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

1. Executive Summary

South Dakota's rural profile—42.8% of residents living in Census-defined rural areas in 2020 and more than half of counties classified as maternity care deserts—creates both urgency and opportunity for the Rural Health Transformation (RHT) Program. The RHT Collaborative can support a state-led strategy that emphasizes right-sizing rural service lines, expanding virtual care and EMS supports, modernizing data and cybersecurity, and building durable provider networks with rural governance. These capabilities align with RHT uses of funds and timelines posted by CMS in September 2025 (applications due early November 2025; awards by December 31, 2025). (ncsl.org)

Three offerings have near-term leverage for South Dakota: (1) statewide tele-ER/tele-ICU/tele-behavioral expansion for Critical Access Hospitals (CAHs) and EMS leveraging Avel eCare's 24/7 model and law-enforcement crisis support; (2) chronic condition management combining remote physiologic monitoring (BioIntelliSense) with retail pharmacy engagement (CVS Health, Walgreens) and FQHC primary care; and (3) cyber-secure, FHIR-based data infrastructure on Microsoft platforms with program dashboards and grant compliance tooling from systems integrators (Accenture, KPMG, PwC). These capabilities are described in the Collaborative's member catalog and map to the RHT Program's "Make rural America healthy," "Sustainable access," "Workforce development," "Innovative care," and "Tech innovation" goals.

Financially, RHT funds are cooperative agreements—~$50B nationally over FY26–FY30, with equal baseline and workload-weighted components—and must be used across approved categories (e.g., prevention/chronic disease, workforce, IT/cyber, innovative care models). South Dakota can pair these federal dollars with its Medicaid health homes and state workforce incentives to maximize measurable outcomes while respecting federal administrative, telecom, and other grant restrictions. (cms.gov)

The approach outlined is conditional and dependent on state policy decisions (e.g., scope of practice, EMS act updates), contracting, data-sharing agreements, and integration with tribal/IHS systems. Where the federal NOFO text is not public, we note assumptions for verification before submission.

One-page printable summary (for distribution)

- What RHT funds can support: At least three of the federal categories (prevention/chronic disease; provider payments as specified; consumer tech; training/TA for telehealth/AI/robotics; workforce recruitment/retention; IT/cyber; right-sizing service lines; behavioral health/SUD; innovative/value-based care; capital/equipment/minor renovation; partnerships). (cms.gov)
- Why South Dakota: 42.8% rural population (2020); 56.1% of counties are maternity care deserts; overdose death rate 11.2 per 100,000 (2022); strong CAH and RHC footprint; BEAD initial proposal approved Aug 2024; EMS "Telemedicine in Motion" in 84% of agencies reported in 2025. (ncsl.org)
- Collaborative support examples (conditional on contracting/integration): 24/7 tele-ER/ICU/psych for CAHs/EDs (Avel eCare); BioIntelliSense continuous monitoring; pharmacy-enabled adherence and chronic care programs; cybersecurity hardening and interoperable data exchange; program management, dashboards, and economic modeling; formation of rural High Value Networks (HVNs).
- Governance: State-led steering, rural provider HVNs for accountability, tribal/IHS engagement, payer alignment for value-based models; monthly CMS coordination per cooperative agreement norms.
- Timeframe: Application due early Nov 2025; anticipated awards by Dec 31, 2025; program monitoring begins Q1 2026. (cms.gov)

2. Eligibility and RFP Fit

2.1 Snapshot of federal opportunity (verify NOFO text upon release)

- Eligible applicant: One application per U.S. state; DC/territories ineligible. Governor designates lead; submission through Grants.gov. (cms.gov)
- Calendar: CMS indicates applications close in early November 2025 and awards by December 31, 2025; CMS hosted applicant webinar(s) on September 19, 2025. (cms.gov)
- Funds: ~$50B across FY26–FY30; 50% baseline, 50% workload factors specified by CMS in NOFO; allowable uses listed in Section "Uses of Funds." (cms.gov)
- Compliance anchors: 2 CFR Part 200 and HHS Grants Policy Statement; prohibition on certain telecom/video surveillance (2 CFR 200.216). (ahrq.gov)
- Policy note: HHS finalized a definition at 45 CFR 156.400 for "specified sex-trait modification procedure," with related EHB exclusion timing in §156.115(d) beginning PY 2026; applicants should avoid conflicts with federal exclusions when designing any provider payments or coverage gap pilots. (downloads.regulations.gov)

