Rural Health Transformation Grant Guide — Utah

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Utah can position a credible, evidence-based Rural Health Transformation (RHT) application by pairing state policy and purchasing levers with the Rural Health Transformation Collaborative's provider, technology, and advisory capabilities. CMS will award cooperative agreements to States only, with one submission per State, with an application deadline of November 5, 2025 and expected awards by December 31, 2025. The program totals $50B in FY26–FY30, with 50% distributed equally among approved States and 50% allocated by CMS based on rural and technical factors specified in the NOFO. Utah's minimum annual baseline under the equal-share portion equals $100M if all 50 States are funded; additional workload-based amounts depend on Utah's points and reported performance. (cms.gov)

The Collaborative offers Utah deployable clinical services (e.g., Avel eCare's tele-hospitalist/ICU/ER support), remote monitoring (BioIntelliSense), retail-pharmacy-enabled access (CVS Health, Walgreens, Walmart), consumer engagement/triage and analytics (Humetrix, Pangaea Data), and a secure cloud and cybersecurity backbone (Microsoft). These align directly to RHT uses of funds for prevention/chronic disease, training/TA for technology-enabled care, IT/cybersecurity, workforce recruitment and retention, and innovative care/payment models.

Utah's rural profile—frontier counties with sparse population density, long EMS response times, workforce shortages in primary care/behavioral health, and broadband gaps—maps to the Collaborative's strengths. Utah's Primary Care Office (PCO) and State Office of Rural Health already operate Flex/SHIP and loan-repayment programs; Medicaid administers ACOs (mandatory in 13 counties) and UMIC integrated care for the expansion population in five counties. Those foundations can be extended via RHT to accelerate virtual specialty backup, RPM-enabled chronic care, pharmacy-anchored community management, and value-based rural network formation. (medicaid.utah.gov)

Execution can be staged with low-friction wins (tele-emergency/tele-ICU coverage and AI-assisted stroke detection) while Utah advances policy options that increase technical-factor points (e.g., workforce pipelines, licensure/compact alignment, payment incentives). The Collaborative's program management and data stack support CMS's monitoring and evaluation expectations without duplicating state systems, and can integrate with Utah's HIE, EMS and claims data flows subject to contracting, interoperability, and privacy protections.

1.1 One-page printable summary

- What CMS is offering
    - Cooperative agreements to States; single application; $50B FY26–FY30. 50% equal allocation; 50% points-based; application due Nov 5, 2025; awards by Dec 31, 2025. (cms.gov)
- Why it matters for Utah
    - Frontier geographies; rural EMS times; workforce gaps; behavioral health and maternal health needs; persistent broadband gaps—each has measurable disparities impacting access and outcomes. (ibis.utah.gov)
- How the Collaborative can support Utah (illustrative pairings)
    - Keep care local: Virtual hospital/ER/ICU, tele-pharmacy, tele-behavioral; CAH support.
    - Manage chronic disease: RPM (BioIntelliSense), consumer triage/PHR and multilingual intake (Humetrix), pharmacy outreach/adherence programs.
    - Data and cybersecurity: HIPAA/FHIR-aligned cloud; 700+ rural hospitals on Azure security services; analytics for population health and payment integrity.
- Initial focus candidates for Utah (examples)
    - Rural high-value network (HVN) formation and value-based arrangements; community paramedicine + tele-ER; maternal-behavioral integration leveraging CCBHC pathway; broadband-enabled remote care nodes.
- Key guardrails
    - Follow NOFO category/cap limits; avoid supplanting; align provider payments with NOFO rules; maintain 2 CFR Part 200/HHS GPS compliance. (See Section 2; confirm final NOFO caps before budget load.)

