Rural Health Transformation Grant Guide — Rhode Island

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Rhode Island enters the CMS Rural Health Transformation (RHT) Program with a small but material rural footprint (8.9% of residents lived in rural areas in 2020), concentrated in Washington and Newport counties and rural towns in Kent and Providence counties. This profile suggests a strategy that emphasizes statewide digital infrastructure, targeted rural access points, and integration with existing managed care and behavioral health reforms, rather than large-scale facility expansion. (ncsl.org)

The RHT Collaborative can support Rhode Island's application and execution by providing configurable capabilities across virtual care (tele-ER/ICU/behavioral), continuous remote monitoring, pharmacy-enabled chronic care, data exchange and analytics, and program management. Examples include Avel eCare's Joint Commission–accredited virtual hospital services for rural facilities, BioIntelliSense continuous monitoring for home and post-acute transitions, retail pharmacy partners to extend prevention and adherence services in rural towns, and systems integrators (Accenture, KPMG, PwC, AVIA) for implementation, reporting, and value tracking. These offerings align with the NOFO's approved uses, technical scoring factors, and initiative-based scoring matrix.

Program fit is strong. The NOFO provides $50B across FY26–FY30 via cooperative agreements to States, with 50% distributed equally and 50% allocated by a points-based workload formula that combines rural facility/population and technical factors; Rhode Island's total in any period equals Total Available Workload Funding × State Points ÷ Sum of All States' Points. Technical factors allow conditional points for Year-1 commitments to policy change with full points upon enactment by Dec 31, 2027 (Dec 31, 2028 for two factors). The NOFO sets caps on certain expenditures (provider payments ≤15%, capital/infrastructure ≤20%, EMR replacement ≤5% if a HITECH-certified system exists as of 9/1/2025) and an administrative cap of ≤10%. The Collaborative's portfolio supports these constraints by emphasizing non-facility-expansion pathways, shared services, and verifiable, metrics-driven results. (files.simpler.grants.gov) (files.simpler.grants.gov) (files.simpler.grants.gov)

Near-term levers for Rhode Island include: (1) a rural virtual-care mesh connecting community sites, EMS, and small hospitals to specialty backup; (2) RPM for heart failure/COPD/diabetes integrated with FQHCs; (3) pharmacy-enabled prevention and adherence in rural towns; (4) data plumbing (HIE, TEFCA-aligned exchange, analytics) to meet initiative/evaluation requirements; and (5) workforce supports leveraging the Nurse Licensure Compact (enacted in 2023, implementation proceeding) and ambient documentation tools to reduce burden in low-density settings. These elements directly map to RHT scoring pillars and Rhode Island's current initiatives in behavioral health (CCBHC launch in 2024) and Medicaid managed care renewal. (ncsbn.org) (eohhs.ri.gov) (healthmanagement.com)

One-page printable summary

- Program window (original NOFO): LOI due Sep 30, 2025; Applications due Nov 5, 2025 11:59 p.m. ET; awards expected Dec 31, 2025; funding FY26–FY30; States only; one official application; no cost-share. (files.simpler.grants.gov)
- Distribution and points: 50% equal/baseline; 50% workload via rural facility/population (50% weight) + technical factors (50% weight). Formula and weights per Table 3. Rural base set once (Q4-2025); technical re-scored each period. Conditional policy points convert to full credit by 12/31/2027 (12/31/2028 for two factors) or revert/recover. (files.simpler.grants.gov) (files.simpler.grants.gov)
- Key caps: Provider payments ≤15%; Capital & infrastructure ≤20%; EMR replacement ≤5% (with prior HITECH-certified EMR as of 9/1/2025); Admin (including indirects) ≤10%. (files.simpler.grants.gov) (files.simpler.grants.gov)
- Rhode Island context: 8.9% rural (2020); 8 FQHC awardees (2024); no CMS-certified RHCs (as of 10/2021); overdose death rate 38.1 per 100,000 (2022). CCBHC network launched Oct 1, 2024 (6 organizations, multiple sites). (ncsl.org) (data.hrsa.gov) (hrsa.gov) (cdc.gov) (eohhs.ri.gov)
- Collaborative alignment (illustrative):
    - Tele-ER/ICU/hospitalist backup (Avel eCare) → access, EMS, outcomes.
    - RPM & AI signal detection (BioIntelliSense) → chronic disease metrics.
    - Pharmacy-enabled prevention/adherence (CVS, Walgreens) → rural access points, adherence gains (vendor-reported).
    - Cybersecurity/data exchange (Microsoft and partners; advisors) → F.2 data infrastructure.