Assumption: Detailed scoring weights, caps (e.g., provider payments, capital), and form-level instructions are

contained in CMS-RHT-26-001 NOFO. Grants.gov shows the opportunity posted; the publicly accessible CMS overview and presentation confirm structure and timelines. South Dakota should confirm caps and scoring tables directly against the final NOFO PDF prior to submission. (cms.gov)

2.2 Requirement–Capability–Evidence mapping

- Requirement: Use funds across ≥3 categories (prevention/chronic disease; workforce; telehealth/AI; IT/cyber; behavioral health/SUD; innovative/value-based care; capital/equipment; partnerships).
    - Collaborative capability: Combined RPM (BioIntelliSense), virtual care (Avel eCare, Teladoc), pharmacy engagement (CVS, Walgreens), secure cloud/data and cybersecurity (Microsoft), program management and analytics (Accenture/KPMG/PwC), HVN formation (Cibolo Health).
    - Evidence: Collaborative member catalog and use-case descriptions.
- Requirement: Rural service right-sizing and EMS support.
    - Capability: Tele-ER/ICU; EMS virtual support; crisis response; service-line analytics.
    - Evidence: Avel eCare tele-hospital, EMS and crisis models; SI analytics for service-line planning.
- Requirement: Data interoperability, reporting, and cybersecurity.
    - Capability: HIPAA/FHIR-aligned platforms; dashboards for KPIs; Microsoft rural cyber program; SI PMO and grants reporting support.
    - Evidence: Collaborative claims; Microsoft 700+ rural hospitals supported; dashboards and governance support.
- Requirement: Behavioral health/SUD access.
    - Capability: Tele-behavioral network (Cibolo Health, Teladoc), 988 support implementation experience (Accenture), overdose risk notifications (Humetrix).
    - Evidence: Collaborative catalog on BH/SUD tools and 988 operations.
- Requirement: Partnerships, workforce recruitment/retention.
    - Capability: HVNs for member-owned rural provider governance (Cibolo Health); pharmacy workforce pipelines; ambient documentation to reduce burnout.
    - Evidence: Collaborative member profiles.

3. South Dakota Context Snapshot (selected 2024–2025 facts; all stats state year and source)

- Rural share: 42.8% of residents live in rural areas (2020 Census). (ncsl.org)
- Maternity care access: 56.1% of SD counties are maternity care deserts (2024), and 23.7% of women have no birthing hospital within 30 minutes. The Collaborative can support virtual maternal consults, RPM in late pregnancy, and pharmacy-facilitated hypertension monitoring. (marchofdimes.org)
- Drug overdose mortality: 11.2 deaths per 100,000 (2022). Behavioral telehealth and SUD coordination tools can support earlier intervention. (cdc.gov)
- Facility mix (outside large urban areas): 40 CAHs; 57 RHCs; FQHC presence statewide (HRSA sites). These are natural anchors for tele-ER/ICU, RPM, and pharmacy-linked chronic care. (July 2025) (ruralhealthinfo.org)
- Broadband and digital readiness: BEAD Initial Proposal approved Aug 29, 2024; state ConnectSD investments since 2019 connected 30,000+ locations by mid-2023; June 2025 guidance to assess ULFW coverage. These conditions support remote care and data exchange if paired with cybersecurity and device deployment. (ntia.gov)
- EMS: “Telemedicine in Motion” tablets deployed in ~84% of ambulance agencies reported July 2025; Avel eCare law-enforcement crisis support can complement this footprint. (southdakotasearchlight.com)
- Medicaid: Expansion effective July 1, 2023 (SPA approved 5/23/2023). South Dakota operates Medicaid health homes; comprehensive risk-based MCO penetration remains limited relative to national averages; state pursued but withdrew 1115 “Career Connector” waiver in 2025. Analytics and value-based constructs can be layered through SPAs/contracting without requiring full-risk MCOs. (medicaid.gov)
- Rural/frontier designation: SD DOH notes 30 rural and 34 frontier counties (Nov 2024), underscoring right-sizing needs and telehealth roles. (doh.sd.gov)

