Rural Health Transformation Grant Guide — Tennessee

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Tennessee can use the CMS Rural Health Transformation (RHT) Program to stabilize rural access, modernize clinical and data infrastructure, and accelerate value-based care. The RHT Collaborative offers a coordinated set of technology, clinical, analytic, and governance capabilities that Tennessee can contract and integrate to meet RHT requirements, with particular strengths in: virtual specialty support for rural hospitals and clinics (e.g., tele-ER/ICU/hospitalist), remote physiologic monitoring for chronic disease, consumer-facing engagement and triage, cybersecurity uplift, and formation of member-owned rural High Value Networks (HVNs) to steward funds and sustain gains. These capabilities align directly to RHT's five strategic goals and eleven use-of-funds categories, and to the technical scoring factors that shape workload funding in later years.

RHT funding totals $50B across FY26–FY30, with one application opportunity per state and awards expected by December 31, 2025. Funds flow 50% baseline and 50% workload, with workload points weighted across rural facility/population factors and technical factors; technical factors include policy actions where states may claim points conditionally in Year 1 and must finalize most actions by December 31, 2027 (with two nutrition-related exceptions through December 31, 2028). Tennessee's plan can use collaborative partners to deliver credible initiatives, document measurable outcomes, and support policy changes that improve scoring. (files.simpler.grants.gov)

Given Tennessee's rural profile (33.8% of residents in rural areas in 2020) and high 2023 drug overdose mortality (52.3 per 100,000), prioritized initial focus areas include: rural acute care support and transfer avoidance, maternal and perinatal outcomes, chronic disease prevention and management, behavioral health and SUD access, workforce retention via digital tools, and statewide cybersecurity and data interoperability. (ncsl.org)

Highest-leverage offerings for near-term impact include: (a) Avel eCare's virtual hospital services to support rural ER/ICU/hospitalist workflows and reduce transfers; (b) BioIntelliSense continuous RPM for high-risk chronic and maternal populations; (c) Microsoft-anchored secure cloud, identity, and cybersecurity uplift with analytics; (d) consumer-facing intake/triage and multilingual engagement (Humetrix) integrated with care navigation; and (e) Cibolo-enabled state or regional HVNs for transparent governance, pooled purchasing, and value-based contracting. These offerings are described in the Collaborative's consensus brief and member appendices.

One-page printable summary (for distribution)

- Program window: Optional LOI by Sep 30, 2025; Application by Nov 5, 2025; Awards Dec 31, 2025. One application per state; no cost sharing. (files.simpler.grants.gov)
- Funds/limits: Five budget periods; annual funds may be spent into the next fiscal year. Caps: ≤20% Capital (J); ≤15% Provider payments (B); ≤5% EMR replacement if a HITECH-certified EMR was in place on Sep 1, 2025; Admin (incl. indirect) ≤10%; Catalyst-like initiatives ≤ the lesser of 10% or $20M per period. (files.simpler.grants.gov)
- Scoring: Baseline + workload; Table 3 weights rural facility/population (50%) and technical factors (50%). Policy-action points must be finalized by 12/31/2027 (except B.2 and B.4 by 12/31/2028) or funds are recovered. (files.simpler.grants.gov)
- Tennessee context snapshots (examples; 2023–2025): Rural residents 33.8% (2020); CAHs 15; REHs 2; RHCs 623; rural FQHC sites 100; drug overdose mortality 52.3/100k (2023). (ncsl.org)
- Collaborative alignment: Virtual care across hospital/clinic/EMS; continuous RPM; consumer triage and engagement; statewide cyber/data modernization; HVN governance.

2. Eligibility and RFP Fit

2.1 Snapshot of key NOFO terms

- Eligible applicants: Only the 50 states; DC and territories ineligible. One official application per state; governor endorsement letter; AOR signature. (files.simpler.grants.gov)
- Deadlines and forms: LOI due Sep 30, 2025; Application due Nov 5, 2025; award by Dec 31, 2025. Required narratives (project summary 1p; project narrative ≤60p; budget narrative ≤20p), required forms (SF-424, SF-424A, SF-LLL, Project/Performance Site), and attachments (governor letter; indirect rate, if any; business assessment ≤12p; program duplication assessment ≤5p). Check "No" on SF-424 Item 19c (EO 12372 not applicable). (files.simpler.grants.gov)