2. Eligibility and RFP Fit

- Who may apply: Only U.S. States (not DC or territories). Cooperative agreements; one State application; CMS will engage States during the open period; single competition round. (cms.gov)
- Timeline: NOFO posted mid-September 2025; optional LOI by Sept 30, 2025; application due Nov 5, 2025; awards by Dec 31, 2025; monthly CMS engagement anticipated post-award. LOI and due date reinforced by national trade advisories. (cms.gov)
- Funds structure and uses: $10B/yr in FY26–FY30; 50% equal, 50% factor-based; uses include chronic disease, provider payments (with conditions), consumer-tech, training/TA for advanced tech, rural workforce, IT/cybersecurity, right-sizing services, behavioral health/OUD, innovative models/APMs. (cms.gov)

Table—Requirement to Collaborative capability mapping (selected)

- Rural chronic disease prevention/management → RPM (BioIntelliSense), multilingual digital intake/triage and PHR (Humetrix), analytics for gap closure (Pangaea Data), retail pharmacy adherence. Evidence: partner descriptions and deployment examples in the Collaborative dossier.
- Training/TA for tech-enabled care (telehealth, AI) → Avel eCare clinical ops training; ambient documentation tools; advisory/SI support (Accenture/KPMG/PwC) for workflow integration.
- IT/cybersecurity and data infrastructure → HIPAA/FHIR-aligned cloud; Azure security adopted by 700+ rural hospitals; integration with state data flows subject to BAAs and state standards.
- Workforce recruitment/retention → On-demand provider-to-provider tele-consults; pharmacist-enabled care models and pipelines; CHW training; state loan repayment integration (separate).
- Innovative models/payment → Claims modernization, payment integrity analytics, value-based program design; rural HVN governance to operationalize shared-savings/global budget-like constructs (subject to State authority).

Compliance checkpoints

- Single State applicant; Grants.gov submission; cooperative agreement terms; NOFO-defined budget category limits; 2 CFR Part 200/300 and HHS GPS apply. (CMS program materials and NOFO govern.) (cms.gov)

3. Utah Context Snapshot

Selected indicators and where Collaborative capabilities slot in

- Rural and frontier context
    - Utah recognizes “frontier” counties as ≤6 persons/sq. mile; frontier areas cover a majority of land with sparse populations. Utah IBIS definitions are used across public reports. (ibis.utah.gov)
    - EMS response times are longest in frontier areas: 18.0 minutes in 2023 vs. shorter in rural/urban areas—underscoring tele-supported pre-hospital care and right-sizing service lines. (ibis.utah.gov)
- Population and facilities
    - Nonmetro population: 401,587 (12.1%) (ACS 2023 5-year). Facilities: 13 CAHs, 21 RHCs, 26 FQHCs, 10 short-term/PPS hospitals in rural areas (as defined by HRSA site metadata, July 2025). Collaborative can extend virtual specialty coverage and RPM to these assets. (ruralhealthinfo.org)
- Workforce/HPSAs
    - Utah has designated primary care, dental, and mental health HPSAs (state-level counts vary as HRSA updates; use HRSA dashboard exports for the application attachment). The HRSA map gallery/data explorer provides current HPSA designations (as of Oct 2025). Collaborative tools can target shortage areas for virtual services and recruitment. (data.hrsa.gov)
- Medicaid program
    - Managed care (ACOs) is mandatory in 13 counties; optional elsewhere. UMIC plans integrate physical and behavioral health for the expansion group in Davis, Salt Lake, Utah, Washington, and Weber counties. (medicaid.utah.gov)
    - 1115 developments: CMS approved Jan 8, 2025 amendments enabling HRSN services, NMT to HRSN, adult dental expansion, and fertility preservation; Utah also submitted a July 3, 2025 amendment proposing a

community engagement requirement (federal review pending as of Oct 2025). Collaborative analytics and SDOH connectors can support measurement and compliance. (content.govdelivery.com)