Table—Selected metrics and candidate Collaborative supports

- Rural residents (2020): 42.8% (NCSL/Census) → HVN structure, tele-ER/ICU, RPM, pharmacy care. (ncsl.org)
- Maternity care deserts (2024): 56.1% counties (March of Dimes) → virtual OB consults, RPM, pharmacy BP monitoring. (marchofdimes.org)

- Overdose death rate (2022): 11.2/100k (CDC) → tele-BH, risk alerts, 988 integration. (cdc.gov)
- CAHs (2025): 40; RHCs: 57 (RHIhub/HRSA) → tele-hospitalist/ICU, RPM hubs. (ruralhealthinfo.org)
- Broadband: BEAD approval (2024); 30k+ locations connected (2019–2023) → remote monitoring scaling; cybersecurity. (ntia.gov)
- EMS: 84% agencies tablet-enabled (2025) → teleconsult at scene; triage to avoid unnecessary transports. (southdakotasearchlight.com)

4. Strategy Aligned to RFP

4.1 Model overview (state-directed; conditional on policy/contracting)

- Access and outcomes: Deploy tele-ER/ICU/psychiatry across all CAHs/EDs and EMS; embed RPM for CHF/COPD/diabetes; expand pharmacist-supported chronic care; integrate behavioral crisis response.
- Technology and data: State data platform (HIPAA/FHIR) with role-based dashboards; statewide identity and consent flows; rural cybersecurity hardening; TEFCA-aligned exchange through designated QHINs (e.g., eClinicalWorks designated Jan 2025). (sequoiaproject.org)
- Workforce: Ambient documentation, tele-mentoring, pharmacy workforce pipelines, and rural recruiting supports; align with state RHFRAP incentives where applicable.
- Financial sustainability: Value-based constructs (rural ACO networks/HVN shared savings), bundled chronic care, and targeted provider payments within federal caps.

4.2 Alignment to scoring pillars (selected examples; verify NOFO scoring table)

- Prevention/chronic disease: BioIntelliSense RPM + pharmacy adherence programs show capacity to reduce admissions/readmissions and improve hypertension/diabetes control—outcome metrics consistent with RHT goals.
- Partnerships: Member-owned HVNs convened by Cibolo Health to coordinate investments and track outcomes statewide.
- EMS and right-sizing: Tele-ER and hospitalist support; service-line analytics for obstetrics, inpatient rehab, swing beds, to avoid overextension.
- Data/cyber: Microsoft rural cyber experience with 700+ rural hospitals and dashboards for KPIs and grant reporting.

4.3 Equity for rural and Tribal communities

- Integrate IHS/Tribal clinics into data sharing and outreach; leverage CMS guidance and state SPA approvals to support care beyond clinic walls. (cms.gov)
- Multilingual consumer tools and culturally informed navigation (Humetrix) to reduce access barriers.

4.4 Privacy and security

- Conformance with HIPAA, FHIR, TEFCA exchange via designated QHINs; state adoption of 2 CFR 200.216 telecom prohibitions in procurement. (sequoiaproject.org)

5. Program Design Options (state-selectable; not prescriptive)

Option A: Tele-ER/ICU + EMS Virtual Support Network

- Target: All CAHs/EDs; EMS agencies, especially frontier counties.
- Problem: Limited specialty access, workforce burnout, avoidable transfers; 84% EMS tablet coverage (2025) indicates foundation. (southdakotasearchlight.com)
- Components: Avel eCare tele-ER/ICU/psychiatry; hospitalist backup; crisis co-response; EMS teleconsult.
- Payment logic: Time-limited provider payments (≤ NOFO cap, verify), avoided transfer/shared savings models, and DRG/CAH-aligned support.
- Enabling policy: State EMS protocols for teleconsult; cross-facility credentialing compacts; data-use MOUs.
- Partners/IT: Avel eCare; Microsoft cloud/cyber; SI dashboards.
- Pros/risks: High access impact; risk—change management and 24/7 coverage sustainability; mitigation—HVN governance and phased rollout.