2. Eligibility and RFP Fit

- Applicant/Timing. Eligible applicants are the 50 U.S. States (not DC or territories). Optional LOI by Sep 30, 2025; application due Nov 5, 2025; anticipated awards Dec 31, 2025; one on-time official application per state; no cost-share. Submit via Grants.gov; complete SAM/UEI. (files.simpler.grants.gov)
- Funds/Distribution. $50B total across FY26–FY30; 50% equal baseline; 50% workload using a points framework (formula specified). Rural facility/population score is set using Q4-2025 data; technical score updates each budget period. (files.simpler.grants.gov) (files.simpler.grants.gov)
- Scoring weights (Table 3). Rural facility & population (50%): A.1 10%, A.2 10%, A.3 10%, A.4 6%, A.5 6%, A.6 5%, A.7 3%. Technical (50%): B.1 3.75%, B.2 3.75%, B.3 3.75%, B.4 1.75%, C.1 3.75%, C.2 3.75%, C.3 1.75%, D.1 3.75%, D.2 1.75%, D.3 1.75%, E.1 3.75%, E.2 3.75%, E.3 1.75%, F.1 3.75%, F.2 3.75%, F.3 3.75%. (files.simpler.grants.gov)
- Conditional policy scoring. Year-1 conditional points for proposed policy changes; full credit upon enactment by Dec 31, 2027 (Dec 31, 2028 for B.2/B.4). Failure to enact by deadlines triggers point drop to zero and recovery of funds tied to those points. (files.simpler.grants.gov)
- Caps/limits. Provider payments ≤15%; capital & infrastructure (Cat. J) ≤20%; EMR replacement ≤5% if prior certified system exists (as of 9/1/2025); administrative expenses (including indirects) ≤10%. Certain procedures excluded (45 CFR 156.400). (files.simpler.grants.gov)
- Required content. Project summary, Project narrative ≤60 pp with specific headings; Budget narrative ≤20 pp; attachments including Governor's endorsement, business assessment, program duplication assessment; forms SF-424, SF-424A, SF-LLL, site locations. (files.simpler.grants.gov)

Mapping RFP requirements to Collaborative capabilities (selected)

- Use of funds A/C/D/F/F.1/F.2/F.3: prevention, consumer-tech, training, remote care/data/consumer tech → BioIntelliSense RPM, pharmacy screening and adherence, telehealth expansion, HIE/analytics, cybersecurity assistance from technology partners; advisory partners for deployment and training. Evidence: Collaborative capability descriptions and partner profiles.
- Technical factors C.1/C.2/E.1/F.1/F.2: rural networks, EMS linkages, payment incentives, remote care, data infrastructure → Avel eCare virtual hospital/EMS support; economic modeling and performance tracking; claims modernization/analytics.
- Workforce and licensure D.1/D.2/D.3: recruitment/retention, licensure compacts, scope of practice → NLC enacted in RI (implementation underway); collaborative training, ambient clinical documentation to reduce burden; pharmacy scope pilots subject to RI law/SPA. (ncsbn.org)

3. Rhode Island Context Snapshot

- Rural footprint. 8.9% of residents were rural in 2020; rural needs cluster in Washington County and parts of Kent and Newport counties. Frontier measures are effectively negligible in RI. (ncsl.org)
- Facility mix and networks.
    - FQHCs: 8 Health Center Program awardees (2024). (data.hrsa.gov)
    - RHCs: 0 CMS-certified Rural Health Clinics (as of Oct 2021). (hrsa.gov)
    - CCBHCs: Program launched Oct 1, 2024; currently Community Care Alliance, Family Service of Rhode Island, Gateway (Pawtucket/Johnston/South County), Newport Mental Health, The Providence Center, Thrive Behavioral Health. (eohhs.ri.gov)
- Medicaid structure. Managed care under RIte Care/Rhody Health Partners; new Medicaid MCO contracts begin July 1, 2025 with two plans (Neighborhood and UnitedHealthcare), including phased integration of MLTSS and D-SNP linkages. (regulations.justia.com) (rhodeislandcurrent.com)
- Behavioral health and SUD. Drug overdose death rate was 38.1 per 100,000 (age-adjusted) in 2022; CDC funding supports Overdose Data to Action activities. Providence also authorized a state-sanctioned supervised consumption site (local implementation noted). (cdc.gov) (cdc.gov) (apnews.com)
- Workforce. RI enacted the Nurse Licensure Compact in 2023; implementation steps are in progress. (ncsbn.org)
- Broadband/telehealth enablers. Every state received >$100M BEAD allocations in 2023; Rhode Island's share supports gap closure in remaining unserved pockets relevant to rural towns. (bidenwhitehouse.archives.gov)

