title: Rural Health Transformation Grant Guide — Kentucky version: 1.0 date: 2025-10-14 audience: State health agencies, Medicaid, rural providers, collaboratives

1. Executive Summary Kentucky begins from a strong—but strained—rural health base: 41.3% of residents lived in rural areas in 2020; the state operates 29 Critical Access Hospitals (CAHs), 2 Rural Emergency Hospitals (REHs), over 400 Rural Health Clinics (RHCs), and more than 400 FQHC service sites in rural geographies as of 2025. These assets are distributed across Appalachia, the Ohio River valley, and Western Kentucky—regions where provider shortages, chronic disease burden, behavioral health needs, and cybersecurity risks intersect. The Rural Health Transformation (RHT) Program's cooperative agreement model and five-year funding horizon allow Kentucky to stabilize access, modernize infrastructure, and strengthen outcomes at scale, with technical scoring that rewards measurable progress and policy follow-through. (ncsl.org)

The RHT Collaborative can support Kentucky as an implementation engine—subject to contracting, interoperability, and governance—across three near-term priorities aligned to the NOFO: (1) rural clinical and digital infrastructure uplift (telehealth, remote monitoring, analytics, cyber hardening), (2) workforce recruitment/retention and tele-specialty support, and (3) consumer-facing chronic disease prevention and behavioral health integration through retail, community, and home-based access points. Capabilities include 24/7 tele-hospital services (Avel eCare), remote patient monitoring (BioIntelliSense), population analytics and triage (Humetrix, Pangaea Data), secure cloud and cybersecurity (Microsoft), and retail/telehealth access pathways (CVS Health, Walgreens, Walmart), coordinated by system integrators (Accenture, KPMG, PwC, AVIA) and rural provider networks (Cibolo Health).

This guide translates RHT NOFO requirements (deadlines, scoring, caps, reporting) into Kentucky-specific program designs. It maps where Collaborative offerings align to each technical factor, with policy dependencies (e.g., licensure compacts, CON modernization, payment arrangements) flagged for conditional points and sustainability provisions. All budget illustrations follow the NOFO's $200M/year planning placeholder and category caps (e.g., provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5%; administrative ≤10%). (files.simpler.grants.gov)

Kentucky's overdose mortality has now declined for three consecutive years—down 30.2% in 2024 to 1,410 deaths—yet fentanyl and methamphetamine remain pervasive. RHT funds, combined with Kentucky's 12-month Medicaid postpartum coverage and evolving 1115 authorities (TEAMKY; pending community engagement) can anchor maternal, behavioral health, and SUD care models with integrated analytics, remote monitoring, and tele-behavioral pathways, while protecting data and critical infrastructure. (justice.ky.gov)

1.1 One-page printable summary

- What RHT funds can do for Kentucky (subject to award and budget negotiation)
  - Stabilize rural access via tele-hospital (tele-ED/ICU/hospitalist), remote monitoring, and regional referral models; uplift cybersecurity for small facilities.
  - Expand retail/community access to prevention and chronic care; deploy multilingual triage and navigation; stand up rural provider High Value Networks for shared services and value-based arrangements.
  - Strengthen workforce with tele-mentoring, ambient documentation, and pipeline partnerships; align Medicaid payment and analytics for rural sustainability.
- RHT NOFO facts (for application compliance)
  - Eligibility: only the 50 states; DC/territories ineligible. Optional LOI by Sep 30, 2025; application due Nov 5, 2025; earliest start Dec 31, 2025. Cooperative agreement with substantial CMS involvement. (files.simpler.grants.gov)
  - Funds split: 50% baseline (equal among awardees) + 50% workload points; workload uses a published formula and Table 3 weights across rural/population and technical factors. (files.simpler.grants.gov)
  - Caps: provider payments ≤15%; Category J (capital/infrastructure) ≤20%; EMR replacement ≤5% (if HITECH-certified in place 9/1/2025); "Rural Tech Catalyst Fund" ≤ the lesser of 10% or $20M; admin ≤10%. (files.simpler.grants.gov)
- Kentucky context (selected 2025 metrics)
  - 41.3% rural residents (2020). 29 CAHs, 2 REHs, ~420 RHCs, ~414 rural FQHC sites. Medicaid postpartum extension to 12 months since 4/1/2022. 2024 overdose deaths 1,410 (−30.2% vs. 2023). (ncsl.org)
- Primary options (examples)
  - Rural hospital/clinic regional network with tele-ED/ICU and RPM; retail-pharmacy chronic care support; maternal-behavioral integration with postpartum RPM; community paramedicine with data-driven triage.