Option B: Statewide Chronic Care Acceleration (RPM + Pharmacy Care)

- Target: Adults with CHF, COPD, diabetes, hypertension across CAHs, RHCs, FQHCs; high-risk postpartum hypertension.
- Problem: Rural chronic disease burden and maternal HTN; 56.1% maternity desert counties. (marchofdimes.org)
- Components: BioIntelliSense RPM; pharmacist-enabled monitoring and medication therapy management

(CVS/Walgreens); tele-primary/specialty e-consult; multilingual self-management apps.
- Payment logic: Care-management PMPM; outcomes-based pharmacy incentives; gap-filling provider payments per NOFO limits (verify cap).
- Policy: Pharmacist scope and standing orders where permissible; SPA updates for RPM billing if needed.
- Pros/risks: Reduced admissions/ED; risk—device logistics and broadband; mitigation—BEAD alignment and device inventory; cyber controls. (ntia.gov)

Option C: Rural Maternal Health and Newborn Safety Collaborative

- Target: Frontier counties lacking OB units.
- Problem: 23.7% of women lack a birthing hospital within 30 minutes. (marchofdimes.org)
- Components: Tele-OB consults; RPM for BP/weight; community pharmacy BP checks; transport protocols; doula/community health worker training; perinatal mental health virtual care.
- Payment: Bundled prenatal-postpartum episodes; targeted provider payments within cap; value-based newborn outcomes metrics.
- Partners: Avel eCare; retail pharmacies; FQHCs; tribal/IHS; SI evaluation.

Option D: Rural High Value Network (HVN) Formation & Data Modernization

- Target: Independent CAHs/RHCs/FQHCs and small systems statewide.
- Components: Member-owned HVN with shared analytics, contracting, workforce pipeline, cybersecurity uplift, and grant reporting; TEFCA connectivity.
- Payment: Shared savings and global budgets pilots with CMS technical assistance (align to RHT innovative care).
- Pros/risks: Scale and accountability; risk—governance alignment; mitigation—charter and RACI, transparent dashboards.

Primary recommendation (conditional): Combine A+B statewide under HVN governance, phased by region; C as a targeted pilot in frontier clusters.

6. Governance and Collaborative Roles

6.1 Conceptual diagram (textual)

- State lead agency (Governor-designated) sets policy, approves portfolio, oversees PMO.
- HVN Board (rural providers) stewards funds and outcomes at network level.
- Medicaid agency aligns payment models/SPAs; DOH EMS/Office of Rural Health leads EMS integration and workforce programs.
- HIE/QHIN connections for data exchange.
- Collaborative members deliver technology, clinical services, program management, and analytics under state contracts.

6.2 RACI (abbrev.)

- Portfolio strategy: State (R), Medicaid (A), HVN (C), Collaborative SIs (C), Payers (C).
- Tele-ER/ICU deployment: HVN (A), Avel eCare (R), CAHs (R), State (C).
- RPM + pharmacy: HVN (A), Providers (R), BioIntelliSense/Pharmacies (R), Medicaid (C).
- Data/cyber platform: State CIO/HIE (A), Microsoft (R), SI (R), HVN (C).
- Evaluation/reporting: State PMO (A), SI (R), HVN (C), CMS (I).