- Funding distribution and scoring: Five periods; workload formula; Table 3 weights A1–A7 and B1–F3; initiative-based scoring up to 100 points per initiative. (files.simpler.grants.gov)
- Program-specific funding limitations and prohibitions: Capital ≤20%; provider payments ≤15%; EMR replacement ≤5% if a HITECH-certified EMR existed as of Sep 1, 2025; admin (incl. indirect) ≤10% of allotment; restrictions include 2 CFR 200.216 (telecom/video surveillance), and prohibitions on funding certain procedures defined in 45 CFR 156.400. (files.simpler.grants.gov)

2.2 Compliance checkpoints Tennessee should track

- SAM.gov/UEI active; Grants.gov submission; one application; AOR signature. (files.simpler.grants.gov)
- SF-424 Box 19c = "No"; formatting and page limits enforced; completeness/responsiveness criteria; no duplication of billable clinical services. (files.simpler.grants.gov)
- Use of funds must address ≥3 categories across initiatives; report on measures; annual continuation. (files.simpler.grants.gov)

2.3 Requirement–Collaborative mapping (examples)

- Requirement: Initiative-based outcomes with baselines/targets. Collaborative capability: RPM with clinician dashboards and exception management; tele-ICU/ER/hospitalist support; analytics. Evidence: BioIntelliSense RPM description; Avel eCare virtual hospital model; MS/Accenture analytics.
- Requirement: Data, cybersecurity, interoperability. Capability: HIPAA/FHIR-based cloud data platform, cybersecurity uplift; integration across providers and HIEs. Evidence: Collaborative tech stack; Microsoft cyber support for rural hospitals.
- Requirement: Partnerships and governance. Capability: Cibolo-enabled provider-owned HVNs with transparency, pooled services, and value-based arrangements. Evidence: HVN model and governance roles.

3. Tennessee Context Snapshot

3.1 Population and rural profile

- Rural share: 33.8% of Tennessee residents lived in rural areas in 2020 (2,333,558 people), per Census tabulation summarized by NCSL. This indicates large potential reach for statewide investments in rural access and prevention. (ncsl.org)

3.2 Rural facility mix and capacity (2025)

- 15 Critical Access Hospitals; 2 Rural Emergency Hospitals; 623 Rural Health Clinics; and 100 rural FQHC sites (locations outside Urban Areas ≥50,000). These data (updated 9/11/2025) suggest wide primary care access points that can be augmented with tele-specialty, RPM, and care coordination tools. (ruralhealthinfo.org)

3.3 Health need indicators (recent)

- Drug overdose mortality: 52.3 per 100,000 in 2023 (CDC NCHS), among the highest rates nationally. Collaborative behavioral health tele-consults and consumer risk-flagging can support access and retention in treatment. (cdc.gov)
- Infant and maternal outcomes: 2023 infant mortality 6.5 per 1,000 live births; preterm birth 11.3% (March of Dimes), and multi-year maternal mortality estimated at 41.1 per 100,000 (2018–2022). These point to opportunities for maternal RPM, perinatal tele-specialty support, and team-based primary care. (marchofdimes.org)

3.4 Medicaid delivery system baseline

- Demonstration authority: TennCare III 1115 demonstration, approved January 8, 2021, in effect through December 31, 2030 (aggregate cap model with reinvestment of savings under agreed parameters). (cms.gov)
- Managed care penetration and MCOs: Statewide, at-risk MCOs deliver medical, behavioral, and LTC. Current MCOs:

BlueCare (BCBSTN), UnitedHealthcare Community Plan, Wellpoint (formerly Amerigroup); TennCare Select serves specific groups. (tn.gov)

- Implication for RHT: Collaborative partners can support actuarial and analytic inputs for APMs and program integrity while integrating claims and clinical data for monitoring.