Metric-to-capability table (examples)

- Rural share (8.9%, 2020; Census-based): supports statewide-plus-targeted approach; align telehealth, RPM, retail access in rural towns. (ncsl.org)
- 8 FQHC awardees (2024): integration points for RPM, virtual specialty consults, and AI-supported documentation; training for CHWs. (data.hrsa.gov)
- 0 RHCs (2021): emphasizes alternative rural access (telehealth hubs, pharmacy clinics, mobile units) subject to licensure/scope. (hrsa.gov)
- CCBHC network (2024): tele-behavioral integration, crisis response augmentation, 24/7 consult backup; care navigation tools. (eohhs.ri.gov)
- Overdose death rate 38.1/100k (2022): deploy digital triage/alerts, naloxone outreach via retail partners, virtual MAT connections. (cdc.gov)

4. Strategy Aligned to RFP

Proposed model. A "distributed rural access and stabilization" model: connect rural primary care, EMS, pharmacies, and small hospitals to a specialty and monitoring backbone; extend prevention and chronic care into community sites; modernize data/cyber capabilities; and reinforce behavioral health access through the CCBHC network. This model is modular and subject to contracting, policy alignment, and data-sharing agreements.

Alignment to NOFO pillars and scoring:

- Make rural America healthy again: pharmacy-enabled screening/adherence; RPM and virtual check-ins; community education modules; county-level outcomes tracked (e.g., hypertension control).
- Sustainable access: tele-hospitalist/ICU/ED support reduces transfers and stabilizes staffing; rural provider networks (HVNs) improve shared services/economics.
- Workforce development: ambient clinical documentation and tele-mentoring; licensure compact leverage; pharmacist and CHW pipelines. (ncsbn.org)
- Innovative care and payment: value-based design for rural networks; analytics for payment integrity and incentive design.
- Tech innovation: secure cloud, FHIR-centric data exchange, cybersecurity uplift; remote care services.

Equity strategy. Focus on rural low-income and medically underserved populations (FQHC/CCBHC/EMS/pharmacy touchpoints); multi-language digital front-doors and triage; proactive outreach to high-risk duals and maternal populations via analytics and community partners.

Data and privacy. Use State-approved cloud and HIE pathways; apply least-privilege, consent-managed sharing; adopt TEFCA-aligned exchange as available; adhere to 2 CFR and HHS GPS data protection; cyber hardening per partner programs.

5. Program Design Options

Option A. Rural Virtual Access and Stabilization Network (primary)

- Target population: Rural residents in Washington, Newport, and rural towns in Kent/Providence counties; EMS-served geographies. Need: small-volume hospitals/clinics struggle with specialty coverage and transfers. (ncsl.org)
- Components: 24/7 tele-hospitalist/ICU/ED; tele-behavioral; EMS tele-support; referral pathways to CCBHCs; RPM for post-ED/post-discharge.
- Payment logic: within RHT caps; focus on services, shared infrastructure, and incentives (E.1) without exceeding provider-payment cap (≤15%). (files.simpler.grants.gov)
- Enablers: MCO alignment for RPM and telehealth coverage; compact-enabled cross-border nursing where applicable. (rhodeislandcurrent.com) (ncsbn.org)
- Pros/risks: Pros—broad rural reach, measurable reductions in transfers; Risks—credentialing, network contracting; Mitigation—phased site onboarding, common protocols.

Option B. Pharmacy-Enabled Rural Prevention and Chronic Care

- Target: Adults with hypertension/diabetes in rural towns. Problem: adherence gaps and limited in-person preventive

services.

- Components: blood pressure/retinopathy screening kiosks; pharmacist-led adherence coaching; virtual primary/specialty referrals; RPM integration.
- Payment: mix of RHT prevention/consumer tech/training categories; careful tracking to stay under provider-payment cap. (files.simpler.grants.gov)
- Pros/risks: Pros—high convenience, equity; Risks—scope/reimbursement variability; Mitigation—policy analysis under D.3 and E.1 factors.