- Behavioral health and maternal health
    - Suicide: Age-adjusted suicide rate 2021–2023 was 20.93 per 100,000 (696 deaths in 2023). Rural Utah's 2023 suicide death rate reached 26.0 per 100,000 vs. 18.6 in urban Utah. Tele-behavioral and crisis supports are therefore priority capabilities. (ibis.utah.gov)
    - Maternal mortality: Utah pregnancy-related mortality ratio was 24.0 per 100,000 in 2022; substance use and mental health contribute materially, and postpartum risks extend through 12 months—now aligned with Utah's 12-month Medicaid postpartum coverage (SB133 implementation). Virtual perinatal care and CCBHC pathway can complement. (ibis.utah.gov)
- Broadband
    - Utah's BEAD allocation totals $317,399,741.54; initial proposal approved July 22, 2024. UBC's draft Final Proposal indicates 43 projects to connect ~32,229 locations (subject to final NTIA approval). RHT can leverage BEAD-backed middle/last-mile to expand remote care in rural clinics, pharmacies, schools, and EMS. (ntia.gov)

Table—Utah metrics and matching Collaborative capability (illustrative)

- Nonmetro population 12.1% (ACS 2023) → distributed RPM + retail-based screening and adherence to extend reach. (ruralhealthinfo.org)
- Frontier EMS response 18.0 min (2023) → Avel eCare tele-EMS/ER backup and protocols. (ibis.utah.gov)
- CAHs=13 → virtual ICU/hospitalist, stroke AI alerts, pharmacy transitions management. (ruralhealthinfo.org)
- Suicide (2023) rural 26.0 → 24/7 tele-behavioral; 988 crisis integration; pharmacy screening/naloxone referral. (ruralhealth.utah.gov)
- BEAD $317.4M → secure telehealth nodes and RPM endpoints at rural anchor sites on HIPAA/FHIR platforms. (ntia.gov)

4. Strategy Aligned to RFP

Concept: A statewide Rural High-Value Network (HVN) scaffolds virtual specialty access, continuous monitoring, and pharmacy-enabled community management atop secure cloud and analytics. This aligns to prevention/chronic disease, sustainable access, workforce, innovative care/payment, and tech innovation pillars in the RHT Program.

- Prevention and chronic disease
    - Consumer triage/PHR and multilingual intake (Humetrix), RPM (BioIntelliSense), pharmacy-led adherence and BP programs, and value-driven outreach analytics (Pangaea Data) anchor measurable improvement in BP control, diabetes ABCs, COPD readmissions, and post-discharge follow-up.
- Sustainable access/right-sized services
    - Virtual hospitalist/ICU/ER, tele-pharmacy, and tele-specialty clinics (Avel eCare) help CAHs maintain local access and appropriate transfers; Growth/footprint analytics guide right-sizing service lines.
- Workforce
    - Provider-to-provider tele-consults, ambient scribing, and pharmacist pipeline/"top-of-license" pathways address burnout and recruitment/retention.
- Innovative care/payment
    - Payment integrity and claims modernization; statewide HVN governance supports shared services and value-based arrangements, with actuarial support and SPA/contracting pathways led by the State (collaborative advisors provide technical assistance).
- Tech innovation and cybersecurity
    - HIPAA/FHIR data platform, privacy-preserving APIs, and rural hospital cybersecurity improvements (Azure program footprint in 700+ rural hospitals) underpin interoperability and risk reduction.
- Equity and Tribal

- Tools support language access and culturally adapted engagement; CCBHC pathway and 988/crisis integration target behavioral needs; analytics flag gaps by geography/race/ethnicity for targeted interventions; implementation contingent on Tribal consultation protocols.

