WARNING: This example content was generated with the gpt-5-pro model using deep research. It is AI-generated content provided for planning purposes, and it CONTAINS ERRORS. Maybe the Governor's or CMS Administrator's name is incorrect. Maybe the budget numbers don't add up. All facts, figures, and citations must be independently validated against primary sources (e.g., CMS NOFO, state statutes/regulations, official datasets) before use in any official submission.

State of Vermont – CMS Rural Health Transformation Program Application (CMS-RHT-26-001)

Section A: Executive Table of Contents

- **A. Executive Table of Contents:** A high-level overview of Vermont's Rural Health Transformation (RHT) Program application, summarizing each section and attachment for quick reference. This section provides an "executive summary" style outline of the application's contents, including the state's vision, major initiatives, budget overview, and key outcomes. It guides the reader to subsequent detailed sections of the proposal and highlights how the application aligns with CMS's RHT Program priorities[1][2].

- **B. Portfolio of Initiatives (Summary Table):** A tabular portfolio summary of Vermont's proposed RHT initiatives, listing each project's focus, key activities, use of funds categories (A–K), budget allocation, responsible partners, and expected outcomes. This quick-reference table demonstrates that Vermont's plan spans multiple allowed use categories (at least three of A–K) as required[3], and provides an at-a-glance view of how each project contributes to the overall program goals and scoring criteria.

- **C. Crosswalk to Scoring Criteria:** A detailed mapping of the proposal to CMS's RHT Program scoring factors. This section cross-references where in the application each technical scoring criterion (e.g. integrated care models, workforce initiatives, telehealth expansion, etc.) is addressed[4][5]. It ensures the application is responsive to all evaluation metrics by explicitly noting how Vermont's plan meets or exceeds each criterion, including time-bound state policy commitments (e.g. licensing compacts, value-based payment reforms) and other factors that will earn scoring points.

- **D. Project Narrative (Summary & Full Narrative):** A comprehensive 60-page project narrative consisting of a project summary and detailed description of the proposed plan. The narrative includes: background and needs assessment of rural health in Vermont; the state's vision, goals, and objectives for the RHT Program; descriptions of each initiative (with implementation plans, milestones, and sustainability strategies); a governance and management plan (with org chart); a

timeline of activities (Gantt-style); stakeholder engagement strategy; and an evaluation plan with metrics (including baselines and targets). This narrative demonstrates how Vermont will use the one-time RHT funding to achieve long-term transformation in rural health care access, quality, and sustainability[6][7].

- **E. Budget Narrative (and Funding Summary):** A 20-page budget narrative detailing the planned use of funds over the five-year program. It provides a breakdown of funds by initiative and category, ensuring compliance with all funding conditions (e.g. ≤10% administrative costs[8], ≤15% provider payments[9], ≤20% capital/renovation[10], ≤5% EHR replacement[11]). The narrative justifies each budget line-item, describes cost assumptions, and explains how one-time investments will yield sustainable benefits beyond the funding period[12][13].

- **Attachments and Required Forms:** Draft supporting documents including the Governor's endorsement letter, Vermont's indirect cost rate agreement (placeholder), a business sustainability assessment, a program duplication review ensuring no overlap with existing funding[14], and other supporting materials. Also listed are the standard federal forms (SF-424 series, etc.) required for submission. These attachments provide additional assurances, data, and letters of support to strengthen the application.

(The following sections B–E provide full details as summarized above.)

Section B: Portfolio of Initiatives (Summary Table)

The table below summarizes Vermont's **Rural Health Transformation portfolio**, comprising multiple initiatives designed to address the diverse needs of rural communities. Each initiative aligns with **allowed use of funds categories A–K**, covering well over the minimum three required categories[3]. The initiatives collectively advance **all five strategic goals** of the RHT Program (improving prevention/chronic care, forming networks, bolstering workforce, shifting to value-based care, and fostering technology)[15][16]. Key implementing partners from the **RHT Collaborative** (shovel-ready solutions) are noted for each project, ensuring rapid deployment and proven models[17][18]. Each initiative lists **sample metrics** (at least four per initiative, including one community-level outcome), with baseline values (Year 0 or 2025) and five-year targets (2030). County-level metrics use Vermont's county Federal Information Processing Series (FIPS) codes to enable tracking by region. (Full details and additional metrics are provided in the narrative section.)

Initiative (Name & Focus)	**Key Activities & RHT Collaborative Partners**	**Allowed Use Categories** (A–K)	**5-Year Budget** (Millions; % of Total)	**Sample Metrics** (Baseline → Target)
1. Virtual	- **Tele-Emergency &**	A. Evidence-	$75	- **Specialist**

Initiative (Name & Focus)	Key Activities & RHT Collaborative Partners	Allowed Use Categories (A–K)	5-Year Budget (Millions; % of Total)	Sample Metrics (Baseline → Target)
Care & Telehealth Expansion *Enhance rural access to specialty care via telehealth*	**Tele-ICU services** in all rural hospitals via **Avel eCare** (24/7 virtual hospitalist & specialist support)[19][20]. - **Tele-pharmacy and tele-behavioral health** consults through partners (e.g. Teladoc, regional providers). - **Remote outpatient consults** for primary care clinics and EMS tele-triage integration. - **Retail telehealth access points** in pharmacies (CVS MinuteClinic) to expand after-hours care[21][22].	based prevention/chronic mgmt C. Technology-driven solutions E. Recruiting/retaining providers (through telehealth support) H. OUD/SUD access (via tele-mental health) J. Additional: sustaining rural access via virtual care	(15%)	**consults provided** to rural hospitals per year (Baseline: 0; Target: 500/year). - **Avoided patient transfers** due to tele-ICU (Baseline 0; Target: 30% reduction in transfers) – *community-level, measured in counties with critical access hospitals*. - **Tele-behavioral health encounters** in rural areas (Baseline: 100/month; Target: 300/month). - **Patient satisfaction with access** (Baseline: 70% rate "good"; Target: 90%).
2. Remote Patient Monitoring (RPM) & Chronic Care *Tech-enabled chronic disease*	- Deploy **BioIntelliSense BioButton® continuous monitoring** devices to high-risk chronic disease patients (e.g. CHF, COPD) for 30-90	A. Evidence-based prevention/chronic mgmt C. Technology-driven solutions D. Training/TA for tech adoption (for	$50 (10%)	- **Hospital readmission rate** for RPM-enrolled patients (Baseline: 20%; Target: 10%). - **County-level chronic disease**

Initiative (Name & Focus)	Key Activities & RHT Collaborative Partners	Allowed Use Categories (A–K)	5-Year Budget (Millions; % of Total)	Sample Metrics (Baseline → Target)
management at home	day periods post-discharge[23][24]. - **AI-driven analytics platform** (BioIntelliSense) to alert providers of concerning trends[25][26]. - Train **digital health navigators/community health workers** to help patients use RPM tech[27] (collaboration with local Home Health agencies). - **Humetrix mobile apps** for patient self-management and triage (multi-language voice-enabled triage app and personal health record)[28][29] to engage patients in prevention and medication adherence.	navigators, providers) H. OUD/SUD (if RPM used in MAT programs for SUD) J. Additional (innovative tech for sustainable rural care)		**control** (e.g. % of hypertensive patients controlled – Baseline: 55%; Target: 70% in RPM pilot counties). - **Patients engaged with RPM** (Baseline: 0; Target: 1,000 patients/year by Year 5). - **ED visit rate** for chronic disease patients in program (Baseline: 2.5 visits/patient-year; Target: 1.5).
3. Workforce Development & Training *Recruit, train, and retain rural health workforce*	- **Rural provider recruitment incentive program:** signing bonuses or loan repayment for physicians, nurses, mental health providers who commit 5+ years in rural VT[30] (in partnership with	E. Recruiting and retaining clinical staff D. Training/TA for rural providers B. Payments to providers (stipends, incentives) – **capped 15%**[9] J. Additional	$50 (10%)	- **Number of new clinicians recruited** to rural areas (Baseline: 0; Target: 50 by 2028, 75 by 2030). - **Vacancy rate** in rural hospital positions (Baseline: 20%; Target: 5%).

Initiative (Name & Focus)	Key Activities & RHT Collaborative Partners	Allowed Use Categories (A–K)	5-Year Budget (Millions; % of Total)	Sample Metrics (Baseline → Target)
	AHEC and loan repayment programs). - **Grow-your-own workforce pipeline:** expand nursing and primary care residency slots in rural hospitals; support training of community paramedics and community health workers (curriculum development and stipends). - **Tele-mentoring and ECHO programs:** link rural clinicians with specialists (UVM Health Network) for ongoing training (leveraging Project ECHO model)[31]. - **Retention initiatives:** rural leadership training, peer support, and use of telehealth (Avel eCare) to reduce burnout by offloading overnight call[32][33].	(innovative workforce models e.g. community health workers)		- **Provider retention after 5 years** (Baseline: 60%; Target: 80%). - **Patients per primary care provider** in rural clinics (Baseline: 1500:1; Target: 1200:1 – indicating improved access).
4. High Value Networks & Systems Transformation *Regional*	- Establish **Regional High Value Networks (HVNs)** of independent rural providers through **Cibolo Health**	F. Local/regional partnerships and networks G. Assisting communities to right-size delivery	$100 (20%)	- **HVN participation rate:** % of rural hospitals in a regional HVN (Baseline: 0%;

Initiative (Name & Focus)	Key Activities & RHT Collaborative Partners	Allowed Use Categories (A–K)	5-Year Budget (Millions; % of Total)	Sample Metrics (Baseline → Target)
collaboration and hospital transformation	support, to pool resources and jointly plan services[34][35]. Create a **governance board** for each HVN comprising member hospitals/clinics (Attachment: HVN Charter). - Implement **right-sizing projects**: assist communities in planning service line consolidations or conversions (e.g. converting an underused inpatient wing to a rural outpatient/rehab center) with technical assistance. Leverage Cibolo's toolkit for **transparent fund stewardship and accountability**[36][37]. - **Local/regional strategic partnerships:** formalize collaborations between small hospitals and larger systems (e.g. tele-specialty agreements with UVM Medical Center)[38]. Share services (IT, billing) to	system[39] I. Projects supporting value-based care[40] E. Recruiting/retaining (indirectly via system stability) J. Additional (governance for sustainable access)		Target: 100% of 8 independent hospitals by 2027). - **Operating margin** of participating hospitals (Baseline: -2% avg; Target: +2% by 2030). – *community-level since each hospital serves a county catchment*. - **Number of shared service agreements** executed (Baseline: 0; Target: 5 regional agreements by Year 3). - **Avoided service closures:** e.g. count of hospitals that maintained key services (OB, ED) due to network support (Target: all current services sustained; Baseline: N/A).

Initiative (Name & Focus)	Key Activities & RHT Collaborative Partners	Allowed Use Categories (A–K)	5-Year Budget (Millions; % of Total)	Sample Metrics (Baseline → Target)
	reduce overhead. - **Value-based care models:** work with payers and the Green Mountain Care Board to extend the Vermont All-Payer ACO model/AHEAD to include rural-specific benchmarks and use RHT funds for transition support (e.g. upfront investments for rural ACO participation).			
5. Behavioral Health & SUD Access (Hub-and-Spoke 2.0) *Expand mental health and addiction treatment access*	- **Expand Hub-and-Spoke model for Opioid Use Disorder (OUD):** Use RHT funds to bolster the "hub" (regional opioid treatment centers) and equip more "spoke" primary care practices in rural areas with tele-addiction consult support and nurse care managers[41]. Integrate with tele-psychiatry (through Avel eCare or partner networks) for 24/7 crisis consults in EDs and law enforcement (virtual crisis response)[42]. - **School and**	A. Evidence-based prevention (addressing behavioral health) H. Supporting access to OUD/SUD treatment[43] C. Technology solutions (tele-mental health tools) E. Workforce (training peer counselors, etc.) J. Additional (community partnerships for mental health)	$30 (6%)	- **OUD treatment engagement:** % of known OUD patients in treatment (Baseline: 60%; Target: 85% in pilot regions). - **Overdose deaths per 100k** in pilot counties (Baseline: 20; Target: 15). - **Tele-mental health consults** provided to schools/community sites (Baseline: 0; Target: 200/year by Year 5). - **Follow-up after ED visit for**

Initiative (Name & Focus)	Key Activities & RHT Collaborative Partners	Allowed Use Categories (A–K)	5-Year Budget (Millions; % of Total)	Sample Metrics (Baseline → Target)
	community-based mental health: fund pilot programs in two rural counties to deploy tele-mental health kiosks in schools and libraries, leveraging **Humetrix multilingual triage app** for initial intake[28]. Partner with local mental health agencies for follow-up care. - **SUD recovery support:** increase capacity of community health teams (Blueprint for Health's regional teams) to provide home visits for SUD patients (transportation support, peer counselors). - **Metrics and outcomes:** track treatment retention and community-level overdose rates as key outcomes.			**mental health** (Baseline: 50%; Target: 80%).
6. Health Data Infrastructure & Analytics *Improve data sharing,*	- **Upgrade the Vermont Health Information Exchange (HIE):** Invest in data integration tools and	C. Technology solutions (data and telehealth infra) F. Data infrastructure	$45 (9%)	- **Health Information Exchange usage:** % of rural providers actively exchanging data

Initiative (Name & Focus)	**Key Activities & RHT Collaborative Partners**	**Allowed Use Categories** (A–K)	**5-Year Budget** (Millions; % of Total)	**Sample Metrics** (Baseline → Target)
analytics, and telehealth infrastructure	rural hospital connectivity (ensuring all critical access hospitals can exchange data). Improve real-time data feeds to support population health analytics and care coordination[44][45]. Emphasis on **cybersecurity improvements** (in partnership with Microsoft's rural cybersecurity program)[46][47]. - **Implement analytics platform:** Deploy a population health analytics solution (potentially **Humetrix analytics** or a similar platform) to stratify risk, identify care gaps, and monitor outcomes across rural populations[48][49]. Generate county-level dashboards for RHT metrics (to be used by the Program Office and HVNs for decision-making). - **Broadband and telehealth equipment:** (In	enhancement[52] F. Remote care service infrastructure[5] J. Additional (innovative tech and cybersecurity)		(Baseline: 50%; Target: 100%). - **Time to retrieve patient record** across settings (Baseline: 5 days; Target: real-time, <1 minute). - **Telehealth utilization rate** in rural clinics (visits per 1,000 residents, Baseline: 50; Target: 150). - **Cybersecurity risk score** for rural hospitals (Baseline: high risk; Target: moderate risk – as measured by a standard index, showing improvement).