Option C. Rural Behavioral Health Integration via CCBHC Hubs (backup)

- Target: Rural residents with SUD/mental health needs; maternal behavioral health.
- Components: expand CCBHC tele-psychiatry, crisis response, digital triage; integrate EMS and retail points for naloxone/bridge-to-MAT. (eohhs.ri.gov)
- Pros/risks: Pros—leverages 2024 CCBHC launch; Risks—workforce supply; Mitigation—tele-psychiatry bench, licensure compact, loan-repayment programs. (ncsbn.org) (health.ri.gov)

Option D. Data Infrastructure and Cyber Uplift for Rural Sites

- Target: Rural clinics/hospitals, FQHCs, EMS.
- Components: secure cloud landing zone; HIE connectors; dashboards; TEFCA-aligned exchange; cyber hardening.
- Pros/risks: Pros—supports F.2 scoring; Risks—change management; Mitigation—advisor-led PMO and training.

6. Governance and Collaborative Roles

Architecture (illustrative):

- State (Governor-designated lead agency): strategy, compliance, single award management, interagency coordination.
- Medicaid/EOHHS: payment alignment, SPA/contract updates (as appropriate), data-use approvals.
- Hospital Association/FQHCs/CCBHCs/EMS: implementation sites, clinical governance.
- Collaborative members:
    - Avel eCare (tele-hospital, tele-ER/ICU, EMS support).
    - BioIntelliSense (RPM, analytics/reporting kits).
    - Retail health (CVS, Walgreens) for rural access and adherence services (subject to RI rules).
    - Systems integrators (Accenture, KPMG, PwC, AVIA) for PMO, analytics, and evaluation.

RACI (selected)

- Strategy and NOFO compliance: State lead R / CMS approves; Collaborative A/C (PMO templates, crosswalks).
- Clinical operations: Providers R; Avel eCare/CCHBCs C; State A; MCOs C.
- Data and reporting: State/MCO/HIE A; tech partners R; providers C.
- Workforce supports: State A; providers R; collaborative trainers C; compact leverage C. (ncsbn.org)

7. Payment and Funding

CMS rules (illustrative guardrails)

- Provider payments (cat. B) ≤15% of annual award; capital/infrastructure (cat. J) ≤20%; EMR replacement ≤5% if prior HITECH EMR existed by 9/1/2025; admin ≤10% including indirects. (files.simpler.grants.gov) (files.simpler.grants.gov)
- No construction or supplanting; 2 CFR Part 200/300 and HHS GPS apply. (files.simpler.grants.gov)

Illustrative cost/work product table (indicative order-of-magnitude; subject to procurement)

Work product	Core elements	Key deliverables

Work product	Core elements	Key deliverables
Tele-hospital/ICU/ER network	Services, carts, telemetry, training	SLA adherence, credentialing, quality dashboards
RPM bundle	Devices, software, monitoring	Enrollment metrics, utilization, outcomes
Data and cyber stack	Landing zone, connectors, dashboards	KPI suite, compliance reports
Pharmacy-enabled prevention	Screening and adherence programs	Screening volumes, blood-pressure control rates
(Each mapped to NOFO categories and kept within caps.)		

8. Data, Measurement, and Evaluation

Core measures and cadence

- Access/utilization: ED transfer rate; time-to-tele-consult; RPM adherence; pharmacy screening counts (monthly/quarterly).
- Quality/outcomes: readmissions; avoidable ED use; hypertension control; depression remission (quarterly/annual).
- Financial: PMPM total cost of care trends for rural cohorts; payment integrity flags (quarterly).
- Implementation: site activation, training, uptime, cyber posture (monthly/quarterly).

Data sources/integration

- Claims (Medicaid and MCOs), HIE, EHRs, EMS run data, CCBHC encounters, pharmacy feeds, social services linkages. The Collaborative's advisors can support connectors, normalization, and reporting per NOFO.

Evaluation approach

- Align initiative-level outcomes to the NOFO's initiative-based scoring matrix (Strategy, Workplan & monitoring, Outcomes, Projected impact, Sustainability; 0–20 points each). Design county-level outcomes for at least one measure per initiative. (files.simpler.grants.gov)

9. Implementation Plan

12-24 month workplan (illustrative Gantt)

Workstream	Start	End	Owner	Outputs
Tele-ER/ICU/EMS onboarding	2026-02	2026-12	Providers/Avel eCare	Credentialed sites, SLA, monthly quality reports
RPM for HF/COPD/diabetes	2026-03	2026-11	FQHCs/BioIntelliSense	Enrolled patients, alert triage SOPs, adherence dashboards
CCBHC tele-behavioral expansion	2026-02	2026-10	CCBHCs	24/7 coverage, crisis protocols, outcomes grid (eohhs.ri.gov)
Pharmacy-enabled prevention	2026-04	2026-12	Pharmacies/FQHCs	Screening volumes, adherence metrics
Data and cyber platform	2026-01	2026-12	State/Tech partners	HIE connectors, KPI dashboards, ATO artifacts

