data and privacy: use HITRUST/ISO-aligned cloud controls; TEFCA participation (via PRISMANet QHIN) to support cross-network exchange; consent and privacy tooling for patients (Humetrix). [2–4]

5. Program Design Options (Indiana-tuned; each subject to policy and procurement)

Option A: Rural Cardiometabolic and Maternal Risk Network

- Target: Adults with hypertension/diabetes; perinatal people at risk of preeclampsia; Medicaid/duals in nonmetro counties (2024 FQHC patients 676k). [10] (data.hrsa.gov)
- Problem: High rural chronic disease burden; maternal safety risks flagged by MMRC. [15–17] (in.gov)
- Components: Consumer BP/glucose/retina screening (Higi/Topcon), pharmacist-enabled management with linkages to CHCs; RPM (BioIntelliSense) for high-risk pregnancy/postpartum BP and CHF/COPD; multilingual intake (Humetrix); tele-consults (Avel/Teladoc). [2–6]
- Payment logic: Time-limited provider support payments within 15% cap; value incentives via Medicaid APM or HVN shared-savings; braid PathWays quality metrics for elders. [1][2] (files.simpler.grants.gov)
- Pros/risks: Rapid reach through retail/CHC networks; dependency on data integration and retail-clinical workflows; mitigate with phased pilots and standard interfaces. [2]

Option B: Rural Hospital Virtual Support and Right-sizing Initiative

- Target: CAHs and small rural PPS; EMS-linked facilities. [8][11] (ruralhealthinfo.org)
- Components: 24/7 tele-ICU/ER/hospitalist (Avel), clinical decision support (Viz.ai), virtual pharmacy; capital upgrades and equipment under Category J (≤20%); cyber uplift. [1][2] (files.simpler.grants.gov)
- Payment logic: Facility stabilization via HVN shared services; APM pilots with payers; avoid duplication with existing

reimbursements per NOFO. [1][2] (files.simpler.grants.gov)

Option C: Tele-EMS and Community Paramedicine Expansion

- Target: Rural EMS and frontier-adjacent areas with long transports. [11] (in.gov)
- Components: Tele-EMS consults; e-triage (Humetrix); community paramedicine kits; integration with trauma transfer protocols. [2]
- Payment logic: Subawards to EMS; equipment and training under tech/capital categories; align with Medicaid transport and quality metrics. [1] (cms.gov)

Option D: Rural High Value Networks (HVNs) for Shared Services

- Target: Independent rural hospitals/clinics seeking scale for data, contracting, and workforce support. [2]
- Components: Cibolo-enabled HVN governance; pooled analytics, contracting, and training; APM design with integrators. [2]
- Payment logic: Network-level quality incentives; shared savings; catalyst funds within NOFO constraints. [1] (files.simpler.grants.gov)

6. Governance and Collaborative Roles

- State lead (Governor-designated agency): Accountable to CMS; sets statewide goals; oversees subawards; chairs Steering Committee. [1] (files.simpler.grants.gov)
- Medicaid (OMPP/FSSA): Aligns PathWays/HIP/Hoosier programs, SPAs/waivers as needed for APMs; provides data extracts for evaluation. [12–14] (in.gov)
- Provider stakeholders (Hospital Association, CAHs, CHCs, EMS): Implementation partners; clinical councils.
- Collaborative (illustrative RACI):
    - R (Responsible): Avel (tele-ICU/ER), BioIntelliSense (RPM ops), eClinicalWorks (interoperability), Microsoft (cloud/cyber), Humetrix (intake/PHR), Cibolo (HVN governance), SI partners (program management).
    - A (Accountable): State PMO; HVN boards.
    - C (Consulted): Payers; AHA/ASA; universities (workforce).
    - I (Informed): Community orgs; consumers. Evidence of roles and offerings is described in the Collaborative consensus document. [2–6]

7. Payment and Funding

- Within NOFO caps: Admin ≤10%; provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% (if HITECH EMR in place by 9/1/2025). [1] (files.simpler.grants.gov)
- Medicaid alignment opportunities: PathWays MLTSS quality measures (CAHPS, care coordination) and MA D-SNP alignment for duals; APM design with actuarial support (SIs). [13][2] (in.gov)
- Illustrative cost categories and timing (ROM only; subject to procurement):
    - Tele-specialty/virtual care services: subscription + per-encounter (Years 1–5); deliverables: coverage SLAs, transfer avoidance dashboards. [2]
    - RPM kits/services: device bundles + monitoring (Years 1–5); deliverables: enrollment/alerts, outcome reports. [2]
    - Data platform/cyber: cloud tenancy, identity, logging, TEFCA connectivity (Years 1–3 build; 4–5 run); deliverables: data model, KPIs, security attestations. [2–4]
    - Training/workforce: curricula and tele-mentoring; deliverables: trained counts, retention metrics. [2]

8. Data, Measurement, and Evaluation

- Core measures: access (ED transfer rates, tele-consult response times), quality (BP control, A1c), maternal safety (post-partum BP follow-up), behavioral health engagement, financial (operating margin, avoidable transfers), tech (uptime, cyber events), implementation (enrollment, go-live milestones). Aligned to Table 2 emphasis on outcomes

and sustainability. [1] (files.simpler.grants.gov)