Initiative (Name & Focus)	Key Activities & RHT Collaborative Partners	Allowed Use Categories (A–K)	5-Year Budget (Millions; % of Total)	Sample Metrics (Baseline → Target)
	coordination with other funding sources to avoid duplication) support last-mile broadband expansion for clinics where needed and procure telehealth carts/equipment for every rural clinic and EMS service. This ensures technology can be fully utilized (note: major broadband projects are leveraged through other programs; RHT funds only fill minor gaps to avoid duplication). - **Consumer digital tools:** Support patient-facing digital tools, e.g. Medicaid patient portal enhancements and integration of **Humetrix WhatMeds** app for medication safety for rural Medicare beneficiaries[50][51].			
7. Program Administration & Evaluation *Grant management,*	- **RHT Program Office operations:** Staff and operate a central program management office within AHS to oversee	(Administration & evaluation touches on all categories; primary classification:)	$25 (5%)	- **On-time reporting compliance:** Yes/No (Target: 100% on-time submission of all

Initiative (Name & Focus)	Key Activities & RHT Collaborative Partners	Allowed Use Categories (A–K)	5-Year Budget (Millions; % of Total)	Sample Metrics (Baseline → Target)
oversight, and evaluation (10% cap)	RHT projects (grant management, compliance, reporting)[53][54]. This includes a full-time Program Director, financial analyst, and support staff, funded under the 10% admin cap[8]. Also includes indirect costs per approved rate (see Attachment: Indirect Cost Agreement). - **Interagency Steering Committee:** Convene bi-monthly meetings of a cross-agency committee (health, mental health, social services, public health, etc.) to guide implementation and ensure alignment with other initiatives (see Governance section). - **Independent evaluation contract:** Hire an external evaluator (university or independent firm) to design and execute the evaluation plan. Conduct annual performance	J. "Additional uses… to promote sustainable access" (per statute)[55] + covers required admin functions (≤10% of total funding)		reports to CMS). - **Percent of funds disbursed** on schedule (Baseline: 0%; Target: >95% utilized by deadlines annually)[56]. - **Stakeholder satisfaction** (survey of rural providers on support received – Target: >85% positive). - **Evaluation completion**: Independent evaluation delivered by Q4 2030 with actionable findings (Target: 100% completion).

Initiative (Name & Focus)	Key Activities & RHT Collaborative Partners	Allowed Use Categories (A–K)	5-Year Budget (Millions; % of Total)	Sample Metrics (Baseline → Target)
	assessments and a final outcomes evaluation in Year 5, including community impact analysis. Data collection will leverage improved HIE and analytics infrastructure. Evaluation design aligns with CMS requirements and will inform any needed course corrections.[14] - **Stakeholder engagement and communications:** Ongoing engagement with rural communities, hospitals, and providers (listening sessions, advisory groups) to solicit feedback and report progress (ensuring transparency and public buy-in).			

Note: Budget figures are illustrative for planning purposes. Vermont's actual award is estimated at **$500 million over 5 years**[6][57]. The portfolio above allocates these funds across initiatives (final amounts may adjust based on award and refined cost estimates). Importantly, the distribution meets all funding limitations (administrative costs = 5% of total in plan, under the 10% cap[8]; direct provider payments ≈5%, under 15% cap[9]; capital/renovation ~15%, under 20% cap[10]; EMR replacement <1%, under 5% cap[58]). Each initiative's detailed description and justification are provided in the narrative that follows.

Section C: Crosswalk to Scoring Criteria

This section provides a **crosswalk between Vermont's proposal and the RHT Program scoring criteria** outlined by CMS. The table below lists each relevant technical scoring factor (grouped by category B through F as defined in the NOFO scoring rubric) and describes how and where Vermont's application addresses it. It also notes any **time-bound state policy commitments** associated with the factor, as required to maximize scoring. This crosswalk demonstrates that Vermont's plan is comprehensive and aligns with CMS's priorities, ensuring a competitive score on the technical review. (Data-driven scoring factors related to state demographics are omitted, as they are derived from Vermont's characteristics and not applicant-controlled.)

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
B.1 Population Health Clinical Infrastructure (*Enhance integrated care models for prevention and chronic management*)[4]	States implement interventions that improve access to preventive, chronic, behavioral, and prenatal care (e.g. community health workers, care coordination models) to make "rural America healthy again."	**Integrated care initiatives:** Vermont's plan funds community health worker training and deployment (Initiative 2) and expands care coordination via HVNs. The **Blueprint for Health** advanced primary care model will be extended to more rural practices using RHT funds (embedding care coordinators and community health teams in rural areas). These efforts directly bolster preventive and chronic care management at the local level. Vermont also commits to maintain these expanded care teams post-grant through value-based payment savings.	**2026 launch**, ongoing
B.2 Health and Lifestyle (Chronic Disease Initiatives) (*Implement evidence-based programs to reduce chronic*	Examples: diabetes prevention programs,	**Chronic disease focus:** The **RPM & Chronic Care** initiative (Initiative 2) is explicitly an evidence-	Starts **2026**, DPP expansion

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
disease incidence and improve management)[59][60]	hypertension control initiatives, lifestyle coaching, etc.	based program to improve chronic disease management via continuous monitoring and early intervention[26]. Additionally, Vermont will invest in lifestyle programs like the **Diabetes Prevention Program (DPP)** through community health centers (complementary to RHT, not duplicative of CDC grants – see duplication review). The proposal's metrics (e.g. improved hypertension control rates) reflect these efforts.	by **2027**
B.3 SNAP and Nutrition (*Implement policies to improve nutrition, e.g. restrict sugary foods under SNAP, require nutrition education for clinicians*)[61][62]	CMS example: States get credit for leveraging nutrition policy to improve health.	**Nutrition policy alignment:** Vermont will explore a Section 1115 waiver or state policy to pilot **healthy food incentives** in SNAP for rural residents (such as enhanced 3SquaresVT benefits for fruits/vegetables) instead of outright restrictions. While not a core part of the RHT funding, Vermont acknowledges this criterion and will coordinate with its Department of Health to incorporate nutrition and obesity prevention in	Policy proposal by **2027** (if feasible)

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
		rural health strategy. (E.g., partner programs offering produce prescription initiatives in rural clinics by 2027).	
C.1 Rural Provider Partnerships (*Partner with stakeholders to share best practices, resources for financial stability*)[63]	Emphasis on forming networks, consortia, partnerships among rural providers and with larger systems.	**HVN networks & partnerships:** Vermont's plan centers on **High Value Networks (HVNs)** of rural providers (Initiative 4)[34][36]. The state will formalize partnerships via MOUs among all critical access hospitals and Federally Qualified Health Centers (FQHCs) in each region to share resources and best practices. We will also strengthen partnerships with tertiary centers (UVM Health Network) for referral protocols and tele-specialty support. This is a cornerstone of our application – creating a sustainable network for rural health transformation.	HVNs established **2026-27**; formal MOUs by **2027**
C.2 EMS Integration (*Support coordination between Emergency Medical Services and other providers*)[64]	Improve how EMS interacts with hospitals/clinics (e.g. community paramedicine, data linkage).	**EMS coordination:** Vermont's plan invests in **community paramedicine** training under the Workforce initiative and equips EMS with telehealth capabilities (Initiative 1). The state will implement a **statewide EMS**	Pilot tele-triage in **2026**, statewide rollout by **2028**

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
		hospital radio report system and teletriage protocol linking EMS crews with hospital ED physicians (leveraging telehealth devices). We will also include EMS leaders in the RHT Program steering committee to ensure alignment. These steps fulfill the EMS coordination criterion.	
C.3 Certificate of Need (CON) Reform (*Loosen CON laws to allow new providers or services in rural areas*)[65]	E.g. making it easier to introduce new services or facilities in underserved areas.	**Regulatory flexibility:** Vermont historically has a CON process; to support transformation, the state commits to **review and update CON regulations by 2027** specifically to streamline critical access hospital service changes or new rural provider entry. For example, if a rural region needs a new dialysis center or mobile clinic, the process will be expedited. We will work with the Green Mountain Care Board (which oversees CON) and the legislature on any statutory changes. *This commitment is time-boxed:* draft revisions by Q4 2026, enacted by 2027 (subject to legislative approval).	CON policy changes by **2027**
D.1 Talent Recruitment	Expand	**Workforce expansion:**	**2026 start**,

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
(*Build up rural healthcare workforce*)[66][67]	workforce via training, recruitment, "broader set" of providers (e.g. community health workers, pharmacists).	Vermont addresses this fully in Initiative 3 (Workforce Development), including recruitment incentives and new provider types (training community health workers, integrating pharmacists into care teams). We will increase rural residency slots and utilize the 5-year obligation incentive for recruits[30]. We are also leveraging partnerships with the University of Vermont and Area Health Education Centers to pipeline graduates to rural areas. These efforts match D.1's intent.	new incentives in place by **2026**
D.2 Licensure Compacts (*Enable providers to practice across state lines to support telehealth*)[68][69]	E.g. join Interstate Medical Licensure Compact, Nurse Licensure Compact, etc.	**Licensure reciprocity:** Vermont will pursue joining key interstate licensure compacts to facilitate telehealth and provider mobility. Vermont is not yet in the Interstate Medical Licensure Compact (IMLC); we commit to introduce legislation by 2026 to join the IMLC for physicians and consider the Nurse Licensure Compact for RNs. Additionally, we will streamline licensing for mental health providers	Legislation in **2026**, enact by **2027**

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
		who serve Vermont via telehealth. By removing licensure barriers, we expand the pool of providers available to rural communities (fulfilling D.2).	
E.1 Medicaid Provider Payment Incentives (*Create value-based payment incentives to improve quality and reduce costs*)[70][71]	Develop or expand payment models (ACO incentives, quality bonuses, etc.) focusing on rural providers.	**Value-based payment model:** Vermont is enhancing its All-Payer Model to specifically support rural providers. Using RHT funds, Vermont will create a **Rural ACO Innovation Fund** that provides financial incentives or care management payments to rural hospitals and practices that meet quality and cost targets (e.g. reduced avoidable admissions). We will implement a **multi-payer prospective payment** for Blueprint primary care practices in rural areas (combining Medicaid, Medicare, commercial contributions) by 2027 to stabilize revenue[72][73]. These initiatives align with E.1.	Design in **2026**, implement by **2027**
E.2 Integrating Dual Eligibles (*Increase dual-eligible participation in coordinated programs like PACE, FIDE-*	Focus on improving care for individuals on both Medicare and	**Duals coordination:** Vermont will expand programs for dual-eligibles in rural areas. Specifically, we plan to	New PACE site by **2028**; ongoing D-SNP efforts

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
SNPs)[74][75]	Medicaid.	**expand PACE (Program of All-Inclusive Care for the Elderly)** to at least one additional rural region by 2028, providing integrated care for frail elders (many of whom are dual-eligible). We'll also work with our Medicaid office to encourage enrollment in integrated Dual Eligible Special Needs Plans (D-SNPs) where available. RHT funds may support outreach and care coordination for duals (though not direct services). This addresses E.2 by improving duals' coordinated care.	
E.3 Insurance – Short-Term Plans (*Align state rules on short-term limited-duration insurance (STLDI) with new federal guidelines*)[76][77]	Loosen restrictions on STLD plans to potentially increase coverage options.	**Insurance policy:** Vermont currently has strict rules limiting short-term plans. While STLDI is a contentious issue (due to concerns about skimpy coverage), to align with federal guidance Vermont will **review its insurance regulations in 2026**. If federal guidelines encourage allowing slightly longer short-term plans for specific gaps in coverage, Vermont will consider modest regulatory adjustments. However, any changes	Review in **2026**, decision by **2027**

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
		will ensure consumer protections. This demonstrates Vermont's willingness to consider federal alignment, addressing E.3.	
F.1 Remote Care Services (*Support legislation/infrastructure for telehealth and remote care*)[5][78]	Improve telehealth access via policy or investment (broadband, etc.).	**Telehealth support:** Vermont will strengthen its telehealth statute to make permanent the COVID-era expansions (e.g. payment parity for telehealth visits, allowing audio-only services in Medicaid where appropriate). We will also invest in telehealth infrastructure (Initiative 6) – for example, funding telehealth equipment grants and supporting broadband for clinics[79][80]. The combination of supportive legislation (already largely in place, to be refined by 2025's telehealth working group) and infrastructure investments fulfills F.1.	Legislation updated **2025** (in progress); infra investments **2026-27**
F.2 Data Infrastructure (*Enhance rural health data infrastructure*)[52][81]	Invest in HIE, data systems, cybersecurity, etc., to improve data sharing and security.	**Data enhancements:** Initiative 6 squarely addresses F.2, with major HIE upgrades and cybersecurity improvements. Vermont will use RHT funds to ensure every rural provider can connect to the VHIE and to	Projects begin **2026**, completed by **2028**

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
		implement modern data analytics platforms[48][49]. Additionally, Vermont is partnering with **Microsoft** to leverage their Azure cloud security program that has already benefitted 700+ rural hospitals nationally[46][82]. These efforts improve data exchange and protect against cyber threats, directly meeting F.2.	
F.3 Consumer-Facing Technology (*Support development/implementation of tools for patient use in prevention/chronic care*)[83][84]	Encourage patient-facing apps, portals, remote monitoring, etc., to engage consumers.	**Consumer tech:** Vermont's plan strongly emphasizes consumer-facing tools. The **Humetrix suite** (multi-lingual triage app, personal health record apps) will be introduced for patient use[85][28]. We will also expand our patient portal efforts through the Vermont Health Information Exchange to give rural residents easier access to their data. The **BioIntelliSense RPM** initiative is inherently consumer-facing, as patients wear and interact with the BioButton device and receive tailored alerts. By deploying these modern health tools, Vermont	Pilot apps in **2026**, wider rollout by **2027**

Scoring Criterion (NOFO Ref.)	Description	Vermont's Response/Commitment	Timeframe
		addresses F.3.	