3.5 Workforce and access (selected indicators)

- HPSA snapshot: As of 3/31/2025, HRSA data (summarized regionally) show Tennessee with substantial unmet need across primary care, dental, and mental health HPSAs, indicating demand for recruitment/retention, telehealth, and team-based models. (commentary.healthguideusa.org)

3.6 Metric-to-capability table (illustrative)

- Rural residents (2020): 2.33M (33.8%) → Consumer engagement, community screening, and navigation apps; RPM for chronic disease. (ncsl.org)
- CAHs (2025): 15 → Tele-ICU/ER/hospitalist; pharmacy consults; stroke detection AI. (ruralhealthinfo.org)
- REHs (2025): 2 → Virtual specialty extensions; transfer coordination; data reporting. (ruralhealthinfo.org)
- Overdose mortality (2023): 52.3/100k → Tele-behavioral access; medication safety analytics; consumer alerts. (cdc.gov)
- Infant mortality (2023): 6.5/1,000; preterm 11.3% → Maternal RPM; remote consults; perinatal education. (marchofdimes.org)

4. Strategy Aligned to RFP

4.1 Transformation model for Tennessee

- Core approach: Build regional HVNs anchored by rural hospitals/clinics, with tele-specialty backstops (ER/ICU/hospitalist), RPM for high-risk conditions and perinatal care, consumer engagement/triage, and a secure cloud-based data backbone for analytics and reporting. This aligns with RHT uses of funds across prevention, care innovation, workforce, IT/cyber, and partnerships.

4.2 Alignment to RHT pillars and scoring

- Make Rural America Healthy Again: Consumer screening (retail/community), multilingual intake tools, RPM, and proactive care-gap analytics.
- Sustainable Access: HVNs and regional partnerships; right-sizing service lines; tele-specialty to keep patients local.
- Workforce Development: Ambient clinical documentation and tele-mentoring reduce burden and support retention; pharmacy workforce integration where permitted.
- Innovative Care & Tech: AI decision support (e.g., stroke detection), secure data exchange, cybersecurity uplift, and remote care services.

4.3 Equity strategy

- Rural and frontier (if any) geographies prioritized with county-level targeting; consumer tools in multiple languages; CHW and pharmacy engagement for chronic disease and maternal health; evaluation stratified by SDOH and geography.

4.4 Data use and privacy

- HIPAA/FHIR-based cloud architecture with role-based access; integration of claims, EHR, HIE, EMS, and social services feeds; cybersecurity controls aligned to HHS Cybersecurity Performance Goals.

5. Program Design Options (Tennessee-tuned)

Option A: Rural Acute Care Stabilization and Transfer Avoidance

- Target: CAHs/REHs and PPS rural hospitals with thin night/weekend specialist coverage.
- Problem/data: 15 CAHs and 2 REHs; elevated overdose mortality increases acute complexity (2023 rate 52.3/100k). (ruralhealthinfo.org)
- Collaborative services: Tele-ER/ICU/hospitalist; tele-pharmacy; stroke AI; logistics support for transfers; ambient documentation.
- Payment logic: Shared-savings with regional partners; Medicaid directed payments aligned with reduced avoidable transfers (E.1). (files.simpler.grants.gov)
- Enabling policy: Confirm licensure/credentialing portability via IMLC; explore compacts for other professions. (imlcc.com)
- Pros/risks: Pros—local care retention, faster specialist input. Risks—provider adoption, connectivity; mitigated via training, backup cellular/satellite kits.

Option B: Maternal and Early-Childhood Outcomes Collaborative

- Target: Rural birthing facilities/clinics and perinatal networks.
- Problem/data: 2023 infant mortality 6.5/1,000; preterm 11.3%; multi-year maternal mortality ~41.1/100,000. (marchofdimes.org)
- Services: Maternal RPM bundles (BP, glucose, weight); perinatal tele-specialty and simulation; multilingual education/triage; CHW supports; pharmacy BP management.
- Payment: MCO quality incentives and directed payments for maternal episodes; VBP for neonatal outcomes (E.1). (files.simpler.grants.gov)
- Pros/risks: Pros—prevent complications, reduce costly transfers. Risks—device adherence; mitigated via navigator support and text-first engagement.

Option C: Rural Behavioral Health and SUD Access

- Target: Rural clinics, pharmacies, and EDs.
- Problem/data: High overdose mortality (52.3/100k, 2023). (cdc.gov)
- Services: Virtual behavioral consults; consumer medication safety and overdose risk prompts; pharmacy-based BP and behavioral screening with referral.
- Payment: Support via H and I categories; MCO incentives for follow-up after ED visit for SUD; alignment with SAMHSA CCBHC providers (state to confirm roster as of Sep 1, 2025). (files.simpler.grants.gov)
- Pros/risks: Pros—rapid access, reduced no-shows. Risks—workforce burnout; mitigated with ambient tools and tele-mentoring.

