Rural Health Transformation Grant Guide — North Dakota

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary North Dakota's rural health system spans 37 Critical Access Hospitals (CAHs), dozens of Rural Health Clinics, and eight state-operated regional behavioral health clinics that anchor access across a low-density, frontier geography, with 39% of residents living in nonmetro areas as of 2023–2025 data [1][2][3][4]. (ncsl.org) The CMS Rural Health Transformation (RHT) Program provides a cooperative-agreement pathway—$50B nationally over FY26–FY30 with awards by Dec 31, 2025—to invest in access, workforce, technology, innovative care, and sustainable payment models; applications are due Nov 5, 2025 [5][6][7]. (cms.gov)

The Rural Health Transformation (RHT) Collaborative can support North Dakota with configurable capabilities mapped to all RHT uses of funds. Example high-leverage offerings include: 24/7 virtual hospital services (Avel eCare) to stabilize rural EDs/ICUs; continuous remote physiologic monitoring (BioIntelliSense) to extend care into homes; AI-enabled triage and patient engagement (Humetrix) to lower access barriers; and a secure cloud and cybersecurity backbone (Microsoft) with documented deployment experience in 700+ rural hospitals [8][9][10][11].

These capabilities align to pressing state needs: rural EMS fragility and service gaps projected over the next decade; L&D service reductions with only ~21% of rural ND hospitals offering obstetrics; overdose mortality concerns; and the need to safeguard digital infrastructure while enabling data exchange across providers and payers [12][13][14][15]. (northdakotamonitor.com) The Collaborative also supports governance and program management (Accenture/KPMG/PwC/AVIA), and convening provider-owned High Value Networks (Cibolo Health) to steward funds and standardize performance [16].

Page-following printable summary

North Dakota RHT at-a-glance (printable, 1 page)

- Program window (federal): Application due Nov 5, 2025; awards/earliest start Dec 31, 2025 [6][7]. (cms.gov)
- ND rural context: 39% nonmetro population (2023 ACS 5-yr); 37 CAHs; 59 RHCs (2024); eight regional behavioral health clinics [1][2][3][4]. (ruralhealthinfo.org)
- Broadband: ~95%+ of residents with ≥100 Mbps access; <10k addresses lack 1 Gbps (state) [15]. (ndit.nd.gov)
- Medicaid delivery: ND Medicaid Expansion managed by BCBSND (only MCO); D-SNPs implemented Jan 1, 2025 (≈13k duals) [17][18]. (hhs.nd.gov)
- Key gaps: rural EMS sustainability risks; reduced rural OB availability; overdose deaths (116 in 2023) alongside >33,000 naloxone kits distributed July 2024–June 2025 [12][13][14]. (northdakotamonitor.com)
- Priority fit: Collaborative supports virtual specialty care, RPM, behavioral health, workforce skilling, cybersecurity, value-based payment modeling, and HVN governance [8][9][16].

2. Eligibility and RFP Fit 2.1 RHT snapshot (what CMS requires)

- Eligible applicant: only States (DC/territories ineligible). Cooperative agreement; single application per State [5]. (cms.gov)
- Funding: $50B total FY26–FY30; 50% equal "baseline," 50% "workload" by factors specified in NOFO; awards by Dec 31, 2025 [5][6]. (cms.gov)
- Key timeline: NOFO posted mid-September; application due Nov 5, 2025; optional LOI by Sep 30 per field summaries; applicant webinars in late September [5][7]. (cms.gov)
- Uses of funds: chronic disease prevention/management; provider payments; consumer-facing tech; TA for tech-enabled care (telehealth, RPM, AI); workforce; IT/cyber; system right-sizing; behavioral health/SUD; innovative/value-based models [5]. (cms.gov)

2.2 Requirement-to-Capability Mapping (evidence-linked)

RHT NOFO requirement (summary)	**Collaborative capability**	**Evidence**
Extend access to specialty care and stabilize ED/ICU	Avel eCare virtual hospitalist/ICU/ED support	RHT Collaborative PDF, Appendix 1–Avel eCare [8].
Enable remote care and chronic management	BioIntelliSense continuous RPM; exception-based dashboards	Collaborative PDF, pages 15–16 [9].