In summary, Vermont's application has been carefully aligned with all **CMS RHT scoring criteria**. The crosswalk above shows that for each element CMS is looking to incentivize, Vermont has a corresponding initiative or policy commitment. All policy-related commitments (e.g. licensure compacts, payment model changes, etc.) are **time-boxed with target dates** to demonstrate a clear plan and accountability. These will be incorporated into our implementation timeline and tracked. Vermont's proactive stance on difficult items (like CON reform and insurance rules) further illustrates our dedication to fully meeting the program's intent.

Section D: Project Narrative (Summary and Full Narrative)

D.1 Project Summary

Overview: The State of Vermont seeks to transform its rural health care system through a comprehensive, **forward-looking plan** funded by the CMS Rural Health Transformation Program. Vermont's application responds to the urgent challenges faced by its rural communities – from aging populations and provider shortages to geographic barriers and outdated infrastructure – with a **bold portfolio of initiatives** that invest in workforce, technology, and new models of care. The overarching vision is **"Right Care, Right Time, Right Place, at an Affordable Cost,"** ensuring every rural Vermonter can access high-quality health services when and where they need them[86][87].

Goals: Vermont has identified three primary goals for its RHT Program effort, each aligned with both state-identified needs and CMS's strategic goals[86][88]:

- **Goal 1: Strengthen the Rural Healthcare Workforce.** Increase the supply of rural clinicians and support staff, and enhance their capabilities through training and tele-support, so that care can be delivered locally by a robust workforce[86].
- **Goal 2: Increase Access to Timely Care Across Rural Communities.** Expand and modernize care delivery options – including telehealth, remote services, and integrated community networks – to ensure rural residents get the care they need promptly in their own communities[86].
- **Goal 3: Improve Quality of Care and Reduce Costs through Innovation.** Implement innovative strategies (e.g. value-based payments, data analytics, AI tools) that improve health outcomes while controlling costs, creating a sustainable rural health system for the future[89][90].

These goals build on years of groundwork Vermont has laid in health reform – including the All-Payer ACO Model (now evolving into the AHEAD model), regional hospital planning (Act 167), and the Blueprint for Health primary care initiative[72][73]. **RHT funding provides a**

rare opportunity to accelerate and amplify these efforts[87], injecting significant resources to tackle longstanding gaps and inequities in rural health infrastructure.

Summary of Initiatives: Vermont's plan comprises **seven integrated initiatives** (detailed in Section B and the narrative below) that together address the full spectrum of allowed activities under the RHT Program[1][91]. Highlights include establishing 24/7 telehealth coverage for rural hospitals (leveraging a proven model from Avel eCare), deploying cutting-edge wearable technology (BioIntelliSense) for chronic disease management in patients' homes, forming regional High Value Networks of rural providers with the help of Cibolo Health to drive systems change, and investing in our healthcare workforce via incentives and training programs. We also dedicate funds to bolster mental health and substance use disorder services in rural areas (building on Vermont's successful Hub-and-Spoke model[41][92]) and to upgrade critical data and telehealth infrastructure (ensuring rural facilities are secure, connected, and data-driven). An administrative and evaluation component ensures proper oversight, rigorous measurement of outcomes, and the meeting of all federal requirements.

Outcomes and Impact: Over the five-year program, Vermont expects to achieve measurable improvements in rural health care access and outcomes. For example, we anticipate a reduction in potentially avoidable hospital transfers by at least 30% due to new tele-specialty capabilities, a significant uptick in chronic disease control rates (e.g. hypertension control improving 15 percentage points in targeted areas), and stabilized or improved financial health of rural provider organizations (with all participating hospitals moving into positive operating margins by Year 5). We also aim to close key service gaps – such as **eliminating mental health provider shortages in at least half of Vermont's rural counties** through telehealth and workforce measures – and to see improvements in population health metrics like a decline in emergency department visits for ambulatory-care-sensitive conditions. The plan will directly benefit all of Vermont's 14 counties, 8 critical access hospitals, 2 rural PPS hospitals, dozens of rural health clinics and FQHC sites, and an estimated **200,000+ rural residents** (about 30% of Vermont's population)[1][93].

Finally, Vermont's application underscores sustainability: each initiative is designed not as a one-time service funding, but as an **investment in capacity** that will yield benefits beyond the grant period[12][13]. By the end of five years, Vermont's rural health system will be on a stronger footing – with networks, technologies, and workforce pipelines that continue to function and evolve using regular reimbursement streams and state support. In essence, this RHT Program funding will enable Vermont to **"build on years of work and invest in the infrastructure Vermonters need"** for the future[87].

(The remainder of Section D provides the full detailed narrative of the project, organized by topic and initiative, including context, implementation plans, and how each component ties together to achieve the above goals.)

D.2 Background and Needs Assessment

Vermont is a small state with a largely rural character – and our rural communities face outsized challenges in accessing and delivering healthcare. **Approximately 55-60% of Vermonters live in rural areas or small towns**, and even those in larger towns often rely on small community hospitals and clinics that serve rural regions[1]. Key background factors informing our RHT proposal include:

- **Aging Population & Chronic Disease:** Vermont has one of the oldest populations in the U.S., especially in rural counties[94]. This drives higher rates of chronic conditions (e.g. heart disease, diabetes) and greater demand for healthcare services. Rural areas struggle with higher prevalence of chronic disease and risk factors, partly due to older demographics and socioeconomic factors (e.g. higher rates of poverty and transportation barriers). Prevention and proactive management are urgent needs.

- **Workforce Shortages:** Rural Vermont faces persistent shortages of healthcare providers. Many towns lack full-time primary care physicians; mental health and dental providers are even scarcer. Residents often endure **long wait times for primary and specialty care** or must travel long distances[95]. Vacancy rates for nurses and technicians in critical access hospitals are high (often >20%). Vermont's workforce is aging alongside the population, meaning many current rural practitioners are nearing retirement with few replacements in the pipeline[94].

- **Financial Strain on Rural Providers:** Small hospitals and clinics operate on thin margins. External pressures – including Medicaid payment shortfalls (Medicaid is a major payer for rural hospitals) and rising operational costs – have led to instability. The **Rural Health Redesign Center (RHRC)** engagement earlier in 2025 identified several Vermont hospitals at risk of service reduction or conversion absent intervention[96][97]. Ensuring **long-term financial solvency** and viability of rural providers is a critical need[98]. This includes right-sizing infrastructure (some hospitals have excess inpatient capacity but lack outpatient services in demand) and moving toward value-based models that reward quality over volume.

- **Gaps in Services & Access:** Certain essential services are not consistently available locally. For example, labor and delivery units have closed in some rural hospitals; specialty services like dialysis or mental health crisis care may not exist in a given region, forcing patients to travel or go without. **Transportation barriers** (limited public transit, long distances in winter) exacerbate access issues[99][100]. Additionally, gaps in community-based services (like home health, preventive care programs) lead to higher utilization of hospitals for issues that could be managed upstream[95][101].

- **Infrastructure & Technology Deficits:** Many rural facilities in Vermont operate with **outdated equipment and IT systems**. While all have some form of EHR, not all are

fully integrated with state HIE or analytics. Broadband connectivity, while much improved, still has last-mile gaps affecting telehealth uptake. Cybersecurity is a concern – rural hospitals have been targets of cyber attacks but often lack resources for robust defense. Investments in modernizing infrastructure and adopting new technology (telehealth, remote monitoring, data analytics) have been limited by funding constraints.

- **Existing Reform Efforts:** Vermont isn't starting from scratch – the state has been innovating in healthcare reform for years. The **All-Payer ACO Model** (now transitioning to an AHEAD initiative post-2022) has built a platform for value-based care, but rural participation has lagged due to resource constraints. Vermont's **Blueprint for Health** provides a strong primary care foundation with community health teams and medical homes, though these need bolstering in rural areas. Recent legislation (Act 167) pushes for **regionalization of hospital services** (tiering local, regional, state-level services)[99][102], which dovetails with the RHT Program's aims. The Agency of Human Services (AHS) ended its RHRC engagement but is now integrating transformation planning internally[102][103]. All these efforts provide a strategic context – Vermont has plans and ideas, and the RHT funding is the catalyst to implement them at scale.

In summary, Vermont's rural health system needs **targeted, large-scale investment and transformation**. The needs align well with the RHT Program's purpose as defined by Congress: to offset rural provider losses from broader health reforms by infusing funds for modernization and system redesign[104][93]. Vermont's situation – high rural population share, numerous at-risk rural facilities, and a proactive health reform environment – makes it an ideal candidate for this program. The funds will allow Vermont to address root causes: bolster the workforce, update technology, redesign care models, and ultimately improve outcomes for rural residents. Without this investment, Vermont risks further erosion of rural health access (e.g. more hospital service closures, worsening provider shortages, declining health metrics). With the investment, Vermont can become a **national model for rural health transformation**, demonstrating how to integrate innovation in a small, predominantly rural state.

D.3 Project Description by Initiative

Vermont's RHT plan consists of seven major initiatives (A–G) as introduced. Below, each initiative is described in detail, including objectives, key activities, partners, implementation steps, and how it addresses the identified needs. We also discuss how each will be sustained after RHT funding ends. The initiatives are designed to be mutually reinforcing; for instance, telehealth (Initiative A) supports workforce (Initiative C) by reducing strain, and data systems (Initiative F) support all others by enabling measurement and coordination.

Initiative 1: Virtual Care & Telehealth Expansion

- **Objective:** Ensure that rural communities have round-the-clock access to specialty care and urgent medical expertise via virtual channels, thereby improving outcomes and reducing the need for patient transfers to tertiary centers. This addresses the access gap for specialty and emergency care in isolated areas[105].

- **Key Activities:** Vermont will partner with **Avel eCare** to implement a statewide **virtual care hub**. Avel eCare brings 30+ years of telemedicine experience geared towards rural settings[106][19]. Each critical access hospital and rural hospital in Vermont will be equipped with telehealth technology (cameras, carts, secure connectivity) and connected to Avel's Joint Commission-accredited virtual hospital center. Services include **Tele-ICU, Tele-ER, Tele-Pharmacy, Tele-Specialty Clinics, and Tele-Behavioral Health** consultations. For example, at night or during busy times, a rural ER physician or nurse can press a button and get an **immediate virtual consult with an Avel critical care or emergency specialist** who can see the patient via high-definition video, review monitors/EHR, and help manage care[32][20]. This strengthens local care delivery by **bridging gaps caused by workforce shortages and geography** – instead of automatic transfers, many patients can be treated locally with remote specialist guidance[20][107].

In addition to Avel's services, Vermont will expand telehealth partnerships with **CVS MinuteClinics and Walgreens**, integrating their virtual care offerings for primary care and simple acute issues, thereby **extending after-hours and convenient care** options in rural towns[21][22]. Retail clinics will serve as telehealth access points in communities (e.g. a patient can walk into a pharmacy and have a telehealth visit if no local doctor is available).

EMS integration: Paramedics in the field will have telemedicine links to hospitals (tele-triage) to consult on treatment or transport decisions, which is especially critical in our mountainous areas in winter.

- **Partners: Avel eCare** (core telemedicine partner) – already identified as a shovel-ready solution in the RHT Collaborative[108][106]; **Teladoc Health** (for direct-to-consumer telehealth and specialty networks as needed); Retail partners like **CVS Health** (MinuteClinic) and **Walgreens** for community access; University of Vermont Medical Center (to provide in-state specialty tele-consults and backup to Avel when needed, and to accept transfers that are truly necessary).

- **Implementation Steps:** In Year 1, assess technology needs at each site and install standardized telehealth equipment (leveraging any existing grant equipment first to avoid duplication). Train local staff on telehealth protocols. Establish contractual arrangements with Avel eCare for 24/7 coverage (covering hospital inpatient support, ED backup, pharmacy verification overnight, etc.). **Go-live by Q4 2026** at all CAHs and small rural hospitals for tele-ER and tele-ICU. Year 2 will expand to tele-specialty clinics (e.g. schedule virtual cardiology or pulmonology clinics so patients don't travel) and implement pharmacy and behavioral health consult

services. By Year 3, integrate EMS tele-triage statewide. Throughout, gather data on utilization and outcomes (e.g. number of avoided transfers, response times).