2. Eligibility and RFP Fit 2.1 Snapshot of NOFO requirements (excerpts)

- Applicant: State government only; Governor designates lead; one official application; AOR signature required. (files.simpler.grants.gov)
- Deadlines: LOI by Sep 30, 2025; application due Nov 5, 2025 11:59 p.m. ET; expected award and earliest start Dec 31, 2025. (files.simpler.grants.gov)
- Funds distribution: 50% baseline + 50% workload; workload funding = Total Available Workload Funding × State Points ÷ Sum of All States' Points. (files.simpler.grants.gov)
- Scoring: Table 3 weights across rural facility/population and technical factors (A.* and B–F.*) with conditional points for state policy commitments; initiative-based matrix (0–100 potential) informs later-year workload. (files.simpler.grants.gov)
- Caps and limitations: Category J ≤20%; provider payments ≤15%; EMR replacement ≤5% with prior HITECH; Rural Tech Catalyst ≤ the lesser of 10% or $20M; administrative ≤10%. Prohibitions include 2 CFR 200.216 telecom/video surveillance and specific clinical exclusions at 45 CFR 156.400. (files.simpler.grants.gov)
- Budget narrative: use $200M/year planning figure; show admin ≤10%; annualize FY26–FY31. (files.simpler.grants.gov)
- Cooperative agreement: CMS substantial involvement and monthly touchpoints; standard post-award reporting and monitoring. (files.simpler.grants.gov)

2.2 Requirement-to-Collaborative mapping (illustrative)

- Requirement: Telehealth/remote care adoption; cybersecurity uplift under "Tech innovation." Collaborative capability: Microsoft secure cloud and cybersecurity services; Avel eCare tele-hospital; integrators for deployment/PMO. Evidence: Collaborative member statements and role descriptions.
- Requirement: Chronic disease prevention/consumer tech. Capability: BioIntelliSense RPM; Humetrix multilingual triage/PHR; Topcon AI ophthalmic screening; retail clinic pathways via CVS/Walgreens/Walmart. Evidence: Collaborative catalog and member profiles.
- Requirement: Workforce recruitment/retention. Capability: ambient clinical documentation, tele-mentoring, pharmacy workforce pipelines; training curricula via NACHC; SI partners for workforce strategy. Evidence: Collaborative workforce sections.
- Requirement: Partnerships and provider networks. Capability: Cibolo-enabled High Value Networks; payer engagement; economic modeling and governance frameworks via integrators. Evidence: Collaborative governance/value sections.

3. Kentucky Context Snapshot 3.1 Needs and assets (selected)

- Rural residents: 1.86M (41.3%) in 2020. (ncsl.org)
- Facilities (2025): 29 CAHs; 2 REHs; ~420 RHCs; ~414 rural FQHC sites; ~41 rural PPS hospitals. Collaborative can support tele-specialty, RPM, and cyber uplift across these sites. (ruralhealthinfo.org)
- Workforce: KHA hospital vacancy rate fell to 8.9% in 2024 (RNs 11.5%); tele-mentoring, ambient documentation, and retail partnerships can reduce burden and extend capacity. (kyha.com)
- Medicaid and managed care: Anthem exited Kentucky Medicaid MCO market Jan 1, 2025; members transitioned to Humana or UHC—relevance for network continuity and data exchange. (chfs.ky.gov)
- Maternal health: Kentucky Medicaid and CHIP postpartum coverage extended to 12 months effective 4/1/2022 (SPA approvals). Tele-OB/RPM and perinatal care bundles can leverage this policy. (medicaid.gov)
- Behavioral health/SUD: Overdose deaths decreased 30.2% in 2024 to 1,410; fentanyl present in 62.3% of 2024 deaths. Continued integration of tele-behavioral and SUD treatments remains critical. (justice.ky.gov)
- Broadband/cyber: Many small rural facilities face resource-constrained cyber defense; Microsoft rural hospital cyber program and integrator support can help Kentucky facilities meet HHS Cybersecurity Performance Goals.
- Regulatory context: Kentucky maintains a Certificate of Need (CON) program (KRS Ch. 216B; 900 KAR 5 & 6), shaping facility/service expansion; policy levers could influence technical scoring (C.3). (regulations.justia.com)