5. Program Design Options (Utah-tuned; subject to State selection and procurement)

Option A. Rural High-Value Network (HVN) with virtual specialty backbone

- Target: CAHs, RHCs, FQHCs, independent rural hospitals ("Rural 9"), EMS.
- Problem: Frontier EMS times and limited on-site specialty drive transfers and delays. (ibis.utah.gov)
- Collaborative components: Avel eCare (tele-hospitalist/ICU/ER), Viz.ai stroke AI; BioIntelliSense RPM post-discharge; Microsoft secure cloud/cyber; pharmacy transitions and medication reconciliation (Walgreens/CVS).
- Payment logic: RHT funds for technology/TA and shared services; Medicaid value-based add-ons via UMIC/ACO contracts or SPA; monitor transfers avoided, LOS, readmissions.
- Enablers: HVN governance (Cibolo), SI support (Accenture/KPMG/PwC) for operating model and data sharing.
- Pros/risks: Rapid statewide lift; dependency on CAH staffing and licensure/credentialing across systems; sustainment via payer contracts.

Option B. Community paramedicine + tele-ER + home RPM

- Target: High-risk chronic disease; post-discharge rural patients; EMS agencies.
- Problem: Readmissions and long transports; rural ED boarding.
- Components: Tele-ER support (Avel eCare), EMS tele-consult, BioIntelliSense RPM, Humetrix consumer triage/PHR, pharmacy adherence.
- Payment: RHT for RPM kits/training and analytics; Medicaid care-management fees/value incentives; align with ACO quality metrics.
- Risks: Connectivity gaps; mitigate via BEAD/CPF-supported middle/last mile and device provisioning. (ntia.gov)

Option C. Rural maternal-behavioral integration with CCBHC pathway

- Target: Rural pregnant/postpartum persons; SUD/OUD; perinatal mood disorders.
- Problem: Utah's pregnancy-related mortality 24.0 (2022) with behavioral contributors; rural access gaps; 12-month postpartum Medicaid coverage now in place. (ibis.utah.gov)
- Components: Tele-behavioral (Avel eCare), CCBHC planning and certification support, pharmacy screening/naloxone education; postpartum RPM for hypertension and depression symptom tracking; referral via LMHAs. (samhsa.gov)
- Payment: RHT for TA, training, enabling tech; Medicaid reimbursement via existing behavioral health/UMIC structures; consider SPA for perinatal RPM reimbursement.
- Risks: Certification timelines; workforce; address via phased ramp and TA (CCBHC S-TAC). (samhsa.gov)

Option D. Pharmacy-enabled rural primary care access and adherence hubs

- Target: Hypertension/diabetes/high-risk meds in frontier/rural towns.
- Problem: Gaps in chronic disease control and follow-up in remote areas.
- Components: Pharmacist-led BP/diabetes support, tele-consult links to PCPs, medication reconciliation and 30-day readmission reduction programs; integrated data connection to provider teams.
- Payment: RHT for training, devices, and interoperability; payer contracts for performance incentives.
- Risks: Scope-of-practice and payment policy; align with State pharmacy board and Medicaid contract levers.

6. Governance and Collaborative Roles

Conceptual roles (subject to State direction)

- State (lead agency/PCO/SORH/Medicaid): Set vision and guardrails; own NOFO application; contract and fiscal oversight; policy options (e.g., SPA/contract amendments); reporting.
- Rural provider HVN (e.g., member-owned): Local decision-rights on service mix; quality and financial performance

management; subrecipient compliance.
- Collaborative providers/tech/advisors: Deliver services, platforms, and TA under State contracts; integrate with State data/reporting; support evaluation.

RACI (abbrev.)

- Strategy & application narrative: State R; Collaborative C/A (technical appendices).
- Program ops (tele-hospitalist/ICU/ER; RPM): Provider/HVN A; Avel/BioIntelliSense R; State C.
- Data/cyber platform: State/HIE C; Microsoft/Advisors R/A.
- Evaluation: State A; Advisors/analytics partners R; providers C.