RHT NOFO requirement (summary)	Collaborative capability	Evidence
Consumer-facing tools and multilingual triage	Humetrix voice-enabled intake/triage; patient PHR and analytics	Collaborative PDF, pages 16–17 [10].
Invest in IT/cybersecurity and data exchange	Microsoft secure cloud, identity, and cyber services; analytics	Collaborative PDF, page 17 (700+ rural hospitals) [11].
Workforce training and burnout reduction	Ambient clinical documentation; SI-led skilling programs	Collaborative PDF, pages 9–11 [8] [16].
Value-based models and analytics	Cibolo Health HVN governance; Accenture/KPMG/PwC analytics	Collaborative PDF, pages 13–15 [16].
Behavioral health and crisis care	Tele-behavioral access; 988/crisis capabilities (Avel eCare, partners)	Collaborative PDF, page 13 [16].
Application/award cadence	CMS RHT page + press release with dates	CMS site and press release [5][6][7]. (cms.gov)

Compliance checkpoints in the NOFO (formatting, forms, reporting, 2 CFR Part 200/300) are program-standard for CMS cooperative agreements; the Collaborative's PMO and SI members can support Grants.gov submission quality, subrecipient monitoring, and federal reporting frameworks [16].

3. North Dakota Context Snapshot 3.1 Demography and geography

- Rural share: 39.0% of ND residents live in rural areas (2020 Census method; NCSL table, 2025) [1]. (ncsl.org)
- Frontier conditions: ND has substantial frontier/remoteness per USDA ERS FAR criteria; ND is among states with the highest shares of FAR populations [19]. (primary.ers.usda.gov)
- Broadband: ND IT reports 95.4% of residents can access ≥100 Mbps; <10,000 locations lack 1 Gbps (posted 2024–2025) [15]. (ndit.nd.gov)

3.2 Facility mix and access points

- Hospitals/CAHs: 37 CAHs (UND Center for Rural Health, 2024–2025) [2][3]. (med.und.edu)
- Rural Health Clinics: 59 RHCs (UND CRH 2024) [2]. (med.und.edu)
- FQHCs: At least four HRSA awardee organizations reported in 2024 (Coal Country CHC, Family HealthCare, Spectra Health, Northland Health Partners) [20]. (bphc.hrsa.gov)
- State regional behavioral health clinics: eight state-operated clinics [4]. (hhs.nd.gov)
- OB access: ~21% of rural ND hospitals offer L&D services (2025 report) [13]. (northdakotamonitor.com)
- EMS: ND EMS Association anticipates potential closure risk for up to ~30 ambulance providers over the next decade (2024 testimony) [12]. (northdakotamonitor.com)

3.3 Workforce and HPSA indicators

- HRSA HPSA designations exist in primary care, dental, and mental health; the HRSA dashboard (data as of 2025-10-12) provides current counts and shortage FTE needs [21], with methodology detail in HRSA scoring guidance [22]. (data.hrsa.gov)
- Collaborative workforce supports include provider-to-provider telemedicine (Avel eCare), pharmacy workforce pipelines (CVS/Walgreens/Walmart), and skilling programs (Accenture/KPMG/PwC) [8][16].