- **Outcomes/Metrics:** As noted, key metrics include reduced transfers (we expect a significant drop in transfers for ICU-level care; baseline data from 2025 shows, for example, 300 transfers from CAHs to Burlington – target to reduce by 30% = ~90 fewer transfers, meaning patients cared for locally), improved time-to-treatment for critical cases (stroke, sepsis – telehealth allows faster specialist input), and high provider and patient satisfaction. Community-level metrics might include mortality rates for emergency conditions (aim to improve due to faster care). We will also measure **cost savings** (each avoided transfer saves costs and burden on patients).

- **Alignment with Allowed Uses:** This initiative fits several allowed uses: "promoting technology-driven solutions for prevention and management" (telehealth for managing conditions)[109], "payments to providers" (we might use a portion of funds to pay for telehealth service contracts or to reimburse rural sites for telehealth costs), "additional uses to sustain access" (telehealth is explicitly to sustain access in remote areas)[55]. It also indirectly helps "recruit/retain staff" by easing workload and providing support (which improves rural provider job satisfaction, thus retention).

- **Sustainability:** Telehealth services will be sustained through a combination of insurance reimbursement (we will leverage Vermont's parity laws requiring insurers to pay for telehealth encounters) and cost-sharing among network hospitals after the grant. By demonstrating success, we anticipate hospitals will incorporate telehealth service fees into their normal budgets or negotiate value-based payment support for telehealth from payers. The state will also consider subsidizing some telehealth infrastructure long-term if needed, but the goal is that efficiencies (keeping patients local, avoiding costly transports) will free up resources to sustain the model. Notably, Avel eCare services have proven ROI by stabilizing staffing and keeping care local[20][107], which we expect will make a compelling case for continuation.

Initiative 2: Remote Patient Monitoring (RPM) & Chronic Care Management

- **Objective:** Improve management of chronic diseases and post-acute care in rural populations through continuous monitoring and proactive intervention, thereby preventing complications and hospitalizations. This addresses the high burden of chronic illness and the difficulty of managing it with infrequent doctor visits.

- **Key Activities:** Vermont will deploy **BioIntelliSense's BioButton® continuous health monitoring** platform to track patients' vital signs and symptoms in real-time[23][24]. We will target patients with conditions like congestive heart failure (CHF), COPD, diabetes with recent hospitalization, etc. These patients will wear a small BioButton sensor that monitors vital signs (heart rate, respiratory rate,

temperature), activity, sleep, and other parameters 24/7. Data is sent to an **AI-powered clinical intelligence engine**, which analyzes for trends and alerts clinicians to early signs of trouble[110][25] – for example, detecting fluid retention in a CHF patient before they become acutely ill.

We will equip each participating rural hospital or clinic with a supply of BioButtons and access to the BioIntelliSense dashboard. A central monitoring team (could be part of a telehealth hub or a new remote care center staffed by nurses) will oversee the data. When an alert triggers (e.g. patient's oxygen saturation trending down), the team contacts the patient and their local provider for intervention (like adjusting meds or arranging a home visit), thus **avoiding an ED visit or admission**.

Additionally, we will implement **training for digital health navigators or community health workers** who can visit patients at home to set up devices and educate them[27]. This addresses digital literacy issues and ensures patients are comfortable using the tech. These navigators (could be new hires or redeployed community health team members) will be crucial, especially for our older patients.

Alongside BioButton, **Humetrix consumer-facing applications** will be introduced: e.g., the multilingual **RAFTR (Rapid Triage) app** for patients to report symptoms with translations to share with providers[28]; the **iBlueButton PHR** app to aggregate their health records on their phone[29]; and **WhatMeds** app for medication management (particularly useful given polypharmacy concerns in Medicare patients)[51]. These tools empower patients and also feed data back to providers (with patient consent).

- **Partners: BioIntelliSense** (technology provider) – they have even prepared an "RHT Program NOFO Kit" for easy integration into state proposals[111]. We'll utilize their expertise and possibly their financial models for scaling RPM[112]. **Humetrix** (for the patient-facing software) – their proven track record with large deployments (e.g., DoD's COVID monitoring of 20 million beneficiaries) assures us they can handle our population[48][113]. Local partners include home health agencies (for on-the-ground support) and Blueprint for Health community health teams.

- **Implementation Steps:** In Year 1, identify two pilot communities (perhaps one in the Northeast Kingdom, one in South/Southwest VT) to launch RPM. Acquire BioButton devices (negotiating volume pricing) and integrate their platform with our HIE or hospital EHRs if possible for seamless data flow[114]. Train a cohort of digital navigators. By mid-Year 1, enroll first patients – likely those transitioning from a hospital stay, as early focus (to reduce readmissions). Expand to ambulatory high-risk patients in Year 2. By Year 3, scale statewide to all rural hospitals and large primary care practices, aiming for hundreds of patients concurrently monitored. Also in Year 1-2, localize and deploy Humetrix apps – e.g., train clinic staff to introduce the PHR app to patients. Throughout, build evaluation around utilization, adherence (are patients wearing devices? using apps?), and outcomes.

- **Outcomes/Metrics:** We expect significant reductions in acute events for enrolled patients. For instance, CHF patients in RPM might have 50% fewer hospitalizations compared to similar patients not on RPM (based on studies). We will track readmission rates at participating hospitals (target 10% drop for target conditions) and ED visits. Another key measure: **medication adherence and safety alerts** – the WhatMeds app can reduce adverse drug events; we'll monitor if polypharmacy alerts are addressed. Patient experience metrics (confidence in self-managing their condition) will also be measured via surveys.

- **Alignment with Allowed Uses:** This strongly fits "promoting evidence-based interventions for prevention/chronic disease management"[1]. It's also a "technology-driven solution for prevention and management"[109]. We include a training component for navigators (fits training/TA category) and it indirectly supports value-based care (keeping people healthier at lower cost). Notably, BioIntelliSense's platform addresses many RHT criteria around data and outcomes focus[26][115].

- **Sustainability:** RPM programs can be sustained if they demonstrate cost savings (Medicaid and Medicare savings through avoided admissions). Vermont will evaluate results and potentially seek Medicaid support for continuing RPM as a covered service or part of value-based payments. If up-front device costs remain an issue, we may partner with health plans or the ACO to cover them, since better outcomes benefit payers. BioIntelliSense offers financial models like per-patient per-episode pricing[112], which could be built into bundles or hospital global budgets. Our aim is that by Year 5, hospitals see RPM as essential and incorporate it into standard care (with payers on board because it reduces total cost of care). Patient-facing apps like Humetrix's have low marginal cost and can continue with minimal expense once deployed.

Initiative 3: Workforce Development & Training

- **Objective:** Attract, develop, and retain a healthcare workforce in rural Vermont that is sufficient to meet community needs and support new care models. This addresses the human resource crisis that underlies access issues.

- **Key Activities:** This initiative has multiple subcomponents:

- **Recruitment Incentives:** Launch the Vermont Rural Provider **Loan Repayment and Incentive Program**. Using RHT funds, offer medical school loan forgiveness or cash bonuses to clinicians (physicians, nurse practitioners, physician assistants, dentists, mental health professionals) who commit to practice in designated rural shortage areas for at least 5 years[30]. We will coordinate with existing federal programs (NHSC, HRSA's loan repayment) to supplement and not duplicate funding – e.g., if a provider maxes out federal loan repayment, we might offer a retention bonus instead. We aim to recruit at least 10 primary care physicians, 10 nurse

practitioners, 5 psychiatrists/therapists, and other needed roles in the first 3 years. Recruitment will focus on recent graduates and also mid-career professionals drawn to Vermont's lifestyle (with incentives to tip the scale).

- **Training and Pipeline:** Expand **residency and training opportunities** in rural areas. For example, fund 2 additional family medicine residency slots per year at the UVM Medical Center specifically for rotations in rural hospitals, with an expectation that graduates will stay in Vermont. Collaborate with nursing schools to create rural clinical rotations and mentoring programs. Train **community health workers (CHWs)** from within rural communities – perhaps 20 CHWs certified – to support care teams (especially for chronic disease outreach and SUD support). Also train **paramedics for expanded roles** (community paramedicine) to integrate with primary care. RHT funds will develop curricula, pay stipends or training costs, and support new educator positions if needed.

- **Retention and Support:** We recognize that recruitment is futile if retention is poor. Thus, invest in **workforce supports**: for example, create a rural provider leadership development program (helping talented clinicians become medical directors or change leaders in their communities), and **wellness initiatives** to combat burnout (peer support groups, tele-mentoring as mentioned). Telehealth (Initiative 1) is itself a retention tool – Avel eCare's virtual hospital model can **stabilize rural staffing by providing relief and backup** so that a single provider at a critical access hospital doesn't feel alone or overwhelmed[32][33]. We will also explore expanding the use of **expanded practice providers** like pharmacists practicing at top of license (e.g., clinical pharmacy in primary care) and dental therapists, to broaden the care team and ease burden on physicians (this ties in with regulatory aspects, possibly requiring legislation or rule changes – which we will pursue under the licensure compact and scope expansions allowed).

- **Partners: Academic institutions**: UVM College of Medicine, UVM College of Nursing and Health Sciences, Vermont Technical College (for nursing, paramedic programs) – all to develop training pipeline. **Professional associations**: Vermont Medical Society, VT Nurse Practitioners Association, Bi-State Primary Care Association – to help advertise programs and identify candidates. **AHEC (Area Health Education Center)**: to assist with connecting graduates to rural opportunities. We will also coordinate with **HRSA workforce grants** that Vermont receives, ensuring no duplication but rather augmentation (see Program Duplication Review attachment for details on complementarity).

- **Implementation Steps:** Immediately in Year 1, stand up the loan repayment/incentive program – get legislative or at least administrative approval for it (if needed, we might need legislative language to allow these payments, but likely AHS can administer via grants). By mid-2026, start accepting applications from providers or offers to new hires. Also in Year 1, finalize agreements for new residency slots (target start in academic year 2027 at latest). Develop CHW training

by partnering with Department of Health and community colleges (classes could start in 2026). Essentially, lots of coordination in Year 1. By Year 2 and 3, providers start arriving through pipeline, CHWs in place. We will measure progress quarterly (how many positions filled, etc.). Throughout, we'll link these efforts to the HVN network – each regional HVN or hospital will have a workforce plan guiding the use of these recruitment resources where they are most needed.

- **Outcomes/Metrics:** The primary metric is number of clinicians added to rural areas (and retained). We set targets (as in portfolio table: e.g. 75 new by end of 5 years across all disciplines). Also measure **vacancy rates** at hospitals/clinics – expecting a drop to under 5% in primary care vacancies. Monitor **tenure** of those recruited (we want them to stay at least 5 years per obligation; hoping many stay longer and embed in community). Another outcome: reduced use of temporary contract staff (traveling nurses, locums) which currently cost a lot – success means by Year 5, hospitals report far less reliance on temps, indicating a stabilized permanent workforce. Community-level impact could be seen in better continuity of care (e.g. panel of patients who now have a consistent primary provider instead of revolving locums).

- **Alignment with Allowed Uses:** This directly corresponds to "recruiting and retaining clinical staff to rural areas with 5-year obligation to stay"[91]. Also "training/TA for developing and adopting tech solutions" if we consider that training workforce to use new tech is part of it[116]. It definitely addresses the intent of sustaining rural access by having providers (since infrastructure means nothing without people).

- **Sustainability:** We view these workforce investments as jump-starting a virtuous cycle. By the end of RHT funding, the hope is rural facilities are in better financial shape (thanks to other initiatives) and can afford to maintain competitive salaries and possibly their own incentive programs. The state will consider continuing a scaled-down loan repayment program using state funds if proven effective – Vermont has done this in the past at smaller scale. Many of these costs (education, training slots) are front-loaded and one-time. Once a provider is recruited and established, they are then sustained by their ongoing employer compensation (often funded by billing revenue). The retention support structures (like Avel eCare, peer networks) will be in place to maintain a positive practice environment. In short, we use one-time funds to bring people in and set up supports, and then normal healthcare funding (improved by our changes) keeps them.

Initiative 4: High Value Networks & System Transformation

- **Objective:** Reorganize and strengthen Vermont's rural providers through regional collaboration and integrated systems, to improve quality, efficiency, and financial viability. This addresses fragmentation and the inability of isolated small providers to survive on their own.

- **Key Activities:** We will implement the **Cibolo Health High Value Network (HVN)** model in Vermont[34][35]. The concept is to create **member-owned networks** among independent providers (hospitals, clinics) with shared resources and joint accountability. Concretely, Vermont will facilitate the formation of (most likely) **3 regional HVNs**: e.g., Northwest, Northeast, and Southern regions (exact grouping will consider patient flow and existing relationships). Each HVN could be structured as a LLC or cooperative owned by the member hospitals/clinics. RHT funds will support initial **network development, legal setup, and planning**. Cibolo Health, as an expert convener, will provide the template governance structures, tools for financial tracking, and strategic guidance[36][37].