7. Payment and Funding

- RHT funds: Use for ≥3 categories (e.g., prevention/RPM; training/TA; IT/cyber; workforce; behavioral health; innovative models). The NOFO sets category caps (confirm final figures in the posted NOFO PDF for budget tables). (cms.gov)
- Medicaid alignment opportunities
    - Embed HVN/shared-services fees and value-based incentives in ACO and UMIC contracts; consider SPA for RPM and community paramedicine reimbursement and for pharmacist-delivered clinical services where permissible. Collaborative advisors support actuarial modeling and SPA drafting (subject to State direction).
- Complementary broadband funds
    - Coordinate BEAD/CPF projects to enable telehealth rooms, remote monitoring connectivity, and secure site-to-cloud networking at rural anchors. (ntia.gov)

Table—Illustrative cost categories, sources, and deliverables (planning-level only)

- Virtual specialty services (tele-ER/ICU/hospitalist): RHT category—technology/training; deliverables—coverage SLAs, credentialing, protocols.
- RPM kits + monitoring service: RHT prevention category; deliverables—enrollment targets, alert-to-action workflows, outcomes reports.
- Pharmacy-enabled access/adherence: RHT prevention/innovative models; deliverables—BP control, adherence, 30-day readmissions.
- Cloud/cyber/data integration: RHT IT/cyber category; deliverables—HIPAA/FHIR endpoints, role-based access, audit logs, incident response.
- Program management & evaluation: RHT TA category; deliverables—workplan tracking, value dashboards, CMS reports.

8. Data, Measurement, and Evaluation

- Data sources: Medicaid and commercial claims; EMS (response times/triage); EHR/CAH and HIE feeds; pharmacy dispenses/MTM; RPM telemetry; HRSA shortage designations; BEAD/CPF deployment status. (data.hrsa.gov)
- Core measures (examples)
    - Access/throughput: tele-coverage hours; EMS consults; transfer avoidance; time-to-stroke activation (Viz.ai).
    - Quality/outcomes: BP/A1c control; COPD/CHF 30-day readmissions; postpartum visit within 7/42 days; SUD engagement; suicide-related ED revisits. (ibis.utah.gov)
    - Financial: total cost-of-care trend for rural lives; avoidable transfer costs; payment integrity recoveries.
- Privacy/security: BAAs, minimum necessary, role-based access, encryption at rest/in transit, logging/monitoring, incident response consistent with State standards; Azure security reference patterns available.
- Evaluation: Mixed methods; quarterly progress measures; annual impact report aligned to CMS continuation requests.

9. Implementation Plan

Gantt-style (12–24 months; dates indicative, contingent on award and procurement)

- Workstream | Start | End | Owner | Outputs
    - Mobilize PMO, finalize scopes, subrecipient onboarding | Jan 2026 | Mar 2026 | State PMO + Advisors | Charter, risk plan, compliance calendar.
    - Cloud/cyber baseline, data integration sprints | Feb 2026 | Aug 2026 | Microsoft + State IT | HIPAA/FHIR endpoints, identity & access, dashboards.
    - Tele-ER/ICU/hospitalist coverage in first 10 facilities | Mar 2026 | Sep 2026 | Avel eCare + Facilities | Coverage SLAs, protocols, credentialing.
    - RPM cohort phase-in (cardio-metabolic, COPD/CHF) | Apr 2026 | Mar 2027 | BioIntelliSense + PCPs | 2,000 enrollees; alert protocol; outcome reports.
    - Pharmacy adherence and BP hubs rollout | May 2026 | Dec 2026 | Walgreens/CVS + FQHCs | Enrolled panels, MTM metrics, readmit tracking.
    - Maternal-behavioral integration pilot (CCBHC path) | Jun 2026 | Jun 2027 | LMHAs + Avel + State BH | Tele-behavioral access, perinatal pathway, CCBHC TA. (samhsa.gov)
    - Value-based contract pilots (ACO/UMIC) | Jul 2026 | Sep 2027 | Medicaid + Plans + HVN | Quality metrics and incentive design. (medicaid.utah.gov)

Procurement/legal

- State contracts for clinical services, cloud/analytics, RPM devices, and pharmacy programs; subrecipient agreements for HVN members; BAAs and data sharing agreements aligned to HIPAA and State statutes.