3.2 Metrics-to-capability table (examples)

- Rural share (2020, 41.3%): supports Avel eCare tele-hospital coverage and RPM for dispersed populations; SI partners manage rollout. (ncsl.org)
- CAHs/REHs/RHCs/FQHCs (2025 counts): target endpoints for tele-ICU/ED, RPM pods, analytics feeds, and cyber tooling. (ruralhealthinfo.org)
- Hospital vacancies (2024: 8.9%): ambient documentation and tele-mentoring can support retention/quality.
- Postpartum extension (effective 2022): enables remote BP/glucose monitoring bundles and tele-perinatal consults. (medicaid.gov)
- Overdose trends (2024): informs resource targeting for tele-behavioral, SUD navigation, and community paramedicine. (justice.ky.gov)

Assumptions and Open Questions (for Kentucky's internal validation)

- Confirm the list and site addresses of Kentucky's Certified Community Behavioral Health Clinics (CCBHCs) as of Sep 1, 2025 (required NOFO attachment), and the most recent State Plan Rate Year count of hospitals receiving Medicaid DSH. (files.simpler.grants.gov)
- Validate county-level broadband/cyber posture and EMS coverage benchmarks to prioritize capital (Category J) within the 20% cap. (files.simpler.grants.gov)
- Confirm licensure compact participation (IMLC, PSYPACT) for scoring under D.2/D.3; Kentucky is an NLC member. (kbn.ky.gov)

4. Strategy Aligned to RFP 4.1 Model overview (conditional; non-prescriptive)

- Regional Rural High-Value Network (HVN): organize independent CAHs, REHs, RHCs, FQHCs, and county health departments into a state-enabled HVN for pooled services (tele-ED/ICU, pharmacy, analytics), with accountable governance and value-based alignment. Collaborative provides convening, program management office (PMO), data infrastructure, and payer engagement.
- Digital/hybrid access fabric: deploy tele-hospitalist/ICU coverage, eConsults, and RPM bundles for CHF/COPD/diabetes, integrated with multilingual triage and consumer navigation; retail partners host screening, immunization, and chronic care follow-ups.
- Cyber and data backbone: Azure-based secure data hub; facility-level cyber uplift mapped to HHS Cybersecurity Performance Goals; analytics for near-real-time program metrics.

4.2 Alignment to Table 3 technical factors (selected)

- C.1 Rural provider strategic partnerships: HVN formation, shared referral/tele-specialty pathways; PMO governance templates.
- C.2 EMS: tele-EMS consults and community paramedicine decision support (Avel eCare), data integration into state hub. ent: ambient documentation to reduce burnout; tele-mentoring; pharmacy pipelines with schools. /data/consumer tech: RPM (BioIntelliSense), secure cloud/HIE integrations (Microsoft), retail kiosks and apps (Humetrix, Topcon; CVS/Walgreens/Walmart). - Appalachian and Black communities disproportionately burdened by SUD and maternal risks. Combine retail/site-based screenings, mobile clinics, community health workers, and 12-month postpartum coverage with RPM and tele-behavioral consults; embed multilingual, low-literacy digital intake and navigation. (medicaid.gov)vacy
- HIPAA/FHIR-conformant architecture; governance for role-based access, consent, and 42 CFR Part 2 where applicable; support for TEFCA-aligned exchanges. tions (tuned to Kentucky) Option A. Rural hospital network with tele-ED/ICU + RPM
- Target: CAHs/REHs in high-transfer counties; CHF/COPD/diabetes populations.
- Problem data: 41.3% rural residents; vacancy pressures; transfer burden from lack of on-site specialty. (ncsl.org)nents: Avel tele-ICU/ED; BioIntelliSense BioButton RPM; Microsoft secure cloud/cyber; integrators for rollout and economics. gory B provider payments (≤15%) for gap-filling services; Medicaid value-based add-ons via SPA/contracting; capital in Category J (≤20%) for tele-ICU carts, telemetry upgrades.
- P(files.simpler.grants.gov)T: HVN governance + PMO; hospitalists/ICU e-coverage; data feeds to state hub.
- Pros/risks: reduces transfers/readmissions; risks include connectivity and change fatigue—mitigated by PMO and phased activation.