Option D: Statewide Rural Cyber/Data Modernization

- Target: Rural hospitals/clinics and state PMO analytics.
- Problem/data: Cyber threats and fragmented data impede measurement and payment integrity.
- Services: Secure cloud landing zone; identity/access; log and threat management; data pipelines integrating claims/EHR/HIE; dashboards for RHT reporting.
- Payment: Category F (IT advances/cybersecurity) and administrative (≤10% cap) for PMO; leverage allowable equipment definitions. (files.simpler.grants.gov)
- Pros/risks: Pros—program integrity, faster reporting. Risks—integration complexity; mitigated via phased ingestion and SI partner playbooks.

Recommendation: Pair Option A (primary) with Option B (secondary) for early, visible impact while phasing C and D statewide.

6. Governance and Collaborative Roles

6.1 Structure

- State PMO leads; Medicaid/TennCare oversees payment alignment; HVNs (Cibolo) organize rural providers with formal bylaws, pooled resources, and shared services; SI partners (Accenture/KPMG/PwC/AVIA) support planning, procurement, integration, analytics, and change management; technology/clinical vendors deliver contracted services.

6.2 RACI (abbreviated)

- Strategy and application: State PMO (R/A); TennCare (C/I); Hospital Association, FQHCs, Rural Health Office (C); Collaborative SI (R).
- Initiative delivery: Provider HVNs (R); Avel, BioIntelliSense, Microsoft, Humetrix, Viz.ai (R); State PMO (A); MCOs (C).
- Data and reporting: State analytics team (A/R); SI partners (R); vendors (R); providers/MCOs (C/I).

7. Payment and Funding

7.1 Pathways consistent with NOFO

- Use categories spanning prevention/management (A), provider payments (B, capped), consumer tech (C), training (D), workforce (E), IT/cyber (F), right-sizing services (G), behavioral health (H), care models (I), capital/infrastructure (J, capped), partnerships (K). (files.simpler.grants.gov)
- Respect caps: provider payments ≤15%; capital ≤20%; EMR replacement ≤5% (if prior HITECH system existed on Sep 1, 2025); admin ≤10%. (files.simpler.grants.gov)

7.2 Medicaid alignment

- Use TennCare III structure to support directed payments for stabilized rural access, APMs for maternal and chronic disease episodes, and analytics for payment integrity and evaluation. (cms.gov)

7.3 Illustrative cost categories and deliverables (example, Year 1)

Category	Key elements	Expected deliverables
Clinical virtual services (tele-ER/ICU/hospitalist, tele-BH)	Service contracts, equipment, training	24/7 coverage, transfer metrics
RPM kits/licensing and navigator staffing	Devices, software, care coordination	Reduced readmissions and ED visits
Data and cyber platform (cloud infrastructure, SI services)	Secure environment, integrations, dashboards	Data feeds, dashboards, audit logs
Workforce skilling (ambient documentation, tele-mentoring)	Training, change management, tools	Clinician time saved, retention

8. Data, Measurement, and Evaluation

- Core measures: Access (time-to-specialist, transfer rates), quality (HEDIS-like, maternal/infant outcomes), utilization (ED visits, readmissions), cost (PM-PM, high-cost episode trends), workforce (vacancy/turnover, clin-time per visit), technology (uptime, adoption), program implementation. Scoring aligned to NOFO initiative/impact/sustainability rubric. (files.simpler.grants.gov)
- Sources: Claims (TennCare/MCO), EHRs, HIE, EMS run sheets, consumer app tele-metrics, state vital records; integrated via secure cloud with role-based access.
- Evaluation cadence: Quarterly dashboards; annual continuation packages; support third-party evaluation as required.

(cms.gov)

9. Implementation Plan (12-24 months; Gantt-style overview)

Workstream	Start	End	Owner	Outputs
Program PMO and governance	12/2025	03/2026	State PMO/HVNs	PMO charter, RACI, reporting calendar
Data and cyber landing zone	01/2026	06/2026	State + SI + Microsoft	Cloud environment, data feeds (claims/EHR)
Tele-ER/ICU/hospitalist pilots (10 hospitals)	02/2026	09/2026	HVNs + Avel	Coverage schedules, metrics baseline
Maternal RPM cohort (2,000 patients)	03/2026	12/2026	Providers + BioIntelliSense	Device deployment, navigator workflows
Consumer intake and triage	04/2026	10/2026	Providers + Humetrix	Multilingual web app live; referral pathways
Scale phase (regional)	10/2026	12/2027	State + HVNs + vendors	Coverage to 60-80% target counties
Evaluation and policy checkpoints	06/2026	12/2027	State PMO	Mid-term review; 12/31/2027 policy status (files.simpler.grants.gov)