Workstream	Start	End	Owner	Outputs
PMO and evaluation	2026-01	2026-12	State/Advisors	Workplan, NCC updates, evaluation plan

Critical milestones

- NCC package timing to support period-2 scoring recalculation; conditional policy milestones in 2027/2028. (files.simpler.grants.gov)

Procurement/legal enablers

- Master services agreements with clinical and technology partners; data-use and BAA templates; subrecipient monitoring consistent with 2 CFR. (Subject to State procurement policies.)

10. Risk Register

Risk	Mitigation	Owner
Workforce supply for tele-behavioral/ICU	Leverage NLC, tele-mentoring, staged activation (ncsbn.org)	State/Providers
Data-sharing delays	Pre-negotiated DUAs/BAAs; advisor-led interface planning	State/Tech
Rural adoption and engagement	On-site training, CHW support, usability testing	Providers/Advisors
Cyber incidents	Hardened configurations, monitoring, incident runbooks	Tech partners
Cap overages (15%/20%/5%/10%)	PMO budget tracking, predefined guardrails (files.simpler.grants.gov)	State/PMO
Policy slippage for conditional points	Commit plans with legislative calendars; alternate pathways	State
Vendor onboarding and credentialing lags	Standard onboarding kits; site readiness checklists	Advisors/Providers
Equity gaps persist	Targeted outreach in rural ZIPs; pharmacy/mobile access points	Providers/Retail
MCO alignment	Early benefits design and data extracts; shared incentive logic	EOHHS/MCOs
Evaluation uncertainty	Define baselines; bake county-level measures into contracts (files.simpler.grants.gov)	PMO/Evaluator

11. Draft RFP Response Language

The State proposes to use RHT funding to strengthen rural access, outcomes, and sustainability through a distributed model that connects rural patients and providers to high-reliability clinical backup, remote monitoring, and community-based prevention, while modernizing data and cybersecurity. This model aligns with the NOFO's approved uses (A, C, D, F, F.1–F.3, H, I, J) and technical factors (C.1, C.2, E.1, F.1–F.3), and remains within funding caps (provider payments ≤15%; capital/infrastructure ≤20%; administrative ≤10%; EMR replacement ≤5% per constraints), with all activities compliant with 2 CFR and HHS GPS. (files.simpler.grants.gov) (files.simpler.grants.gov) (files.simpler.grants.gov)

Rhode Island's target populations include rural residents of Washington and Newport counties and rural towns in Kent and Providence counties. The State will leverage existing FQHCs and the 2024 CCBHC network as anchors, integrate EMS and pharmacy-based access points, and deploy tele-hospitalist/ICU/ER coverage and remote monitoring to reduce avoidable transfers and improve chronic disease control. County-level outcomes include ED transfer reductions, hypertension control, and avoidable ED use, with baselines and targets presented per initiative and tracked quarterly. (ncsl.org) (eohhs.ri.gov)

(files.simpler.grants.gov)

To support sustainability, the State (subject to contracting) may draw on the RHT Collaborative's advisory and integration partners for PMO, interoperability, analytics, and evaluation support; clinical partners for tele-care services; and technology partners for RPM, consumer tools, and cybersecurity. All partner deliverables will include explicit data and evaluation outputs to meet initiative-based scoring and annual technical factor updates.

Assumptions and Open Questions

- The NOFO (CMS-RHT-26-001) governs all requirements; any later CMS clarifications supersede this guide. (files.simpler.grants.gov)
- RHC count (0) reflects HRSA as of Oct 2021; confirm current CMS certification status for 2025. (hrsa.gov)
- NLC enactment is confirmed; implementation timeline determines earliest multistate license use for RI-based nurses. (ncsbn.org)
- Broadband investment is ongoing; this guide references national BEAD allocation thresholds (> $100M for each state). (bidenwhitehouse.archives.gov)

12. References

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15. CMS RHT NOFO: Table 3 weights, conditional policy deadlines, caps. Internal citation to NOFO PDF. (files.simpler.grants.gov) (files.simpler.grants.gov) (files.simpler.grants.gov)

(External sources are authoritative public sites; Internal sources are the RHT Collaborative consensus PDF provided to the State.)

13. AI Generation Notice

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