Option B. Maternal health and behavioral integration

- Target: postpartum individuals (12-month coverage), perinatal behavioral health. - (medicaid.gov)BP/glucose RPM; tele-MFM and tele-psych; multilingual triage; retail BP/checks and vaccinations; perinatal quality collaboratives. duplicative services; track impact on ED use and severe maternal morbidity; leverage managed care quality incentives.
- Pros/risks: addresses leading maternal risks; risk is care coordination across settings—mitigated via HVN and data hub.

Option C. Community paramedicine + tele-behavioral for SUD

- Target: counties with high overdose burden; re-engagement after nonfatal overdose. Declines in 2023–2024 create momentum. (justice.ky.gov)havioral consults; home-based RPM (withdrawal risks, vitals); linkage to MOUD; retail naloxone education.
- Payment logic: Category A/H/I; coordination with TEAMKY 1115 authorities for SUD.

(chfs.ky.gov)egrated chronic disease access

- Target: hypertension/diabetes in rural towns with pharmacy density.
- Components: pharmacy-enabled monitoring, point-of-care testing, referrals to tele-primary/specialty; AI-assisted identification of under-treated patients. re non-duplicative payments; use value-based

arrangements with targeted provider payments within ≤15% cap.

6.(files.simpler.grants.gov)llaborative Roles 6.1 Decision structure (illustrative)

- State lead agency (Governor-designated) holds the award, sets policy, and convenes stakeholders; Medicaid leads payment alignment; hospital association/FQHCs co-govern HVN(s); HIE/data entity operates the hub; integrators run PMO; technology/clinical partners execute under State direction. - PMO and reporting: State (A/R); Integrator (R); CMS (C). yment: HVN hospitals (A/R); Avel (R); State (C).
- RPM program: StateIntelliSense (R); payers (C); providers (R).
- Cyber uplift: Staterosoft (R); facilities (R); CMS (C).
- Retail integration:/hospitals (R); State (A); integrator (C).

7. Payment and Fundinonsistent with NOFO

- Use Category B payments (≤15%) only for non-duplicative, gap-filling services with measurable transformation impact; capitalize right-sized renovations/equipment under Category J (≤20%); admin ≤10%.
- Medicaid al(files.simpler.grants.gov)l episodes/global budgets where feasible; update SPAs and MCO contract attachments; actuarial modeling via integrators.

7.2 Budget ROM (illulanning figure; actual varies)

- Categories: A (prevention/RPM), B (gap payments ≤15%), D (training/TA), F (IT/cyber), G/I (care redesign/value models), J (capital ≤20%), K (partnerships), Admin (≤10%). Deliverables tied to initiative milestones and NOFO matrix.

8. Data, Measurement, an(files.simpler.grants.gov)sures: access (tele-visit adoption, transfer avoidance), quality (HEDIS, readmissions), maternal morbidity, SUD engagement, workforce retention, cyber posture; initiative-level milestones per NOFO scoring matrix.

- Data sources: Medicaid (files.simpler.grants.gov)EHR/RPM; EMS; social programs; consumer apps; all mapped to a secure cloud hub with consent/privacy controls.
- Evaluation: learniny dashboards; independent evaluations facilitated by data access agreements.