3.4 Medicaid and coverage context

- ND Medicaid Expansion is administered by BCBSND (only MCO) and distinct from fee-for-service Medicaid enrollment; 25,216 expansion members (April 2024) [17]. (hhs.nd.gov)
- D-SNPs implemented 1/1/2025; state indicates >13,000 dual-eligibles (FFS Medicaid remains secondary) [18]. (hhs.nd.gov)
- State moving to cover community health workers and community paramedics via SPA effective on/after 10/1/2025 (public notice) [23]. (hhs.nd.gov)

3.5 Behavioral health and SUD

- ND recorded 116 overdose deaths in 2023; >33,000 naloxone kits distributed and 870+ reversals reported July 2024–June 2025 (ND HHS) [14]. (hhs.nd.gov)
- National provisional data show a 27% US overdose decline in 2024; monitoring continues (CDC NCHS, 2025) [24]. (reuters.com)

3.6 Metrics-to-capability table

Metric (year)	Value	Source	Collaborative alignment
Rural share (2020/2025 table)	39.0%	NCSL (Census 2020), 2025 [1] (ncsl.org)	Virtual/retail access nodes; RPM; HVN governance [8][9][16].
CAHs (2024–2025)	37	UND CRH; RHIhub [2][3] (med.und.edu)	Tele-ED/ICU; cybersecurity; data/reporting [8][11][16].
RHCs (2024)	59	UND CRH [2] (med.und.edu)	RPM kits via clinics; pharmacist-enabled models [9][16].
FQHC awardee orgs (2024)	4	HRSA QIA-UDS+ awards [20] (bphc.hrsa.gov)	EHR/data exchange; analytics; outreach [10][16].
Behavioral health clinics	8	ND HHS [4] (hhs.nd.gov)	Tele-psychiatry/988 integration [16].
Rural OB availability (2025)	~21%	North Dakota Monitor [13] (northdakotamonitor.com)	Tele-OB, RPM, regionalized referral pathways [8][9][16].
Naloxone distribution (2024–25)	>33k kits	ND HHS [14] (hhs.nd.gov)	Pharmacy-anchored harm-reduction + tele-BH [16].
Broadband ≥100 Mbps	95.4%	ND IT, 2024–2025 [15] (ndit.nd.gov)	Home-based telehealth/RPM + cloud reporting [11].

4. Strategy Aligned to RFP 4.1 Model overview (conditional, non-prescriptive) A statewide Rural Access and Stability Model that networks CAHs/RHCs/FQHCs with:

- Always-available virtual specialty backstop (ED/ICU/hospitalist, pharmacy) to keep care local where clinically appropriate [8].
- Home-centered longitudinal management (BioIntelliSense RPM + clinic dashboards), targeted first to CHF/COPD/diabetes/maternity risk cohorts [9].
- Consumer-facing, multilingual mobile/web tools to triage, navigate benefits, and share patient-authorized data (Humetrix) [10].
- Shared cloud and cybersecurity foundation across rural providers (Microsoft), feeding state dashboards for outcomes and spend [11][16].
- Rural provider High Value Networks (Cibolo Health) as accountable vehicles for shared services and value-based arrangements [16].

4.2 Alignment to scoring pillars and technical factors

- Prevention/chronic disease: screening kiosks/retail, RPM, AI risk identification; patient-authorized data exchange [8][9][10].
- Partnerships: HVN governance, state-level convening, payer engagement for rural APMs [16].
- Workforce: ambient documentation; tele-mentoring; pharmacy pipelines; compact participation (IMLC, NLC, Counseling, OT, APRN, etc.) [8][25]. (compacts.csg.org)
- Policy levers: ND has no CON (neutral-to-positive signal for facility right-sizing); state is implementing D-SNPs; covering CHWs/community paramedics via SPA under consideration for Oct 2025 [18][23][26]. (hhs.nd.gov)
- Data use/privacy: HIPAA/FHIR-based stack; role-based access; audit logs; CMS/ONC alignment noted in

collaborative documentation [8][11].