10. Risk Register (selected)

- Broadband constraints delay remote care → Mitigation: align sites with BEAD/CPF funded buildouts; interim satellite or fixed wireless; device caching. Owner: State/UBC + vendors. (ntia.gov)
- Workforce burnout/turnover → Mitigation: provider-to-provider tele-support; ambient scribing; incentives in VBP contracts. Owner: HVN; Medicaid.
- Data/privacy incidents → Mitigation: zero-trust controls, audit logging, tabletop drills; vendor cyber attestations. Owner: State CISO + vendors.
- RPM engagement failure → Mitigation: CHW and pharmacy coaching; alert fatigue tuning. Owner: Providers + vendors.
- CAH sustainability risk → Mitigation: tele-ICU/ER coverage; right-sizing analytics; HVN shared services. Owner: HVN + Avel + SI advisors.
- Policy delays (licensure/scope) → Mitigation: phased pilots within current rules; evidence packs to inform policy. Owner: State/Boards; advisors.
- Payment integrity disputes → Mitigation: transparent analytics; agreed documentation standards. Owner: Plans; advisors.
- CCBHC schedule risk → Mitigation: SAMHSA S-TAC TA; phased compliance plan. Owner: State BH + LMHAs. (samhsa.gov)
- Public reporting burden → Mitigation: automated feeds, shared data dictionary, QA routines. Owner: PMO + vendors.
- Community trust → Mitigation: LMHA/LHD and pharmacy presence; multilingual tools and local engagement. Owner: State + partners.

11. Draft RFP Response Language (Utah-tailored excerpts; adapt to final NOFO text)

- Program purpose and alignment
    - “Utah proposes to improve rural access, outcomes, and sustainability through a statewide Rural High-Value Network that combines virtual specialty services, continuous remote monitoring, pharmacy-enabled community management, and a secure data/cyber backbone. The approach aligns with the RHT Program’s uses of funds (prevention/chronic disease, training/TA for technology-enabled care, IT/cybersecurity,

workforce, behavioral health, and innovative models) and will be implemented through subrecipient rural providers organized under a member-governed network." (cms.gov)

- Technical approach
    - "Utah will contract for tele-hospitalist/ICU/ER coverage at rural hospitals and EMS tele-consult support; deploy FDA-cleared RPM for high-risk conditions; roll out multilingual digital intake and consumer PHR; and stand up a HIPAA/FHIR platform with enterprise cybersecurity controls. Pharmacy partners will deliver adherence and BP management programs integrated with FQHCs and rural practices."
- Workforce and equity
    - "Provider-to-provider tele-consults and ambient documentation tools reduce burden and support retention. Equity strategies include language access, culturally adapted outreach, and prioritization of frontier counties and Tribal communities in site selection and resource allocation."
- Medicaid/payment integration
    - "Utah Medicaid will align ACO and UMIC contracts to test value-based incentives for rural episodes and condition bundles while retaining fee-for-service where appropriate. The State will assess SPA options (e.g., RPM, pharmacist-delivered clinical services) and will report results per CMS continuation guidance." (medicaid.utah.gov)
- Data and evaluation
    - "The program will report quarterly on access, quality, workforce, financial, technology, and implementation measures, using automated feeds to minimize burden. Independent evaluation support will be procured to validate impact and inform sustainment."

12. References

Internal (Collaborative dossier)

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3. BioIntelliSense RPM (BioButton) description. In: Rural Health Transformation Collaborative. R1. 10-11-25, p.16. Accessed 2025-10-14.
4. Humetrix consumer PHR/triage/analytics. In: Rural Health Transformation Collaborative. R1. 10-11-25, pp. 6, 17. Accessed 2025-10-14.
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6. Microsoft cloud/cyber summary (HIPAA/FHIR, 700+ rural hospitals). In: Rural Health Transformation Collaborative. R1. 10-11-25, p.4. Accessed 2025-10-14.
7. Cibolo Health HVN governance and value. In: Rural Health Transformation Collaborative. R1. 10-11-25, pp. 5, 23. Accessed 2025-10-14.