9. Implementation Plan ((files.simpler.grants.gov)cative) Gantt-style table (calendar quarters)

- Workstream; Start; End; Owner; Outputs
- PMO standing up; Q1-2026; Q2-2026; State/Integrator; Charter, governance, reporting plan.
- Data/cyber platformate/Microsoft; Secure hub, identity, logging, incident response.
- Tele-hospital cover; Q4-2026; HVN/Avel; Tele-ED/ICU SLAs, training, go-lives.
- RPM cohorts (CHF/COPD/DM, 3,000 pts); Q2lliSense/providers; Device distribution, protocols, dashboards.
- Retail chronic care pilots (20 sites); Q3cies/FQHCs; SOPs, eReferral, outcomes tracking.
- Maternal-behavioral integration pilots; Q3/FQHCs/hospitals; Tele-MFM/psych, RPM, equity metrics.

Procurement/legal: master services agreemet terms, cyber requirements; non-duplication SOPs for Category B; CON considerations for service line changes.

10. Risk Register (selected)

- C(files.simpler.grants.gov) Mitigation: Microsoft security baseline, 24/7 monitoring, incident playbooks; Owner: State CISO/facility CIO.
- RPM adoption fatigue; Mitigation: phased ambient documentation; Owner: Providers/PMO.
- MCO network transition disruptions; Mitigat, continuity mapping; Owner: Medicaid/MCOs.
- Policy commitments missed (conditional poin(chfs.ky.gov)islative calendar alignment, interim rules; Owner: State policy lead.
- Retail integration data gaps; Mitigation: con(files.simpler.grants.gov)PIs; Owner: Data hub lead.
- CON timing for service shifts; MitigationON office; Owner: State CON liaison.
- SUD linkage post-overdose; Mitigation: tele(regulations.justia.com) naloxone education; Owner: ODCP/Local partners.
- Workforce burnout; Mitigation: tele-mentori(justice.ky.gov)cheduling redesign; Owner: Providers/HVN.
- Budget caps exceeded; Mitigation: live cap finance; Reference caps.
- Reporting slippage; Mitigation: automated das(files.simpler.grants.gov)O; CMS engagement.

11. Draft RFP Response Language (paste-ready; (files.simpler.grants.gov)11.1 Rural health needs and target population (excerpt) “Kentucky’s rural population (41.3% in 2020) experiences higher chronic disease burden and provider shortages, with 29 CAHs, 2 REHs, ~420 RHCs, and >400 rural FQHC service sites serving dispersed communities. We will target high-need Appalachian and Western Kentucky counties for

initial activation, focusing on CHF/COPD/diabetes, maternal morbidity, and SUD recovery."

11.2 Goals and strategies (exc(ncsl.org)outcomes, technology, partnerships, workforce, data, and financial sustainability. Over FY26–FY31 we will reduce avoidable transfers and readmissions, improve BP and A1c control, and decrease severe maternal morbidity, leveraging tele-hospital coverage, RPM, multilingual triage, and cybersecurity uplift. We will pursue regulatory and contracting changes necessary for value-based alignment; we will track progress via initiative milestones and statewide dashboards."

11.3 Proposed initiatives (excerpt) "Initiross 10 CAHs; Category F/J/A; B.1, C.1, F.1–F.3; outcomes include 15% reduction in transfers and 10% reduction in 30-day readmissions by Q4-2027."

11.4 Implementation plan & timeline (excerpt) "We will operate tegrator support. Phase 0–1 (Q1–Q2 2026): PMO/cyber baseline; Phase 2–3 (Q2–Q4 2026): first 10 CAH tele-hospital activations, RPM cohorts; Phase 4–5 (2027): retail chronic care and maternal-behavioral integration scale."

11.5 Stakeholder engagement (excerpt) "We will convene hospitalsarmacies, payers, tribes/IHS (as applicable), universities, and community organizations, using HVN governance to sustain alignment."

11.6 Metrics & evaluation (excerpt) "We will provide quarterly de with CMS/third-party evaluations, using claims, EHR, RPM, EMS, and social data feeds into a secure hub."

12. References

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13. AI Generation Notice(regulations.justia.com)It may contain errors or omissions. All facts, figures, and citations must be independently validated against primary sources (e.g., CMS NOFO, state regulations, and official datasets) before use in planning or submission.