4.3 Equity strategy for rural and Tribal communities

- Co-design with the ND Indian Affairs Commission and the five Tribal Nations (Standing Rock, Spirit Lake, MHA Nation, Turtle Mountain Band of Chippewa, Sisseton-Wahpeton Oyate), with IHS/638 and Tribal health programs as key implementers [27]. (indianaffairs.nd.gov)
- Respect Tribal data sovereignty; incorporate Tribal consent and governance for data-sharing and evaluation workstreams (Collaborative PMO supports templates) [16].
- Leverage local tele-enabled care delivery and pharmacist-led community programs to reduce travel burden and expand preventive services in frontier counties [8][16][19]. (primary.ers.usda.gov)

5. Program Design Options (ND-tuned; modular; subject to policy, contracting, and integration) Option A: Virtual Stabilization + RPM for CAHs

- Target population: Adults with CHF/COPD/diabetes; high-risk ED utilizers.
- Problem data: Rural ED staffing/throughput strain; L&D/ICU service reductions; 39% rural share; frontier travel times [1][13][19]. (ncsl.org)
- Components: Avel eCare virtual hospitalist/ICU/ED; BioIntelliSense RPM; multilingual triage/PHR (Humetrix); Microsoft cyber/data layer; payer analytics for avoidable utilization [8][9][10][11][16].
- Payment logic: hospital quality/avoidance incentives; SPA/State plan amendments for RPM where applicable; D-SNP supplemental alignment (care coordination) [18]. (hhs.nd.gov)
- Pros/risks: Pros—reduced transfers/readmissions; workforce relief. Risks—RPM adherence; device logistics; mitigation—digital navigators and CHW supports [9].

Option B: Rural Maternal & Newborn Access Network

- Target: Pregnant/postpartum individuals in counties without L&D.
- Problem: Only ~21% of rural hospitals offer OB; travel times and preterm risk [13]. (northdakotamonitor.com)
- Components: tele-OB consults; remote maternal monitoring bundles; pharmacist-supported BP/diabetes management; mobile diagnostics and coordinated referral pathways [8][9][16].
- Payment: prenatal RPM codes (payer-specific), Medicaid prenatal care benefits; leverage retail clinic partnerships for vitals/testing [16].

Option C: Community Paramedicine + Behavioral Health Integration

- Target: High-utilizing rural patients with SUD/behavioral needs; fall-risk elders.
- Problem: EMS sustainability; overdose mortality [12][14]. (northdakotamonitor.com)
- Components: EMS-based home visits; tele-BH; naloxone distribution and recovery linkage; CHW/paramedic SPA coverage as proposed for 10/1/2025 [23]. (hhs.nd.gov)
- Payment: State plan coverage for community paramedicine/CHW services; performance payments tied to avoided ED transports [23]. (hhs.nd.gov)

Option D: Pharmacy-Enabled Chronic Care and Navigation

- Target: Hypertension/diabetes; medication reconciliation at transitions.
- Problem: Rural access; need for adherence and reconciliation; strong broadband enables hub-and-spoke [15]. (ndit.nd.gov)
- Components: pharmacist-led chronic programs, telepharmacy, medication reconciliation integrated with FQHCs and CAHs; patient notifications [16].
- Payment: Medicaid medication therapy management benefits where applicable; value-based pharmacy pilots inside HVNs [16].

Primary recommendation: Option A statewide + Option C in targeted counties (phased). Backup: Option B in OB-limited regions plus Option D in pharmacy-dense corridors.

6. Governance and Collaborative Roles 6.1 Structure (illustrative)

- State Lead Agency (designated by Governor) — grant holder, compliance, and statewide convening.
- ND Medicaid — payment alignment, SPA/D-SNP coordination, data-use approvals.
- Provider HVNs (Cibolo Health-enabled) — pooled operations, shared services, subrecipient oversight [16].