Once established, HVNs will undertake initiatives such as **joint contracting** (with larger health systems or payers), **group purchasing**, sharing specialty services (e.g., one hospital provides ortho surgery for the region, another provides OB, etc., reducing duplication), and coordinating recruitment so they don't compete against each other for talent. HVNs will manage the RHT funds deployment in their region to ensure transparency and measure impact[36][37] – essentially acting as steward entities to avoid duplication and waste, as Cibolo's model emphasizes. For example, if two neighboring hospitals both considered buying an expensive piece of equipment, the HVN can coordinate so maybe one purchase serves both, etc., **maximizing economies of scale**.

Another aspect is to **initiate or strengthen affiliations with high-quality larger systems** (some VT hospitals are already loosely affiliated with UVM Health Network; others could partner with DH (Dartmouth-Hitchcock) or Albany Med, etc.). RHT funding can be used for technical assistance for those partnership arrangements (like legal or consultant help to explore affiliations, or seed money for collaborative projects). Where appropriate, we might see formal mergers or conversions (with community input) – e.g., a financially struggling hospital could convert to a rural emergency hospital or outpatient center with network support (ensuring, for instance, emergency and primary care remains while inpatient is closed in a planned way rather than sudden closure).

Also, under this initiative, we want to tackle the **"right-sizing"** of services. RHT funds can help communities assess needs (market studies, community engagement) to decide what services are essential locally (perhaps guided by the **tiered system approach** Vermont has been discussing[99][102]). Funds might renovate facilities to accommodate new service configurations (like turning unused inpatient beds into an infusion therapy suite or telehealth center). We will carefully use capital funds for renovations (ensuring within the 20% cap) – no new full-scale construction, but strategic retrofitting of existing facilities to meet identified needs (like expanded primary care clinic space or a combined lab/imaging center that multiple towns can use).

Value-based care projects also fall here: we plan to leverage our All-Payer model structure to develop **rural-specific ACO programs**. For example, the HVNs could double as ACOs or join the state's ACO as a subgroup with tailored targets. RHT funds would help them invest

in the needed care management (nurse coordinators, data systems) to succeed under value-based contracts, thus moving away from fee-for-service dependence.

- **Partners: Cibolo Health** (central partner for HVN creation) – their tools for governance and financial tracking will ensure accountability[37][117]. **State Offices:** Green Mountain Care Board (regulator for hospital budgets and CON – they'll be involved to align regulatory flexibility with transformation), Vermont Association of Hospitals and Health Systems (VAHHS) to get buy-in from all hospitals. Possibly **consulting partners** from the RHT collaborative like Accenture or KPMG to assist with complex network integration and project management (the RHT Collaborative noted global SIs like Accenture and KPMG are ready to support such transformation with AI tools for tracking outcomes[118][119]). We anticipate needing expert help to manage these multi-organization changes.

- **Implementation Steps:** By Q1 2026, convene leadership of all rural providers to formally launch the idea of HVNs and secure commitment to participate. Use Cibolo's template to set up initial network governance by mid-2026 (perhaps interim steering committees for each region). Through 2026-27, conduct regional needs assessments (with community input – town halls to ensure transparency). By end of Year 2, finalize "regional transformation plans" identifying which services should be provided at which facility (e.g., decide if one hospital becomes a specialty hub and another focuses on outpatient, etc., in a collaborative rather than competitive fashion). Begin implementing those plans in Years 3-4 (including any facility conversions or new partnerships with larger systems). Simultaneously, from Year 1 onward, have HVNs coordinate RHT fund usage – essentially acting as sub-recipients that distribute funds to projects at the member facilities (with state oversight). Each HVN will set up tracking systems for funds and metrics (Cibolo's tools) to ensure **accountability and measurable improvement**[120][117].

- **Outcomes/Metrics:** A key outcome is **no rural hospital closures or uncontrolled service losses** during the program – instead, if changes happen, they're planned and ensure continued access (this is success: transforming rather than having crisis closures). Financial metrics: by Year 5, all participating hospitals reach a sustainable operating margin (we target at least break-even or better for each). Quality metrics: HVNs should drive improvement in outcomes like readmission rates, because members will share best practices (for instance, one hospital that excels in infection control can help others, lifting all boats). We'll track **cost savings** too – e.g. reduction in per capita cost of care in those regions if we manage to eliminate redundancies and focus on preventive care. One quantitative metric: number of formal partnership agreements (affiliations or mergers) that occur – showing consolidation towards stability.

- **Alignment with Allowed Uses:** This hits "assisting rural communities to right-size healthcare delivery by identifying needed services, facilities, etc."[39]. It also covers "projects that support value-based care"[40]. And generally "initiating, fostering,

strengthening local and regional partnerships" which was explicitly listed as a plan requirement by Congress[121] – our HVNs fulfill that mandate.

- **Sustainability:** The intent is to make these HVNs permanent fixtures. They become vehicles for ongoing collaboration beyond RHT. Once established, they can potentially negotiate contracts and bring in revenue (for example, a network might collectively negotiate better payer rates or secure grants as a group). The efficiency gains and cost avoidance (by eliminating duplication) should improve financial standing such that the networks can sustain their operations (they might hire a small staff funded by member dues or savings achieved). The state might also continue to support the networks via policy (ensuring regulatory support, maybe directing some Medicaid value-based payments through them). Essentially, RHT funds cover the start-up costs of organizing and initial projects; thereafter the networks should continue because members see value (it's analogous to rural hospital networks in other states that persist because of ongoing group benefits). Cibolo's model explicitly aims at giving rural communities enduring capacity to govern their transformation beyond the initial funding[117][122].

Initiative 5: Behavioral Health & SUD Access (Hub-and-Spoke 2.0)

- **Objective:** Expand access to mental health and substance use disorder (SUD) treatment in rural areas by building on Vermont's existing Hub-and-Spoke model for opioid treatment and leveraging telehealth and community partnerships to reach underserved populations.

- **Key Activities:** Vermont's **Hub-and-Spoke model** has been nationally recognized for OUD treatment, but rural gaps remain (e.g., spokes may be few and far between in the Northeast Kingdom, and hubs are all in more populated centers). RHT funds will help **augment hub capacity** (e.g., allow hubs to add staff or technology to serve more patients via telemedicine) and **increase the number and capability of spokes** (rural primary care or FQHC sites) to provide Medication-Assisted Treatment (MAT). We will fund training and startup costs for, say, 5 additional rural spoke sites, including providing an **RN or counselor care coordinator** at each new spoke for the first two years. We will also invest in **tele-mental health**: specifically, deploy a platform (possibly via Avel eCare's network or another tele-psych vendor) so that every rural emergency department and law enforcement agency has access to a **24/7 virtual crisis intervention team** (for mental health crises). This builds on the concept of virtual crisis care which some states have implemented[42]. For example, a police officer encountering someone in a mental health crisis in a rural town can call on a tablet to a tele-mental health clinician to assist in de-escalation and determine if hospitalization is needed.

Additionally, RHT funds will pilot innovative community approaches: e.g., **telehealth kiosks or tablets in schools, libraries, and town halls** where residents can have a confidential mental health visit. We'll integrate **Humetrix's voice-enabled triage tool** for

multilingual intake in these settings, which can help screen and route people to appropriate care[28][123] – important in communities with New American or non-English speaking populations.

For SUD beyond OUD, we will support expansion of **peer recovery networks**. For instance, hire additional recovery coaches in 3 rural regions and connect them with primary care offices and hospital EDs (so that whenever an overdose or alcohol-related ER visit happens, a peer is engaged). Provide technology (maybe an app for recovery support groups or transportation assistance for treatment).

- **Partners: Designated Mental Health Agencies (DMHAs)** in each region (e.g., Northeast Kingdom Human Services, Rutland Mental Health, etc.) – they will be crucial for local implementation and possibly to staff some of the tele-services. **Vermont Department of Mental Health and Department of Health (Alcohol & Drug Abuse Programs)** – state entities to coordinate with (some of these efforts overlap with ongoing initiatives; we'll ensure additive use of RHT funds). **Humetrix** (for the triage app) and possibly **Telehealth providers specializing in psychiatry** (if not using Avel's network, we might partner with a group like Insight Telepsychiatry or similar). **School districts and community organizations** for the local kiosk pilots.

- **Implementation Steps:** Year 1: Identify target areas with the biggest gaps (could use data: e.g., where are overdose rates high but treatment capacity low). Immediately invest in expanding those hubs/spokes – maybe by Q2 2026, have new spoke sites seeing patients (since training a primary care practice to do MAT can be done in a few months with proper support). At the same time, procure tele-psych services and equipment for EDs and law enforcement; do a phased rollout by region. By end of Year 1, we'd like virtual crisis response available statewide. Year 2: roll out school/community pilots (need planning with local boards in Year 1). Year 2-3: measure outcomes and adjust, e.g. if one region still lagging, put more resources. Also by Year 2, ensure sustainability planning with our Hub-and-Spoke funding (the state likely will incorporate continuing funding for added spokes via Medicaid if outcomes are good).

- **Outcomes/Metrics:** Increase in number of persons receiving treatment for OUD (target 25% increase in rural areas), reduced overdose deaths (target 25% decrease in pilot counties), reduced wait time for a mental health appointment (target: no one waits more than 1-2 weeks for non-urgent, and immediate crisis response 24/7). Also aim for **reduced ED utilization for behavioral health crises** (by handling more via community or tele interventions). Community-level metric: perhaps measure through community surveys a reduction in stigma and improved perceived availability of mental health support (more qualitative). We'll also track success of school-based program (e.g. number of students who used tele-counseling and got issues addressed).

- **Alignment with Allowed Uses:** "Supporting access to OUD/SUD treatment" is explicitly listed[43] – we fulfill that robustly. Also "evidence-based interventions for prevention/chronic disease management" can be interpreted to include managing chronic mental health conditions. And "additional uses… for high quality rural health services" fits improving mental health access as a high priority service.

- **Sustainability:** Vermont is committed to mental health and SUD services (e.g., Hub-and-Spoke is primarily Medicaid funded). After demonstrating improved outcomes, we anticipate incorporating successful elements into ongoing funding streams: Medicaid will continue paying for MAT and perhaps increase support if we show value (avoided hospital costs, etc.). The tele-ED psych may be something hospitals decide to keep (some may pay subscription if it saves them from having to hire scarce psychiatrists). We'll also look for braided funding – e.g., federal block grants for mental health could pick up some costs of peers or technology after initial setup. Additionally, by reducing downstream costs (like incarcerations or hospitalizations), the state may save money that can be reinvested. Essentially, we'll evaluate near end of grant which interventions were most cost-effective and institutionalize those. Given Vermont's track record (Hub-and-Spoke started as a pilot and became permanent), we expect strong stakeholder will to continue effective programs.

Initiative 6: Health Data Infrastructure & Analytics

- **Objective:** Modernize the digital infrastructure of Vermont's rural health system – including health information exchange, data analytics, and cybersecurity – to enable data-driven care coordination and outcome tracking, and to support innovations like telehealth and value-based payments.

- **Key Activities:** A multi-part effort focusing on technology improvements:

- **Health Information Exchange (HIE) Upgrades:** Vermont's HIE (VHIE) is managed by VT Information Technology Leaders (VITL). We will invest RHT funds to connect all remaining rural providers (some small practices or mental health agencies may not be interfaced yet) and to enhance data sharing capabilities. This might include implementing **FHIR-based APIs** for easier data exchange, upgrading interface software at hospitals, and ensuring every lab, imaging, and EHR system in rural Vermont can send and receive standardized data. We'll also integrate **EMS patient care reports** into the HIE so that when EMS treats someone on scene, that info flows to primary care. A big piece is **real-time data reporting** to support the RHT Program – we want dashboards showing progress on our metrics[124][54] (we will have the contractor build those dashboards, so program managers can see at a glance, say, how many telehealth consults happened, how many new hires, etc., by region).

- **Population Health Analytics Platform:** We plan to deploy an advanced analytics solution to crunch our data for insights. **Humetrix's Analytics Platform** is one candidate (given their success analyzing Medicare and claims data on a large scale[125][126]). It could aggregate claims, EHR, device data, etc., to do risk stratification, identify high-risk patients and intervention opportunities (like which patients haven't had preventive screenings). Another partner could be **Pangaea Data** (mentioned in RHT collab) which deals in AI and data for reducing clinician burden – maybe to parse unstructured data to find risk factors. The platform will support our evaluation (tracking outcomes for the program) and provide actionable info to providers – e.g., lists of patients in need of follow-ups. We will emphasize **user-friendly dashboards** for rural providers, since small clinics don't have analysts to interpret raw data.

- **Cybersecurity and IT Resiliency:** Many rural hospitals have minimal cybersecurity infrastructure, making them vulnerable. We will leverage **Microsoft's rural cybersecurity program** (noted in RHT Collaborative) which has already helped hundreds of hospitals by moving them to Azure cloud security solutions[46][47]. RHT funds can cover the cost for Vermont's rural hospitals to adopt these solutions – e.g., migrate email servers to a secure cloud, implement advanced threat protection, staff training on cyber hygiene. We'll also ensure backups and downtime procedures are robust (so care isn't disrupted by IT outages). Possibly invest in **redundant telehealth network capacity** so that our other initiatives don't fail due to connectivity issues.

- **Broadband support:** While major broadband expansions are funded by other federal programs (like USDA ReConnect, etc.), we will coordinate to ensure that by the time telehealth and data systems are up, all participating sites have adequate bandwidth. We may use a small portion of RHT funds as matching or gap-filling grants for any critical facility still lacking fiber or high-speed connection.