7. Payment and Funding

- RHT structure: Cooperative agreements; half baseline, half workload; awards in five periods (FY26–FY30). Uses of funds specified by CMS; federal grants rules apply (2 CFR; HHS GPS). (cms.gov)
- Medicaid alignment: Use health home, SPA for RPM coverage and pharmacist services where allowed; evaluate HVN shared-savings constructs; avoid funding prohibited telecom per 2 CFR 200.216. (law.cornell.edu)

Illustrative cost categories (rough order of magnitude; contingent on award size and NOFO caps; verify final limits)

- Clinical services enablement (tele-ER/ICU/psych; RPM kits): RHT funds; provider payments within NOFO cap; deliverables: live coverage, avoided transfers, RPM adherence.
- IT/cyber/data platform and dashboards: RHT funds; deliverables: data exchange, KPI reporting.
- Workforce skilling and ambient AI: RHT funds; deliverables: training completions, documentation time saved.
- Capital/equipment (minor renovations/equipment): RHT funds within any cap; deliverables: tele-exam rooms, network upgrades.

- Partnership development (HVN setup): RHT funds; deliverables: governance charter, payer MOUs.

8. Data, Measurement, and Evaluation

- Core measures: Access (tele-ED response times; OB consult availability); Quality (HEDIS-like control rates; readmissions); Financial (transfer rate, LOS, avoidable ED); Workforce (vacancy/turnover, time on documentation); Technology (security incident rates, TEFCA transactions).
- Data sources: Claims (Medicaid, Medicare as available), EHRs (FQHCs, CAHs), EMS run data, pharmacy systems, public health registries, and HRSA HPSA dashboards; integrated via HIPAA/FHIR platforms; TEFCA QHIN connections for cross-system records. (data.hrsa.gov)
- Evaluation approach: Baselines in FY26 Q1; quarterly dashboards; annual independent review aligned to CMS continuation requirements; learning collaboratives hosted with NACHC and SIs.

9. Implementation Plan (12–24 months; contingent on awards and procurement)

Gantt-style overview (illustrative)

- Workstream; Start; End; Owner; Outputs
- Governance and charter; Jan 2026; Mar 2026; State/HVN; HVN charter, bylaws
- Data/cyber platform; Jan 2026; Oct 2026; State/SI/Microsoft; secure cloud, FHIR APIs, role-based dashboards
- Tele-ER/ICU wave 1 (15 CAHs); Mar 2026; Sep 2026; HVN/Avel; 24/7 coverage, protocols
- Tele-ER/ICU wave 2 (remaining CAHs); Oct 2026; Jun 2027; HVN/Avel; statewide coverage
- RPM cohort 1 (2,500 pts); Apr 2026; Sep 2026; Providers/BioIntelliSense; kits deployed, care plans
- RPM cohort 2 (expand to 7,500 pts); Oct 2026; Jun 2027; Providers/BioIntelliSense; expanded enrollment
- Pharmacy chronic care pilots (10 counties); Apr 2026; Dec 2026; Pharmacies/HVN; adherence and BP control programs
- Maternal care pilot (frontier cluster); Apr 2026; Dec 2026; Providers/Avel/Pharmacies; tele-OB pathways
- Evaluation and reporting; Apr 2026; ongoing; SI/State; quarterly KPI, annual CMS report

Key gates: cyber ATO; first 90-day tele-ER performance; RPM adherence >70% by 6 months; payer MOUs; Medicaid SPA as needed.

Procurement/legal: Master services agreements with Collaborative vendors; data-sharing/BAA; tribal consultation for data exchange; telecom compliance per 2 CFR 200.216. (law.cornell.edu)

10. Risk Register (selected)

- Broadband gaps in frontier areas → Mitigation: prioritize BEAD-covered locations; offline-capable kits; cellular failover. Owner: State CIO. (ntia.gov)
- Cyber threats to small facilities → Mitigation: Microsoft rural cyber program uplift; MFA, EDR; incident playbooks. Owner: State/HVN.
- Workforce fatigue/resistance → Mitigation: staged onboarding; ambient documentation; tele-mentoring. Owner: HVN.
- Policy misalignment (scope of practice) → Mitigation: targeted state updates; pharmacist protocols; legal review. Owner: State/Boards.
- EMS adoption variance → Mitigation: leverage Telemedicine in Motion baseline; EMS CME and protocols. Owner: DOH EMS. (southdakotasearchlight.com)
- Maternal pilot acceptance → Mitigation: local champions; community health workers; culturally informed consent. Owner: Providers/IHS.
- Data-sharing constraints with tribal/IHS → Mitigation: SPAs/agreements; TEFCA-aligned exchange. Owner: Medicaid/IHS. (cms.gov)
- Financial sustainability post-grant → Mitigation: value-based payer contracts; HVN shared savings; OPEX budgeting. Owner: HVN/Payers.
- Compliance with evolving federal exclusions (e.g., §156.115/156.400) → Mitigation: legal review of any funded services; monitor rulemaking. Owner: PMO. (law.cornell.edu)
- Grant administrative burden → Mitigation: SI PMO support; automated KPI dashboards; adherence to HHS GPS. Owner: State/SI. (ahrq.gov)