10. Risk Register (selected)

Risk	Mitigation	Owner
Procurement delays	Use existing state vehicles where possible; pre-negotiated SOWs and data protection addenda	PMO
Cyber incidents	Cloud security baseline, monitoring, incident playbooks	State CISO + vendor
Workforce adoption	Tele-mentoring; ambient documentation to reduce burden	Provider leads
Connectivity variability	LTE/5G failover kits; offline workflows	SI/vendor
Policy deadlines (2027/2028)	Policy workplan with legislative counsel; quarterly checkpoints (files.simpler.grants.gov)	State policy lead
Cap overruns (15%/20%/10%)	Budget controls; quarterly variance tracking (files.simpler.grants.gov)	PMO CFO
Duplicate funding risk	Duplication assessment SOP (files.simpler.grants.gov)	Grants management
Data-sharing hurdles	Standard BAAs/DUAs; role-based access	Legal/Privacy
Measure drift	NOFO-aligned measure set; version control (files.simpler.grants.gov)	Evaluation lead
Vendor integration slippage	Intake sprints; interface certification; cutover rehearsals	SI

11. Draft RFP Response Language (Tennessee-ready insert)

- Program purpose and strategy: "Tennessee will deploy a coordinated set of rural access, workforce, and data modernization initiatives focused on tele-specialty coverage for rural facilities, remote physiologic monitoring for chronic and maternal populations, consumer-facing engagement/triage, and statewide cybersecurity and interoperability, governed through provider-owned regional networks. Initiatives align with at least three RHT use-of-funds categories and with Table 3 technical factors." (files.simpler.grants.gov)
- Use-of-funds assurances: "We will allocate within RHT caps, including ≤20% for capital/infrastructure, ≤15% for provider payments, ≤5% for EMR replacement if applicable, and ≤10% administrative. We will not duplicate billable services and will comply with 2 CFR 200.216 and other limitations." (files.simpler.grants.gov)
- Policy actions: "Tennessee will pursue specific policy actions tied to technical factors and understands that conditional points require enactment by 12/31/2027 (or 12/31/2028 for B.2 and B.4), with recovery provisions if unmet." (files.simpler.grants.gov)
- Reporting: "We will provide progress, financial, and performance reporting per CMS guidance, including non-competing continuations and evaluation cooperation." (cms.gov)

Assumptions and Open Questions (to be validated by the State)

- Licensure compacts: Tennessee's membership in the Interstate Medical Licensure Compact is confirmed; nurse licensure compact status and other compacts to be validated for scoring (D.2). (imlcc.com)
- Certificate of Need (C.3): Current CON scope and any 2024–2025 changes to be confirmed for technical scoring.
- SNAP waivers (B.3) and Nutrition CME (B.4): Current state positions, pending legislation, and timelines to be confirmed for conditional points.
- CCBHC roster: Compile official list of Tennessee CCBHCs as of Sep 1, 2025 for the application attachment (state to source from SAMHSA; not included here).
- Broadband: County-level broadband availability metrics to refine connectivity mitigation plans.

Checklists

- Application completeness (referencing NOFO): Narratives (summary 1p; project ≤60p; budget ≤20p); Forms (SF-424, SF-424A, SF-LLL, Performance Sites; SF-424 Item 19c "No"); Attachments (Governor letter; indirect rate, if any; business assessment ≤12p; program duplication assessment ≤5p; supporting docs). (files.simpler.grants.gov)
- Budget caps compliance: Track B ≤15%; J ≤20%; EMR ≤5%; Admin ≤10%. (files.simpler.grants.gov)
- Policy timeline tracker: Identify B.2/B.4 by 12/31/2028; others by 12/31/2027. (files.simpler.grants.gov)

12. References

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12. HPSA summaries (primary care, dental, mental health), HRSA quarterly (3/31/2025) — summarized tables. Health Guide USA Commentary (links to HRSA). https://commentary.healthguideusa.org/ (accessed 2025-10-14). (commentary.healthguideusa.org)

13. AI Generation Notice

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