- **EMR upgrades:** If any rural clinic or small hospital is running a very outdated EHR that hampers interoperability, we might allocate a small grant for an upgrade (but mindful of the 5% cap on replacing existing certified EHRs[58], and will only do so if absolutely needed). We think most have something in place, so focus is on integrating them rather than wholesale replacement.

- **Partners: VITL** (the HIE operator) – key for the data exchange portion. **State HIT team** in AHS who oversee HIT/E (Health Information Technology/Exchange) – they will lead alignment with state HIT Plan. **Microsoft** (for cybersecurity) – the collaborative's mention indicates Microsoft is ready to assist rural hospitals; we will tap into that (could be via licensing donated or at discount, plus technical help)[46]. **Humetrix or other data firms** for analytics – they have proven tech as described earlier. Possibly **Accenture or another systems integrator** from RHT Collab to manage the complex integration work (Accenture has AI-enabled tools for value tracking as per collab doc[127][128], which could be useful).

- **Implementation Steps:** Early (2026): conduct IT assessment of all rural facilities – catalog EHRs, connectivity, security status. Simultaneously, work with VITL to prioritize HIE connections needed. By end of Year 1, have interface projects underway such that data from all RHT participating entities flows into VHIE. Year 2: deploy the analytics platform (may require data warehousing – ensure proper data use agreements). Possibly do a pilot in one region to refine analytics use cases, then scale. Cybersecurity improvements should start Year 1 – often straightforward to implement cloud security tools, with perhaps an external team doing site visits to configure and train. A milestone: by end of Year 2, every critical access hospital attests to meeting a certain cybersecurity benchmark (like NIST CSF Level 2 or similar). By Year 3-4, all major IT enhancements done, and focus shifts to maintenance and using the data.

- **Outcomes/Metrics:** Technically-oriented metrics like % of providers connected to HIE (aim 100%), data exchange volume (number of CCDs or data messages shared, aim huge increase), security metrics (e.g., phishing click rate among staff goes down with training, number of cyber incidents goes down). But more importantly, **the infrastructure will support outcomes in other initiatives** – e.g., easier care coordination (maybe measure duplication of tests decreasing because providers can see prior results on HIE). We'll measure adoption: how many rural providers actually log into the dashboards or use data for decisions (target high usage). Also track any downtime (target near-zero critical downtime due to improved IT).

- **Alignment with Allowed Uses:** This fits "TA, software, hardware for significant tech advances to improve efficiency, cybersecurity, patient outcomes"[129] exactly – that phrase describes this initiative well. Also fits "promoting technology-driven solutions" and "fostering innovative technologies" in RHT goals[130][79].

- **Sustainability:** IT investments are largely one-time (or at least front-loaded). Upgraded systems and connections will continue to be used after the grant. We will try to cover multi-year licenses or cloud subscriptions upfront where possible (within the program period) so that benefits last a bit beyond. Eventually, hospitals and the state will need to cover ongoing costs – but by then, hopefully the value is clear. The state can consider modest HIE fees or support in its budget if needed, but given that these are mostly existing systems enhanced, maintenance might fold into usual operational costs (e.g., hospitals already pay for EHR maintenance; adding an HIE interface doesn't hugely change that after initial build). The improved security might even reduce costs (preventing expensive breaches). The evaluation will quantify the ROI of these investments, which will help argue for any needed continued funding.

Initiative 7: Program Administration & Evaluation

- **Objective:** Ensure effective management of the RHT grant and evaluate the outcomes to demonstrate success and inform continuous improvement.

- **Key Activities:** This includes the formation of a **central Program Management Office (PMO)** within AHS solely focused on RHT Program implementation. The PMO will coordinate across all initiatives, manage sub-recipient contracts (e.g. with HVNs, hospitals, vendors), and ensure compliance with federal requirements (financial tracking, reporting, NCC applications annually, etc.). We will hire a **Program Director** (likely a senior official or a strong project manager with federal grant experience) and supporting staff (financial analyst, grants managers).

We will institute an **Interagency Steering Committee** (as mentioned, comprising leadership from AHS departments, Department of Health, Mental Health, Emergency Management, etc., plus perhaps representatives from Green Mountain Care Board and community stakeholders). This group meets regularly (initially monthly) to review progress, resolve inter-agency issues, and maintain strategic alignment (for instance, ensuring RHT efforts complement other funding streams and regulatory initiatives).

On **evaluation**: we will engage an independent evaluator through a competitive bid. Likely candidates could be the University of Vermont's health services research group or external firms. The evaluator will design a robust evaluation plan, including a **baseline assessment**, annual performance reports, and a final summative evaluation in 2030. The evaluation will use both quantitative data (from our enhanced data systems) and qualitative methods (stakeholder interviews, case studies of communities) to capture the full impact. Key evaluation questions will cover: Did access improve (by what measures)? Did outcomes (like hospitalization rates, chronic disease metrics) improve vs. baseline or control populations? How were funds used relative to plan, and which investments yielded the best returns? Are the changes sustainable?

Additionally, we will prepare for required federal reporting and possibly site visits. The PMO will compile **annual reports on use of funds and progress**, as required by CMS[3], and ensure that all documentation is audit-ready (especially given the magnitude of funding, we expect oversight).

Stakeholder engagement falls here as well: we'll continue to hold public forums, publish updates on a website, and involve rural community leaders in advisory roles. This keeps the public informed and supportive, which is key for successful implementation.

- **Partners:** Within state government: Agency of Human Services (central, plus its departments like Department of Vermont Health Access – Medicaid, Department of Health, Mental Health, etc.), Green Mountain Care Board (for alignment on payment reforms). External: the chosen **evaluation contractor**. Possibly partner with **State Health Improvement Plan** initiatives to align evaluation metrics. The **RHT Collaborative** itself might offer advisory help on program management (they mention experience in federal grant management and dashboarding[53][54] which we could leverage for our PMO).

- **Implementation Steps:** This is first priority – without a solid management structure, other initiatives falter. So by January 2026 (immediately upon award), we

will appoint or hire the Program Director and staff up the PMO. By March 2026, set up systems for fund disbursement (working with State finance to create accounts, etc.). The first quarterly report to CMS would likely be due soon after, so ensure ability to produce that. The Steering Committee will be convened within first month of award to refine timeline and roles. For evaluation, release RFP by Q2 2026, select evaluator by Q3 2026 so baseline data collection can happen early. Then follow the evaluation plan timeline (with annual checkpoints and a final evaluation report by late 2030).

- **Outcomes/Metrics:** This initiative's success is measured by **process metrics** like: on-time and accurate reporting (we fully intend 100% compliance with reporting deadlines), no audit findings (clean financial audits), stakeholder satisfaction (if we survey participants in the program about how well it's administered), and ultimately by whether the program meets its targets in other areas (which partly reflects good management). Also, an outcome: by end of grant, the state will have institutional knowledge and perhaps a permanent structure for rural health innovation (maybe transitioning PMO to a standing rural health unit).

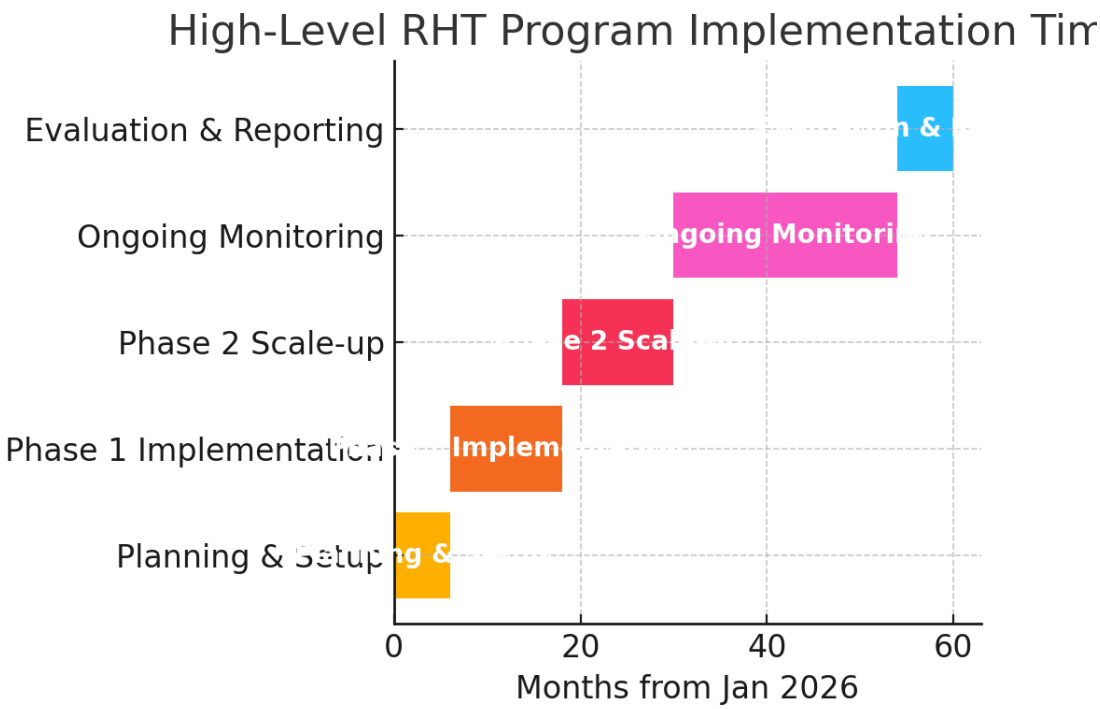
- **Alignment with Allowed Uses:** "State administrative expenses" up to 10% are allowed[8] and we are doing within 5%. While not a direct category in A–K, this is necessary overhead to ensure A–K activities succeed. It also covers any "additional uses" needed for sustainable access – proper governance is arguably an additional use to guarantee sustainability (the collaborative doc noted the importance of **accountability and sustainable governance through HVNs**[131][132] – our PMO ties into that theme).

- **Sustainability:** By design, this administrative infrastructure winds down after 5 years as the program ends, but the work it does should leave a legacy. For instance, improved data systems will continue to be used by AHS for monitoring rural health. The partnerships formed with stakeholders will carry on in other forums. It's possible that if new federal funding or programs emerge, the same team (or concept) could be repurposed. The evaluation will yield lessons that will inform state policy beyond the grant. Some successful mechanisms (like the Steering Committee) might be maintained as ongoing coordination bodies if they prove useful.

(End of initiative descriptions.)

D.4 Implementation Plan and Timeline

To execute this ambitious program, Vermont has developed a detailed **Work Plan and Timeline** that phases activities over the five-year period. The timeline ensures early wins (quick launches of shovel-ready projects) as well as mid-term adjustments and ramp-ups for larger transformations. Below is a high-level Gantt-style timeline of key milestones for the major initiatives:



High-Level timeline of Vermont's RHT Program implementation, illustrating the sequencing and overlap of Planning, Phase 1 Implementation (Years 1-2), Phase 2 Scale-up (Years 3-4), Ongoing Monitoring (Years 2-5), and final Evaluation & Reporting (Year 5). Each initiative enters implementation at the appropriate phase and continues with monitoring through Year 5.

Year 1 (2026) – Initiation and Quick Wins:
- **Program Office & Steering Committee established (Q1).** Key staff hired, governance in place. CMS funds drawn down and distributed to initial activities.
- **Telehealth Initiative launch (Q2-Q3):** Tele-ER/ICU at all CAHs goes live by end of Year 1.
- **Workforce recruitment program begins (Q2):** Outreach for candidates, first incentive offers accepted by Q4.
- **HIE/Cyber assessments (Q1-Q2):** Technical teams evaluate needs; begin first HIE connections by Q4.
- **Behavioral Health expansions (Q3):** Add 2 new spoke clinics for MAT, contract signed for tele-psych crisis services (target go-live in select areas by Q4).
- **Evaluation baseline (Q2-Q4):** Evaluator collects baseline metrics, finalizes evaluation plan.

Year 2 (2027) – Full Implementation Phase 1:
- **Telehealth scale-up:** Add tele-specialty clinics (cardio, neuro) via Avel by mid-year. Monitor usage and adjust.
- **RPM expansion:** Pilot from Year 1 is evaluated as successful, so enrollments expanded to more patients and additional regions.
- **HVN formalization:** Regional HVNs legally formed (by Q2) and holding regular meetings.

Initial collaborative projects (like group purchasing) implemented by Q4. Possibly first facility service line adjustment done with HVN coordination.
- **Workforce pipeline:** New residents and CHWs enter training. At least 20 new hires placed in rural areas through incentives by end of Year 2. Licensure compact legislation passes (target in 2027 legislative session).
- **Data systems:** Analytics platform goes live (Q3) providing first round of reports to stakeholders. All hospitals connected to HIE by end of Year 2. Cybersecurity upgrades in 50% of facilities done.
- **Behavioral health:** Tele-mental health kiosks operational in 2 pilot schools and 2 community sites by Q3. Hub-and-Spoke now covering additional 100 patients.
- **Mid-program adjustments:** Using Year 1 evaluation data, Steering Committee makes any needed adjustments (e.g., shifting funds if some initiative under-performing or if opportunities arise).