- Data sources: Medicaid and MA claims; CHC EHRs; hospital ADT; EMS run sheets; consumer apps/PHR; RPM data; HIE/TEFCA QHIN exchange; integrated via secured cloud. [2–4]
- Evaluation cadence: Baselines at Month 6; quarterly dashboards; annual independent evaluation support; NCC package includes progress evidence per NOFO. [1] (files.simpler.grants.gov)

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

Gantt-style table (quarters = Q1=Jan–Mar 2026; adjust per award date)

- Workstream; Start; End; Owner; Outputs
- State PMO + Steering Charter; Q1; Q1; State lead; Governance, roles, risk log. [1] (files.simpler.grants.gov)
- Data platform & cyber baseline; Q1; Q2; State+Microsoft; Tenant, security plan, data catalog. [2]
- Tele-ICU/ER pilots; Q2; Q3; CAHs+Avel; Live coverage, KPI baseline. [2]
- RPM maternal and CHF cohorts; Q2; Q4; CHCs+Hospitals+BioIntelliSense; Enrolled patients, alert workflows. [2]
- Retail/CHC screening; Q2; Q4; Retail+CHCs; Screening counts, referrals. [2]
- HVN formation (charter/contracts); Q2; Q4; Cibolo+providers; Network bylaws, shared services. [2]
- EMS tele-consult; Q3; Q4; EMS+Avel+Humetrix; SOPs, metrics. [2]
- Evaluation baseline + NCC #1; Q4; Q4; State+SI; Measures, NCC submission. [1] (files.simpler.grants.gov)

10. Risk Register (selected)

- Procurement delays; Mitigation: pre-negotiated vehicles, phased pilots; Owner: State PMO.
- Data-sharing barriers; Mitigation: TEFCA/QHIN participation (PRISMANet), DUAs, consent tooling; Owner: State+eClinicalWorks. [2–4]
- Workforce adoption; Mitigation: training, ambient documentation to reduce burden; Owner: Providers+SI. [2]
- Cyber incidents; Mitigation: managed SOC, MFA, backups; Owner: State+Hospitals+Microsoft. [2]
- Retail-clinical coordination gaps; Mitigation: referral protocols, data exchange; Owner: CHCs+Retail partners. [2]
- Funding cap breaches; Mitigation: budget guardrails matching NOFO caps; Owner: Finance. [1] (files.simpler.grants.gov)
- Duplication with reimbursable services; Mitigation: program duplication SOPs per NOFO; Owner: State PMO. [1] (files.simpler.grants.gov)
- Policy commitments lapse (technical factors); Mitigation: legislative planning timeline; check-ins before Dec 31, 2027/2028; Owner: State policy lead. [1] (files.simpler.grants.gov)
- Broadband or device access; Mitigation: prioritize clinic-based monitoring and low-bandwidth tools; Owner: Providers+Vendors.
- Vendor performance; Mitigation: SLAs, milestone-based payments; Owner: State PMO.

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

11.1 Rural Health Needs & Target Population (Project Narrative §1)

Indiana has a substantial rural population (28.8% in 2020) experiencing access and workforce gaps, including rural EMS shortages and maternal care deserts. We will focus on nonmetro counties and CAH/RHC service areas, as well as seniors in the PathWays for Aging managed LTSS program. [7][11][14] (ncsl.org)

11.2 Goals & Strategies (Project Narrative §2)

Our Rural Health Transformation Plan advances prevention, sustainable access, workforce, innovative care, and technology. It deploys virtual specialty support (Avel), RPM (BioIntelliSense), interoperability and analytics (Microsoft/eClinicalWorks),

consumer-facing screening and triage (Humetrix/Higi/Topcon), and HVN governance (Cibolo) to improve outcomes while maintaining services close to home. [2–6]

11.3 Proposed Initiatives & Use of Funds (Project Narrative §3)

We propose four initiatives aligned to NOFO uses and technical factors: Rural Virtual Care Expansion; Cardiometabolic & Maternal Risk Management; Tele-EMS & Community Paramedicine; and Rural High Value Networks. Each initiative includes ≥4 measurable outcomes, baselines/targets, and county lists; funds comply with NOFO caps (admin ≤10%; provider payments ≤15%; Category J ≤20%). [1] (files.simpler.grants.gov)

11.4 Implementation & Timeline (Project Narrative §4)

We sequence governance, data, clinical launches, and evaluation over 12–24 months, with major procurements and policy milestones aligned to NOFO requirements; annual NCC packages will document progress for continuation decisions. [1] (files.simpler.grants.gov)

11.5 Stakeholder Engagement (Project Narrative §5)

We will convene CAHs, CHCs, EMS, retail health, payers, hospital systems, universities, tribal/IHS as applicable, and community organizations; the Collaborative supports structured facilitation and public-private alignment. [2]

11.6 Metrics & Evaluation; Sustainability (Project Narrative §6)

We commit to data-sharing and participation in CMS/third-party evaluations; our data stack supports quarterly dashboards and annual reporting; sustainability is advanced via HVNs and Medicaid APMs. [1][2] (files.simpler.grants.gov)