External (program and Utah context) 8) Rural Health Transformation (RHT) Program overview page. CMS. Program structure, uses of funds, eligibility, timeline. Accessed 2025-10-14. (cms.gov) 9) Current CMS Grants Program Funding Opportunities (CMS-RHT-26-001 listing). CMS. Posted Sept 2025; links to Grants.gov. Accessed 2025-10-14. (cms.gov) 10) AHA news advisories on LOI (Sept 30, 2025) and application (Nov 5, 2025). American Hospital Association. Accessed 2025-10-14. (aha.org) 11) RHT Program Overview Presentation (Program, uses, timeline). CMS (PDF). Accessed 2025-10-14. (cms.gov) 12) Utah Rural Health (state SORH/PCO). Utah DHHS Office of Primary Care & Rural Health. Accessed 2025-10-14. (ruralhealth.utah.gov) 13) Utah Nonmetro population and rural facility counts. Rural Health Information Hub (HRSA-supported). Updated 2025-09-11. Accessed 2025-10-14. (ruralhealthinfo.org) 14) HRSA HPSA Map Gallery/Data Explorer (designations as of Oct 2025). HRSA data.HRSA.gov. Accessed 2025-10-14. (data.hrsa.gov) 15) Utah Medicaid ACO counties and UMIC overview. Utah DHHS/Medicaid. Accessed 2025-10-14. (medicaid.utah.gov) 16) CMS/Medicaid.gov bulletins: Utah 1115 approvals (Jan 8, 2025) and CE amendment submission (July 3, 2025). Accessed 2025-10-14. (content.govdelivery.com) 17) Utah IBIS: EMS response time (frontier), definitions of frontier. Utah DHHS (IBIS-PH/EPHT).

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Assumptions and Open Questions

- NOFO detailed caps and scoring: This guide references CMS program webpages and national advisories for dates/structure and relies on the NOFO for definitive numerical caps (e.g., category limits, admin/indirect). Grants.gov attachments were not publicly accessible without login at drafting time; Utah should confirm final caps, scoring weights, and any conditional-point deadlines against the posted NOFO PDF before budget finalization. (cms.gov)
- CCBHC site list: SAMHSA maintains national resources; Utah also received a CCBHC planning grant in late 2024/early 2025; confirm the list of Utah CCBHCs as of Sep 1, 2025 from SAMHSA directories for inclusion as a required attachment. (taggs.hhs.gov)
- HIE specifics: This guide assumes availability of a statewide HIE interface to support data exchange; contracting, interface specifications, and consent models to be confirmed by the State.

Checklists

- Application completeness (abbrev.)
    - Single authorized State applicant; Grants.gov forms SF-424/424A, site locations, SF-LLL (as applicable); Governor letter; business assessment; duplication of programs assessment; narratives (summary, project, budget); reporting and risk acknowledgments. (cms.gov)
- Technical fit
    - At least three NOFO use-of-funds categories; data/evaluation plan; alignment to five pillars; subrecipient monitoring plan; cybersecurity/PII safeguards; Medicaid/payment alignment narrative. (cms.gov)
- Utah-specific inserts
    - Rural/Frontier definition reference; nonmetro population and facility inventory; ACO/UMIC map; 1115 approvals; suicide and maternal indicators; BEAD/CPF coordination plan; CCBHC list as of 9/1/2025; Medicaid DSH hospital count (latest SPRY). (ibis.utah.gov)

AI Generation Notice This guide was generated by the gpt-5 model on 2025-10-14. It incorporates internal Collaborative materials and public sources. All facts, figures, and citations must be independently validated against the final CMS NOFO, Grants.gov postings, and Utah’s administrative records before use in any submission.