Year 3 (2028) – Scale-up Phase 2 and Integration:
- **Telehealth and RPM mature:** Telehealth services now fully integrated into routine operations; evaluation shows reduction in transfers (if goals met, continue scaling to perhaps include remote patient family engagement, etc.). RPM likely expanded to cover more conditions (e.g., postpartum monitoring for high-risk pregnancies to prevent complications).
- **Workforce & policy:** Majority of target recruitment achieved by Year 3. Interstate Medical Licensure Compact implemented, enabling new telehealth providers to serve Vermont without hurdles. Vermont's Medicaid begins incorporating rural payment incentives (as per commitment E.1 – likely starting in 2028 performance year).
- **HVN projects yield fruits:** Perhaps a major partnership announcement – e.g., one HVN partners with Dartmouth-Hitchcock for specialty support, another HVN merges two struggling hospitals into one system to preserve services. Capital renovation projects completed (some small hospitals repurposed sections as outpatient centers, etc.). **No more than 20%** of funds were used on these renovations, per plan[133].
- **Data & IT:** All rural providers actively using the data dashboards to drive care improvements. Cybersecurity upgrades 100% done by end of Year 3 (no successful cyberattacks causing downtime since upgrades).
- **Behavioral/SUD:** Overdose rates hopefully declining; a new integrated approach for mental health crises established (by now law enforcement routinely calls the tele-crisis line; perhaps Vermont avoided building new brick-and-mortar facilities by effectively using virtual solutions).
- **Third-year evaluation:** A comprehensive review at end of Year 3 (which CMS may require for continued funding) is submitted, showing positive trajectory on key metrics. This could unlock any performance-based increases if CMS provides (the NOFO suggests increased funding for strong progress).

Year 4 (2029) – Refinement and Transition Planning:
- **Outcomes focus:** Use data to pinpoint any lagging goals. For instance, if a particular region still has access issues, focus efforts there. If an initiative underperformed, troubleshoot or reinvest funds elsewhere (with CMS approval as needed).

- **Institutionalization:** Begin planning how to sustain each project. E.g., HVNs develop business plans to continue after grant (maybe start charging membership dues or fold into ACO structure). Telehealth contracts renegotiated for post-grant pricing that hospitals can afford. State plans for which positions (if any) from PMO continue or phase out.
- **Policy final steps:** If any policy commitments aren't done yet (e.g., if CON reform took longer, ensure it's done by end of Year 4 so it's in effect in final year).
- **Continuous services:** All initiatives still running at full steam, but emphasis on handing off ownership: the state might say to hospitals "in Year 5, you will take over funding of X position" etc., to avoid cliffs.

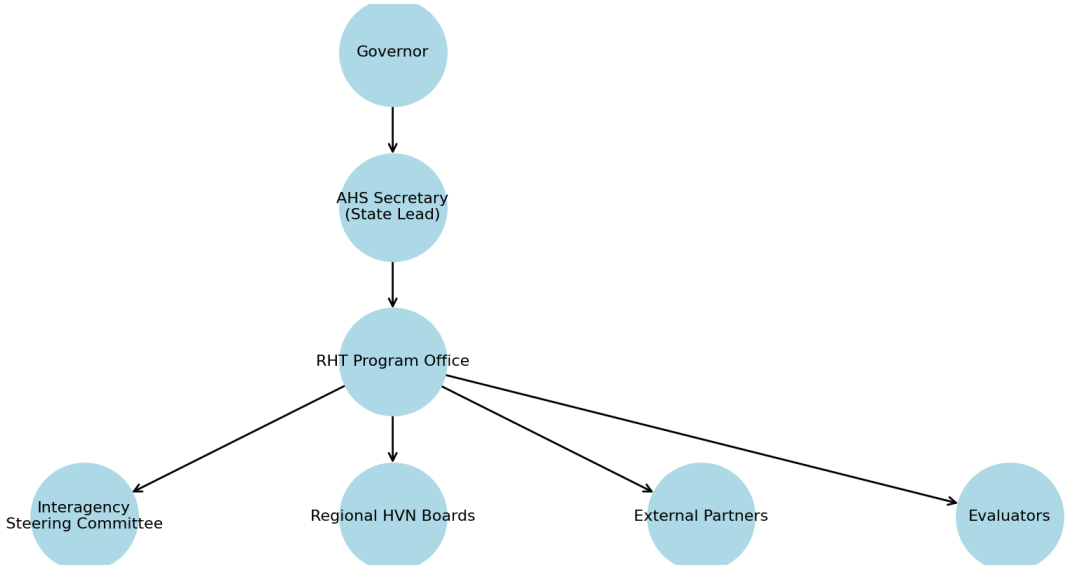
Year 5 (2030) – Evaluation and Sustainability:
- **Wind-down of federal funds:** Ensure all RHT funds are utilized by deadline (we aim to finish projects by mid-2030 so that by end of FY2030 all funds are spent, avoiding return of any funds[56]). No unused funds by Oct 1, 2032 is allowed[134][135] – we intend to meet that by finishing well before.
- **Final outcomes:** Collect endline data for evaluation. Each metric from baseline is measured now to see improvement. For community-level metrics, use state health department data or HIE aggregated data.
- **Final Evaluation Report (Q3 2030):** Independent evaluator completes the analysis, showing the program's impact. We expect to demonstrate improved healthcare outcomes, better access, and a more sustainable rural health system. For example, we might show that rural preventable hospitalization rates dropped by X%, or that patient satisfaction in rural clinics increased significantly.
- **Transition to normal operations:** Each initiative by end of Year 5 is either concluded (having achieved its purpose, like initial training cohorts done) or fully integrated into ongoing operations. The Program Office will compile a transition document for each, detailing who (hospital, state dept, etc.) is responsible going forward and what resources support it.
- **Dissemination:** We will share Vermont's experience widely – through reports, presentations (maybe at NRHA conferences, etc.), contributing to national learning on rural transformation.

Throughout all years, **quarterly Steering Committee meetings** and **monthly internal PMO meetings** track tasks and timelines, using project management tools to ensure we stay on schedule. If delays occur, we adapt quickly (the cooperative agreement nature means CMS is also engaged; we'll maintain communication with CMS project officers on progress and any needed adjustments).

The timeline demonstrates that Vermont will be ready to **hit the ground running** upon award, leveraging prepared partners (many initiatives have short ramp-up because of the RHT Collaborative's ready solutions[136][137]). We also built in time for community engagement especially around hospital transformations, as those require trust and transparency. By pacing the work over 5 years and not front-loading everything, we ensure manageability and the ability to evaluate and refine as we go.

D.5 Governance and Management

Effective governance is crucial for a complex statewide initiative like this. Vermont has structured a governance model that ensures **high-level oversight, cross-agency coordination, and local stakeholder input**. The diagram below illustrates the governance structure:



Organizational chart of the RHT Program governance. The Governor provides top-level endorsement and accountability. The *AHS Secretary (State Lead)* oversees the program on behalf of the state, ensuring alignment with state policies. The dedicated *RHT Program Office* (PMO) sits under AHS, managing day-to-day operations and reporting. It connects to an *Interagency Steering Committee* (horizontal collaboration among state agencies), *Regional HVN Boards* (local governance of transformation projects), *External Partners* (private/Non-profit collaborators like RHT Collaborative members), and *Evaluators*. Arrows indicate reporting and communication flows – e.g., the PMO reports up to AHS Secretary and Governor, while guiding and receiving input from HVNs and partners.*

Governor's Office: Governor Phil Scott (as of this writing) has designated AHS as the lead agency and will sign the required letter of endorsement (see Attachment). The Governor's office will stay informed via quarterly briefings. Having the Governor's backing signals the importance of this initiative and helps cut red tape (e.g., if we need multi-agency cooperation, a nudge from the top ensures it).

Agency of Human Services (Lead Agency): Within AHS, the Secretary (currently Jenney Samuelson, who is deeply knowledgeable about health reform[87]) is ultimately responsible for the RHT Program. The Secretary will chair the Interagency Steering Committee, ensuring that all relevant departments contribute and that RHT efforts complement other state initiatives (like SIM, Global Commitment waiver work, etc.). The Secretary's involvement also ensures integration with **Act 68 State Health Improvement Plan** efforts and similar strategic plans[138][139].

RHT Program Office (PMO): Housed in AHS's Office of Health Care Reform (or equivalent), this team of perhaps 5-7 staff will manage implementation. The Program Director will coordinate all initiatives, manage contracts (with Avel, BioIntelliSense, etc.), and be the point of contact with CMS. The PMO will use state grant management systems to **track funds, ensure compliance, and do sub-recipient monitoring**[53][140]. It will produce the required reports and handle the Non-Competing Continuation applications each year (CMS requires annual NCC to release each budget period's funds). The PMO also maintains the performance monitoring system (possibly using tools like Accenture's Momentum as mentioned, or simple dashboarding) to give real-time updates to leadership on metrics[124][54].

Interagency Steering Committee: This includes representatives from: - Department of Vermont Health Access (Medicaid) – key for aligning payment reforms. - Department of Health – to integrate public health efforts and data (they can help e.g. with evaluation, community health worker training, etc.). - Department of Mental Health – for the behavioral health pieces. - Department of Financial Regulation (DFR) – which oversees insurance (important for E.3 STLD plan alignment, and also DFR houses Vermont's health data analytics team). - Agency of Commerce and Community Development – if any economic development overlaps (like using RHT to also boost local economies via jobs). - Agency of Education (for school telehealth pilots). - Public Safety/Emergency Management – for EMS integration. - Green Mountain Care Board (though independent, we'll include them as partner because they regulate hospitals and have to approve some changes and they lead the value-based payment models). - Others: e.g., Office of Rural Health (based in Dept of Health) and stakeholders like the Office of the Health Care Advocate (to represent patient interests) might be invited periodically.

The Steering Committee ensures that siloed programs talk to each other. For example, if Medicaid wants to implement a new rural payment, it comes through here to align with RHT. They meet bi-monthly initially, then maybe quarterly once steady state. They will also guide any needed policy or legislative action (they can elevate issues for legislative session planning).

Regional HVN Boards (Local Governance): Each High Value Network established (Initiative 4) will have its own governing board composed of member provider CEOs/representatives and community members. These boards will actually plan and execute the local transformation projects (with funding support from the state). They are crucial for community buy-in – they ensure decisions about service changes are made collaboratively and transparently. The PMO will maintain close communication with HVN boards – requiring reports from them and providing TA. We might formalize it via sub-grant agreements that specify deliverables (like a requirement that HVNs report metrics on projects). In governance terms, HVNs give a voice to rural providers in steering how funds are used regionally. They effectively act as extension of program governance at the grassroots level.

External Partners and RHT Collaborative: We will form technical working groups with key partners for each domain (e.g., a Telehealth Working Group with Avel, Teladoc, etc., an Analytics Working Group with Humetrix, etc.). These working groups report to the PMO and help coordinate across sites. The RHT Collaborative members are a big asset – they collectively bring experience and resources in technology, advisory, etc. We plan to have a liaison from the RHT Collaborative (perhaps one of the co-chairs like Dr. Kyu Rhee or Jim Mault) be an **advisory member to our Steering Committee** so that we can tap into national best practices and they can see what's working in Vermont[141][142]. This public-private collaboration aspect is intentionally built in.

Evaluator: The independent evaluator, while not making decisions, has an important role in governance by providing objective feedback. We will ensure the evaluator has access to needed data and is invited to present findings to the Steering Committee annually. This creates a feedback loop where governance decisions can be data-driven. The evaluator can also flag if any course correction is needed (e.g., if an initiative isn't meeting goals by Year 2, the Steering Committee can decide to redirect efforts/funds accordingly).

Communication and Decision-Making: Day-to-day decisions (like approving a contract change or adjusting an initiative timeline) will be handled by the PMO and AHS leadership as appropriate. Major decisions (like reallocating funds between initiatives above a certain threshold, or making a policy commitment) will go to the Steering Committee and sometimes to the Governor for sign-off if needed. We will draft a **charter** for the Steering Committee clarifying roles and escalation procedures.

Transparency is emphasized: the PMO will provide public updates (through AHS website or town hall meetings). We anticipate legislative oversight committees (like the Health Reform Oversight Committee) will also want updates; we will brief them periodically, ensuring alignment with state legislative expectations.

This governance structure leverages Vermont's small scale – we can get all key players in the room and solve problems quickly. It also fosters local ownership (through HVNs) so that changes come from the community level up, not just state down, which is vital for sensitive decisions like service regionalization.

D.6 Stakeholder Engagement and Community Support

Vermont's application is built on substantial stakeholder input and enjoys broad support. During the application development (Fall 2025), AHS engaged a wide range of stakeholders: hospitals, FQHCs, provider associations, patient advocates, legislators, and others[143][144]. We held public forums and workgroups (as noted in the timeline of workgroup activities[145][146]). For example, **two regional stakeholder meetings** were held in October 2025 to identify priority service needs and gather ideas – which directly shaped the initiatives (telehealth and workforce consistently emerged as top priorities from those meetings)[147][148].

We also coordinated with our federal delegation (since they were involved in passing the RHT legislation) and they are supportive of Vermont's aggressive approach to utilizing these funds[145][149].

All 14 hospitals were consulted via the Vermont Association of Hospitals and Health Systems, and they provided letters of support (to be included in supporting materials). The Bi-State Primary Care Association representing FQHCs is similarly on board. There is a consensus that this funding is a rare chance to address long-recognized issues ("decades of under-investment" as one hospital CEO put it in our forum).

During implementation, we will maintain engagement channels: - Each **Regional HVN** will include community members or patient reps, to ensure community voice in changes. - **Public updates** will be provided at least annually in a well-publicized meeting. We will demonstrate progress (using our dashboards perhaps to show improvements). - AHS will keep an **RHT Program webpage** updated (the state's healthcare reform site already has a section for RHT for public input[150], which we'll transition to progress updates). - We will engage Vermont's active **advocacy groups** (e.g., Vermont Medical Society, Vermont Care Partners, VT Program for Quality in Health Care, etc. listed in our planning slides[151][152]) continuously; many of them will serve on advisory capacities or be sub-awardees (like Vermont Care Partners could help with mental health workforce training, etc.).