12. Assumptions and Open Questions

- Indiana's current status for licensure compacts (physician, APRN, behavioral health) and Certificate of Need: confirm for technical factors D.2/C.3. [1] (files.simpler.grants.gov)
- SNAP waiver posture and nutrition CME policies (B.3/B.4): confirm scope and timelines to claim conditional points by 2027/2028. [1] (files.simpler.grants.gov)
- CCBHC inventory as of Sep 1, 2025 (entity and site addresses) and Medicaid DSH hospital count for the most recent SPRY: confirm for Table 4 data elements. [1] (files.simpler.grants.gov)
- Broadband access metrics by rural county: incorporate when selecting sites for RPM and telehealth hubs.
- Final selection of vendors is subject to State procurement; specific products listed are illustrative of Collaborative capabilities.

13. Application compliance checklist (NOFO-based)

- One official State application (Governor-designated lead; AOR signature). [1] (files.simpler.grants.gov)
- Project Summary (1 page); Project Narrative (≤60 pp); Budget Narrative (≤20 pp). [1] (files.simpler.grants.gov)
- Attachments: Governor's endorsement (≤4 pp; required content), Business assessment (≤12 pp), Program duplication assessment (≤5 pp), Other supporting docs (≤35 pp). [1] (files.simpler.grants.gov)
- Forms: SF-424 (Box 19c "No"), SF-424A, SF-LLL, Site forms. [1] (files.simpler.grants.gov)
- Budget caps observed (admin ≤10%; provider payments ≤15%; Category J ≤20%; EMR replacement ≤5%; Rural Tech Catalyst Fund limit). [1] (files.simpler.grants.gov)
- Reporting commitments (progress, FFR, FFATA, SAM/PMS, audit, workplan updates, debarment/suspension). [1] (files.simpler.grants.gov)

14. Timeline (Gantt view excerpt)

- Q1 2026: PMO launch; governance; cyber baseline; data agreements.
- Q2 2026: Tele-ICU/ER pilots; screening rollout; maternal/CHF RPM cohorts.
- Q3 2026: Tele-EMS expansion; HVN stand-up; first outcomes read-outs.
- Q4 2026: NCC #1; budget refresh; scale decisions for 2027 funding. [1] (files.simpler.grants.gov)

15. References

1. Rural Health Transformation Program — Notice of Funding Opportunity (CMS-RHT-26-001), CMS, pdf, accessed 2025-10-14. https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf (files.simpler.grants.gov)

2. Rural Health Transformation Collaborative. R1. 10-11-25 (consensus capabilities and members), internal Collaborative document, 2025, accessed 2025-10-14.

3. CMS Rural Health Transformation Program overview, CMS.gov, last modified 2025-09-26, accessed 2025-10-14. https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview (cms.gov)

4. Press Release: CMS Launches Landmark $50 Billion RHT Program, CMS, 2025-09-15, accessed 2025-10-14. https://www.cms.gov/newsroom/press-releases/... (cms.gov)

5. NCSL, Rural Voters: State Rural Population (2020 Census), accessed 2025-10-14. https://www.ncsl.org/.../voting-for-all-americans-rural-voters (ncsl.org)

6. Rural Health Information Hub — Indiana State Profile (nonmetro share; CAHs; RHCs), updated 2025-09-11, accessed 2025-10-14. https://www.ruralhealthinfo.org/states/indiana (ruralhealthinfo.org)

7. HRSA UDS State Data — Indiana (awardees and patients), reporting year 2024, accessed 2025-10-14. https://data.hrsa.gov/tools/data-reporting/program-data/state/IN (data.hrsa.gov)

8. IDOH Trauma System — Trauma Centers page (EMS/trauma, CAH map link),

accessed 2025-10-14. https://www.in.gov/health/trauma-system/trauma-centers/ (in.gov)

9. IDOH — Critical Access Hospitals in Indiana map (PDF), 2023-01-09, accessed 2025-10-14. https://www.in.gov/health/trauma-system/files/CAH-by-PHPD-2023-no-dunn.pdf (in.gov)

10. Indiana Medicaid (IHCP) — Managed Care Health Plans (HIP, HHW, HCC, PathWays), accessed 2025-10-14. https://www.in.gov/medicaid/partners/.../managed-care-health-plans/ (in.gov)

11. Indiana PathWays for Aging — Providers and timeline, accessed 2025-10-14. https://www.in.gov/pathways/providers/ (in.gov)

12. Indiana PathWays for Aging — Eligibility, accessed 2025-10-14. https://www.in.gov/pathways/who-is-eligible-for-the-pathways-program (in.gov)

13. Indiana MMRC — Maternal Mortality Review Committee (reports page, 2024 report), IDOH, accessed 2025-10-14. https://www.in.gov/health/safesleep/fatality-review/maternal-mortality-review-committee/ (in.gov)

14. IU Public Policy Institute — Maternal mortality in Indiana (brief with statistics), accessed 2025-10-14. https://policyinstitute.iu.edu/research-analysis/research-findings/maternal-mortality.html (policyinstitute.iu.edu)

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