- Collaborative SIs (Accenture/KPMG/PwC/AVIA) — PMO, analytics, security, value realization, evaluation support [16].
- Technology/clinical partners (Avel eCare, BioIntelliSense, Humetrix, Microsoft, Viz.ai, retail health) — contracted implementation and support [8][9][10][11][16].
- Tribal/IHS partners — design, data governance, evaluation, culturally centered deployment [27]. (indianaffairs.nd.gov)

6.2 RACI (excerpt)

Deliverable	State Lead	ND Medicaid	HVNs	Collaborative SI	Clinical/Tech Partners
Grants.gov application & forms	R	C	C	C	C
Subrecipient structure & HVN charters	A	C	R	C	C
Cyber/data architecture	C	C	C	R	R
Tele-ED/ICU rollout	C	C	R	C	R
RPM cohort rollout	C	C	R	C	R
Evaluation & dashboards	A	A	C	R	C

R=Responsible; A=Accountable; C=Consulted.

7. Payment and Funding 7.1 Medicaid alignment opportunities

- D-SNP interface: coordinate care management and supplemental benefits; preserve Medicaid FFS wrap (state notes >13,000 duals) [18]. (hhs.nd.gov)
- SPA supports: CHW/paramedics coverage (public notice targeting 10/1/2025) [23]. (hhs.nd.gov)
- ND Medicaid Expansion (BCBSND MCO): integrate telehealth/RPM policy and coding updates (e.g., 2025 CPT 98001-98015 adoption) to advance virtual care [17][28]. (hhs.nd.gov)

7.2 Illustrative cost categories (observing NOFO caps—see Assumptions)

Category	ROM Yr1 ($M)	Funding source	Timing	Collaborative deliverables
Virtual specialty backstop	12–18	RHT (Use G/H)	Q2–Q4 FY26	Tele-ED/ICU service, credentialing, protocols [8].
RPM devices/services	10–15	RHT (A/F/I)	Q2–Q4 FY26	Devices, dashboards, clinical ops, digital navigators [9].
Cybersecurity & cloud	6–10	RHT (F)	Q1–Q4 FY26	Identity/security hardening, data lake, audit [11].
Workforce skilling	3–5	RHT (D/E)	Q1–Q4 FY26	Training, tele-mentoring, pharmacy pipeline [8] [16].
Provider payments (incentives)	≤ cap	RHT (B/E/I)	Q3–Q4 FY26	Metrics-tied payments; HVN distribution [16].
Capital & minor renovations	≤ cap	RHT (J)	Q3–Q4 FY26	Rooms for telehealth, monitoring spaces [16].

Note: Caps for provider payments, capital, admin are per NOFO—see Assumptions.

8. Data, Measurement, and Evaluation

- Core measures: ED transfer rate; 30-day readmission; RPM adherence; maternal hypertension control postpartum; BH/SUD engagement within 7/30 days; EMS non-transport repeat calls; time-to-tele-consult; cybersecurity posture

(patch/vuln metrics).

- Sources: claims (Medicaid/MCO/D-SNP); CAH EHRs; FQHC UDS; HIE; EMS runs; retail pharmacy data; patient-reported outcomes. Collaborative stack (Microsoft cloud, partner apps) supports HIPAA/FHIR exchange and near-real-time dashboards [11][10].
- Evaluation cadence: quarterly dashboards; annual outcome assessment; learning collaboratives; accommodate CMS or third-party evaluations [5][16]. (cms.gov)

9. Implementation Plan (12–24 months; indicative; subject to procurement) Gantt-style table

Workstream	Start	End	Owner	Outputs
Program initiation & PMO	Jan 2026	Mar 2026	State + SI	Charter, governance, risk plan [16].
Cyber/data landing zone	Feb 2026	Sep 2026	SI + Microsoft	Secure tenant, identity, data lake, role-based access [11].
Tele-ED/ICU wave 1 (10 CAHs)	Apr 2026	Oct 2026	HVN + Avel	24/7 coverage, protocols, QA [8].
RPM wave 1 (1,500 pts)	May 2026	Nov 2026	HVN + BioIntelliSense	Device deployment, triage workflows [9].
Pharmacy-enabled HTN/DM	May 2026	Dec 2026	FQHCs/Retail	Medication reconciliation; adherence support [16].
Behavioral tele-crisis integration	Jun 2026	Dec 2026	State BH + Avel	24/7 access; EMS handoffs [16].
Community paramedicine pilots	Jul 2026	Mar 2027	EMS + Medicaid	Protocols; SPA billing go-live [23]. (hhs.nd.gov)
Evaluation & reporting v1	Oct 2026	Dec 2026	SI + State	Quarterly dashboards; NCC application for continuation [5]. (cms.gov)
Critical gating: executed contracts; data-use agreements; Tribal MOUs; SPA approvals for CHW/paramedic; privacy/security sign-offs.				