11. Draft RFP Response Language (South Dakota—editable inserts; conditional)

11.1 Rural health needs and target population “South Dakota has a high rural share (42.8% in 2020) and a majority of counties (56.1%) lacking full maternity care access. We will initially target frontier counties and CAH service areas with elevated rates of chronic disease and limited specialty access. Baselines include a state drug overdose death rate of 11.2 per 100,000 (2022).” (ncsl.org)

11.2 Goals and strategies “We will implement a statewide tele-ER/ICU network, expand remote physiologic monitoring for chronic disease, stand up pharmacy-enabled adherence programs, and deploy a secure,

TEFCA-aligned data platform. Our goals map to CMS RHT strategic goals and the Uses of Funds described in the CMS RHT overview and presentation." (cms.gov)

11.3 Proposed initiatives and uses of funds "Initiative 1 (Tele-ER/ICU): category H (behavioral health), I (innovative care), F (IT/cyber); Initiative 2 (Chronic Care/RPM): categories A, C, D; Initiative 3 (Maternal Frontier Pilot): categories A, H; Initiative 4 (HVN & Data Modernization): categories F, K. Measurable outcomes include reductions in transfers and readmissions, improved hypertension control, and reduced time to specialist consult." (cms.gov)

11.4 Implementation and timeline "Following award (anticipated by Dec 31, 2025), we will finalize contracting, complete security accreditation, and begin wave 1 deployments by Q2 2026. We will provide quarterly progress reports and annual continuation requests per CMS requirements." (cms.gov)

11.5 Stakeholder engagement "We will establish an HVN governance structure with rural providers, FQHCs, tribal/IHS partners, payers, EMS, and retail pharmacies. Engagements will include listening sessions and performance dashboards accessible to participants."

11.6 Metrics and evaluation "We will track access, quality, financial, workforce, and technology measures using claims, EHR, EMS, and pharmacy data. We agree to cooperate with CMS and third-party evaluators and follow HHS GPS and 2 CFR." (ahrq.gov)

Assumptions and Open Questions (to verify before submission)

- Final NOFO PDF sections on scoring weights, category caps (e.g., provider payment, capital), and administrative cost ceilings. (Grants.gov listing confirms posting; CMS overview confirms timelines.) (cms.gov)
- Medicaid SPA needs for RPM and pharmacist services (verify existing state policy).
- Alignment with federal exclusions at 45 CFR 156.115(d)/156.400 as finalized for PY 2026. (law.cornell.edu)

12. References

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18. HRSA data.hrsa.gov—Health Workforce Shortage Areas (dashboard overview), accessed 2025-10-14. (data.hrsa.gov)
19. South Dakota DOH—National Rural Health Day release (rural/frontier counties), 2024-11-21, accessed 2025-10-14. (doh.sd.gov)

20. The Sequoia Project—QHIN designation (eClinicalWorks added Jan 2025), accessed 2025-10-14. (sequoiaproject.org)

Internal (Collaborative) sources I1) Rural Health Transformation Collaborative. R1. 10-11-25.pdf (member capabilities, examples, and roles; multiple sections cited).

13. AI Generation Notice

This guide was generated on 2025-10-14 using the gpt-5 model. It contains AI-assisted drafting based on public sources and internal Collaborative materials cited herein. All facts, figures, regulatory interpretations, and citations must be independently validated against the final CMS-RHT-26-001 NOFO, state and federal statutes/regulations, and authoritative datasets before use in any official submission.