10. Risk Register (top 10)

Risk	Likelihood/Impact	Mitigation	Owner
Workforce capacity to absorb new models	M/H	Tele-mentoring; phased rollout; ambient documentation	HVNs + SI [8].
RPM adherence/device loss	M/M	Digital navigators; device logistics; patient stipends	HVNs + BioIntelliSense [9].

Risk	Likelihood/Impact	Mitigation	Owner
Data-sharing delays	M/H	Standard DUAs; FHIR APIs; role-based access	SI + Microsoft [11].
Cyber incidents	M/H	Hardening; monitoring; patch SLAs; tabletop exercises	State CISO + Microsoft [11].
EMS program sustainability	M/M	Align payment via SPA; measure avoided transports	State EMS + Medicaid [23]. (hhs.nd.gov)
Maternal program uptake	M/M	Tele-OB with local champions; retail vitals	HVNs + Avel + Retail [8] [16].
Vendor onboarding delays	M/M	Master services agreements; pre-negotiated SOWs	State + SI [16].
Payer alignment variance	M/H	Convene payers in HVN; analytics on shared outcomes	State + HVNs [16].
D-SNP integration complexity	M/M	Joint operating committee; shared care plan	ND Medicaid + D-SNPs [18]. (hhs.nd.gov)
Rural broadband pockets	L/M	Offline-tolerant RPM; store-and-forward; device choice	SI + Tech partners [11] [10][15]. (ndit.nd.gov)

11. Draft RFP Response Language (paste-ready; adapt as needed) 11.1 Project Summary (excerpt, ≤1 page) North Dakota proposes a Rural Access and Stability Model that links CAHs, RHCs, FQHCs, tribal and community providers with virtual specialty care, home-centered monitoring, and a secure data/cyber backbone. The State will prioritize frontier counties and Tribal communities, leveraging statewide broadband to expand timely access, reduce avoidable transfers and readmissions, advance maternal safety in OB-limited regions, and integrate behavioral health and crisis response. Implementation is supported by a provider-owned High Value Network structure and configurable capabilities from the Rural Health Transformation Collaborative, including tele-hospital services, remote physiologic monitoring, multilingual triage/PHR, and cybersecurity/analytics. Activities address at least three uses of funds—prevention and chronic disease, workforce/technology, and innovative care/payment—and include outcome targets with quarterly reporting to CMS [5][8][9][10][11][16]. (cms.gov)

11.2 Rural Health Needs & Target Population (excerpt) As of 2025, 39% of residents live in rural areas; 37 CAHs are distributed across a frontier landscape with long travel times; RHCs and eight regional behavioral health clinics serve as critical access points; only ~21% of rural hospitals offer obstetrics; and the state reported 116 overdose deaths in 2023 with >33,000 naloxone kits distributed the following year [1][2][3][4][13][14]. (ncsl.org)

11.3 Goals, Strategies, and Policy Actions (excerpt) The State will conditionally pursue SPA pathways (CHW/paramedics) and coordinate with ND Medicaid Expansion and D-SNPs for care integration and incentives. The Collaborative can support actuarial modeling, analytics, and stakeholder convening to align value-based arrangements while preserving local autonomy via HVNs [16][18][23]. (hhs.nd.gov)

11.4 Initiatives & Use of Funds (example) Initiative 1: "Keep Care Local" Tele-ED/ICU + RPM

- Uses: A, D, F, G, I. Outcomes: reduced transfers (baseline→–15% yr1), 30-day readmissions (–10%), RPM adherence ≥70%, maternal postpartum BP control (+15%). Timeline: Q2–Q4 FY26. Stakeholders: CAHs, EMS, FQHCs, Tribal health, retail pharmacies. Technology/partners: Avel eCare, BioIntelliSense, Microsoft, Humetrix [8][9][10][11].

11.5 Metrics & Evaluation (excerpt) North Dakota will report quarterly to CMS on access, quality, technology, workforce, and implementation measures, and cooperate with CMS evaluations, using the Collaborative's analytics stack for near-real-time dashboards [5][11][16]. (cms.gov)

12. Assumptions and Open Questions

- NOFO detailed scoring weights, administrative and category caps: This guide relies on the compressed specification provided by the requestor; where precise page/section citations are required (e.g., provider payments ≤15% of annual award; capital ≤20%; EMR replacement ≤5%; admin ≤10%), the State should confirm against the official

CMS-RHT-26-001 NOFO on Grants.gov to finalize compliance cross-references [7]. (ruralhealth.us)

- DSH hospital count and CCBHC list as of Sep 1, 2025: The NOFO requests these items; current public sources do not provide definitive counts statewide. Validation with ND Medicaid finance and SAMHSA/state certification lists is recommended.
- HPSA counts: HRSA dashboard shows current designations and shortage FTEs; exact counts fluctuate. Pull a time-stamped export for the application [21]. (data.hrsa.gov)
- Payment model specifics (e.g., incentive formulas; SDPs with MCOs): ND has a single MCO for Expansion and new D-SNP activity; confirm feasibility and contract updates before committing to directed payments or shared savings in Yr1 [17][18]. (hhs.nd.gov)

13. Checklists Application content checklist (evidence-ready)

- Single State applicant; Governor designation letter; AOR signature [5]. (cms.gov)
- Project narrative (≤60 pp) with: needs, plan/strategies, initiatives (≥3 uses), implementation timeline, stakeholder engagement, metrics/evaluation, sustainability [5]. (cms.gov)
- Budget narrative and SF-424/424A; subrecipient and procurement plans; reporting commitments [5][16]. (cms.gov)
- Attachments: Indirect cost rate (if any); business assessment; program duplication safeguards; CCBHC list; DSH count; HPSA context; broadband plan [5]. (cms.gov)

Operational readiness checklist (Collaborative-supported)

- Cyber/data landing zone provisioned; identity and access configured; BAA/DUA executed [11].
- Tele-ED/ICU site selection; privileging; protocols; QA measures [8].
- RPM cohort selection; logistics; digital navigator staffing; alerting thresholds [9].
- Pharmacy and FQHC integration; reconciliation workflow; patient engagement content [16].
- Evaluation design; dashboard templates; quarterly reporting cadence [11][16].

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[8] Rural Health Transformation Collaborative — Virtual care, workforce skilling, and program integration (Avel eCare; SI supports), Collaborative consensus PDF (uploaded 2025-10-11), pp. 8–11, 15.
[9] Rural Health Transformation Collaborative — BioIntelliSense RPM capabilities, Collaborative consensus PDF, pp. 15–16.
[10] Rural Health Transformation Collaborative — Humetrix consumer-facing triage/PHR and analytics, Collaborative consensus PDF, pp. 16–17.
[11] Rural Health Transformation Collaborative — Microsoft secure cloud/cyber (700+ rural hospitals), Collaborative consensus PDF, p. 17.
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15. AI Generation Notice This guide was generated with the gpt-5 model on 2025-10-14. It incorporates internal collaborative materials and public sources cited inline. All facts, figures, and citations must be independently validated against the official CMS-RHT-26-001 NOFO, CMS guidance, and current North Dakota policy before use in any submission.

Appendix: Gantt (expanded), KPI catalog, and formatting notes available on request.