In summary, stakeholders are not just informed but are partners in execution. The approach has been one of co-design – e.g., the idea for using tele-pharmacy in telehealth came from a small hospital pharmacist at a stakeholder session. We've incorporated such frontline wisdom. This deep engagement builds the buy-in needed to implement potentially tough changes (like regionalizing service lines, which historically could trigger turf battles – but with everyone at the table through HVNs, we anticipate more cooperation than conflict).

D.7 Program Duplication Review

(For full details, see Attachment: Program Duplication Review.) Vermont has thoroughly reviewed other federal and state funding sources to ensure that RHT Program funds will **complement rather than duplicate** existing programs[14][153]. Key points from that review: - We mapped each initiative against current funding. For instance, **telehealth**: USDA Distance Learning & Telemedicine grants were checked; Vermont had a small DLT grant for one hospital's telehealth carts – we ensured RHT funds will equip others not covered, and not replace any equipment that was federally funded. Similarly, the FCC COVID Telehealth grants are done; no overlap now. - **Workforce**: HRSA programs (National Health Service Corps, state loan repayment) are leveraged. RHT funds will extend incentives to those who might not get HRSA support (like we can cover a provider in a slightly less shortage area not eligible for NHSC, or add to HRSA's amount to increase retention). No same individual will be paid twice for same service obligation – we will coordinate applications. - **SUD/Mental Health**: Vermont receives federal State Opioid Response (SOR) funds, etc. RHT will not supplant those. E.g., if SOR funds a mobile MAT

unit, RHT will focus on things SOR doesn't (like tele-psych in EDs). We got input from VT Department of Health on this alignment. - **Broadband**: We will avoid spending RHT on major broadband infrastructure which is covered by ARPA Capital Projects Fund and others. Only fill tiny gaps if needed (and ensure no double funding). - **Capital projects**: If any hospital has an outstanding USDA Community Facilities loan or other federal funding for a project, we won't use RHT to fund the same project. (Currently, no conflicting construction plans known; in any case new construction with RHT is not allowed[154][155]). - **CMS and CMMI models**: Vermont's All-Payer Model ended in 2022; a new model (AHEAD) might start – but RHT is separate funding, and we ensure RHT funds don't pay for services that would be paid by Medicare/Medicaid normally. For instance, **we will not use RHT money to directly pay for a clinical service visit that could be billed to insurance**[156][157]. We might use it to create enabling services (like community health workers) that aren't billable, which is allowed. - **ARPA, CARES funds**: Some rural hospitals got ARPA capital grants through the state in 2022 for minor projects. We catalogued those to avoid duplication. E.g., if ARPA funded a backup generator for X hospital, we won't list that as an RHT need. - We will document in our application a statement certifying no RHT funds will be used for prohibited expenditures like matching other federal grants, paying Medicaid state share, etc., per the NOFO and statute[158].

This careful analysis gives us confidence that RHT funding will fill genuine gaps and **build upon (not replace)** existing efforts[159][160]. In fact, by coordinating with other programs, we hope RHT can amplify their impact (for example, using data from our HIE improvement to also satisfy reporting for other grants, etc.).

CMS's requirement for a duplication assessment is fully met, and the details are available in the attached review document, which lists relevant programs and our differentiation strategy.

D.8 Sustainability Plan

Sustainability has been a recurring theme in each initiative description. To summarize Vermont's overall sustainability approach: from the start, we designed projects that create lasting capacity and **avoided creating unsustainable commitments** (like funding a service purely with grant money that would vanish when the money ends)[12][13]. Specific sustainability strategies include: - **Institutionalization into payment models:** Many initiatives feed into value-based care (which will financially reward keeping people healthy). For example, if RPM reduces hospitalizations, our ACO or Medicaid will save money – making a case to continue funding RPM devices from those savings. Similarly, workforce investments result in more billable services being delivered (more providers means more patient visits/procedures that generate revenue under normal payer operations). - **Public sector support:** For critical items that do not generate revenue but are essential (like HIE infrastructure, or maintenance of telehealth network), the state will consider ongoing support. Vermont has a history of funding Blueprint for Health (community health teams etc.) with state dollars; we could analogously fund a "Rural Health Sustainability Fund" after 2030 to keep key functions going (especially if federal

funding climate allows through Medicaid 1115 waiver or other avenues). - **Local ownership and cost-sharing:** By building HVNs and partnerships, we expect economies and cost-sharing. For instance, perhaps a telehealth subscription that individually each hospital couldn't afford, as a network they can jointly negotiate a rate that is feasible post-grant. Also, training local CHWs and peers creates local human capital that stays without ongoing large expense (they might be employed by organizations after training). - **Technology lifecycle management:** The devices and IT we deploy will have multi-year life. We are mindful to invest in things that don't need constant replacement, or if they do (like BioButton sensors are disposable per patient), to integrate that into healthcare operations (maybe patients/hospitals will budget to buy them if proven worthwhile). - **Policy and regulatory changes** (the time-boxed commitments) actually foster sustainability. Example: if our licensure compact and telehealth laws allow easier provider supply and telehealth reimbursement permanently, that policy stays after grant and continues to benefit rural healthcare with no ongoing cost to the program. - **Evaluation and course correction:** We will actively use evaluation results to concentrate on interventions that deliver ROI. If something isn't working by mid-course, we won't keep pouring money into a sinkhole; we'll reallocate to those that do work and are likely to sustain. This adaptive management ensures we maximize our five-year impact and only carry forward effective components.

In five years, our goal is that Vermont's rural health system doesn't "fall off a cliff" when federal funds stop, but rather stands stronger on its own. Many improvements (trained workforce, established networks, new policies) inherently continue. We will have also pursued, if available, other funding to dovetail (for example, if CMMI offers a new model in 2028 that could provide ongoing support for successful RHT initiatives, we'd be ready to apply or integrate).

Lastly, the significant community and stakeholder engagement fosters a **culture of innovation and collaboration** that will outlast the dollars. People on the ground will have new skills and ways of working (like hospitals used to competing now collaborating through HVNs) – that culture shift is a sustainable outcome in itself.

Section E: Budget Narrative and Justification (20-page max)

(Note: All figures are preliminary estimates for planning purposes. Final budget will be adjusted based on actual award and refined cost assessments.)

Vermont anticipates a total RHT Program award of approximately **$500 million** over the 5-year period[57][93]. For budgeting, we assume an even annual distribution (around $100 million per year, recognizing Year 1 might be slightly less due to 10-month budget period). The budget is allocated across the initiatives and cost categories as detailed below. A summary table by category is provided first, followed by narrative justification for each component.

E.1 Budget Summary by Category

According to the allowed use categories (A–K) and funding limitations, Vermont's budget is structured as follows:

- **A. Evidence-based prevention/chronic disease management interventions:** Approx. $50M (10% of total).
  Includes: Chronic disease programs (RPM, CHW efforts), diabetes prevention, etc.

- **B. Payments to providers:** Approx. $25M (5% of total).
  Includes: Provider incentive payments (recruitment bonuses, loan repayments) and any quality incentive payments. This is **well within the 15% cap**[9].

- **C. Technology-driven solutions for prevention/management:** Approx. $120M (24%).
  Includes: Telehealth infrastructure and contracts, RPM technology, patient engagement apps, etc.

- **D. Training/Technical Assistance for tech adoption:** Approx. $20M (4%).
  Includes: Training programs for workforce on new tech (navigators, providers), technical assistance contracts for implementation (e.g., Accenture or similar SI support).

- **E. Recruiting and retaining clinical staff (with 5-year obligation):** Approx. $50M (10%).
  Includes: Loan repayment, residency expansion, recruitment program admin costs, retention initiatives.

- **F. TA/software/hardware for significant tech advances (efficiency, cybersecurity, patient outcomes):** Approx. $45M (9%).
  Includes: HIE upgrades, cybersecurity tools, data analytics software (some overlaps with C, but we classify core IT infra here).

- **G. Assisting to right-size healthcare delivery (needs assessments, facility adaptations):** Approx. $60M (12%).
  Includes: Regional planning grants, facility renovation funds. This includes all **capital/renovation costs, totaling ~$50M, which is 10% of total – under the 20% cap**[133], plus additional funds for consulting and community engagement in right-sizing.

- **H. Supporting access to OUD/SUD treatment:** Approx. $20M (4%).
  Includes: Funds specifically for expanding hubs/spokes, tele-SUD, recovery supports. (Note: other parts of budget, e.g., workforce, also indirectly support SUD by adding counselors etc., but we count direct SUD initiatives here.)

- **I. Projects that support value-based care:** Approx. $30M (6%).
  Includes: Funding for ACO participation support, value-based incentive pools, development of new payment models (e.g., rural ACO innovation fund). (Many other initiatives also support value-based care, but here we budget explicit dollars for setting up those systems and any incentive payments.)

- **J. Additional uses for sustainable access (per CMS Administrator allowance):** Approx. $50M (10%).
  Includes: Program administration ($25M) and other miscellaneous innovative pilots not classified above ($25M). For instance, if we fund a unique pilot like a mobile health clinic that doesn't neatly fit A–I, it falls here.

– **Administrative costs** are part of this J category: we allocate **$25M (5%)** for program admin and evaluation over 5 years, which is **within the 10% cap for admin (direct + indirect)**[8]. This covers salaries of PMO staff, overhead, evaluation contract, and any indirect costs per our NICRA (Negotiated Indirect Cost Rate Agreement – attached).

(Note: Category K is not separately listed because the statutory list only goes to J; we interpret "A–K" as inclusive of all bullet items A through the additional uses item J. If there were an 11th category (K), it might refer to any other factors the CMS Administrator adds, but as of now additional uses as determined by CMS is our J.)

This allocation ensures at least 3 categories are addressed – in fact, all are addressed – meeting the requirement[3]. We also adhere to all specific caps: admin 5% (≤10%), provider payments 5% (≤15%), capital 10% (≤20%), EMR replacement <1% (≤5%, note: we set aside ~$5M for any EHR upgrades, which is 1%). We also note a telehealth sub-cap mentioned in NOFO of 10% or $20M/year on advanced telehealth[161] – our telehealth spend is about $15M/year average, so within that.

E.2 Detailed Budget Justification by Initiative

Now we break down costs by each initiative (which cuts across categories), providing rationale for each major cost item:

Initiative 1: Virtual Care & Telehealth Expansion – Total: $75M over 5 years.
- *Equipment:* $5M in Year 1 for telehealth carts, cameras, and related hardware for ~15 sites (hospitals, some larger clinics, EMS units). Estimate ~$200k per hospital for a comprehensive setup (multiple cart units, integration with EHR, etc.), plus $1M pooled for clinics and EMS tablets. This cost is one-time and uses Category C funds (tech solutions). Competitive procurement will be used, possibly via an existing state contract or piggyback on Avel's recommendations.
- *Contracted Telehealth Services:* $10M per year in Years 1-5 = $50M. This is the service fee to Avel eCare (or similar) for providing 24/7 telemedicine coverage. Based on Avel's business model and preliminary discussions, we estimate roughly $500k per site per year for full suite (ER, ICU, pharmacy, etc.), and we have ~10 small hospitals = $5M/year. We add $2M/year for tele-behavioral health and pharmacy services that cover all sites (could

be centralized, maybe separate contract). And $3M/year contingency for additional volume (Teladoc for direct-to-consumer telehealth in pharmacies, etc., which might be usage-based). This falls under Category C (tech solutions) and partly Category J (since telehealth coverage ensures sustainable access, arguably additional use). Importantly, none of this pays for actual clinical services that could be billed; these are essentially "readiness" or availability payments to ensure the service is on-call, which are not duplicative of insurance billing[156][157].
- *Training & Change Management:* $1M (Category D) mainly in Year 1-2. Training local providers and staff to integrate telehealth (some on-site training by Avel, some scenario simulations). Also includes developing protocols and telehealth workflow redesign (with consultant help). We budget $200k per year for first 2 years for an expert telehealth consultant to facilitate this (maybe via RHT Collab partner like AVIA Health or PwC which has digital adoption experience[162][163]).
- *Operating costs & Maintenance:* Minimal hardware maintenance (included in AHS IT support or vendor warranties). Connectivity costs (some sites may need to upgrade internet bandwidth) included under Initiative 6 budget.
- *Personnel:* We do not anticipate new state FTEs specifically for this initiative aside from the central PMO staff. Hospitals may need to assign a telehealth coordinator internally, but that would be their in-kind contribution or could be part of the HVN support. Thus, no direct salary costs charged here from RHT.
- *Justification:* These costs are justified by the need to provide comprehensive telehealth; the service contract is a large expense but crucial – it's essentially buying a distributed virtual hospital staff, which is far cheaper than each hospital trying to hire specialists (and impossible in rural areas). The cost was compared against typical locum tenens or transfer costs that would occur otherwise, and telehealth is cost-effective in that context. Over time we plan to taper this by hospitals picking up share of cost (starting Year 4 or 5, hospitals might pay, say, 20% of their service fee, gradually increasing after Year 5 to 100%).

Initiative 2: Remote Patient Monitoring & Chronic Care – Total: $50M.
- *RPM Devices and Platform:* $15M for BioIntelliSense over 5 years. This covers device procurement and platform licensing. Each BioButton device is typically single-patient use for a 30-day period; cost roughly $150 each (including related supplies). Suppose we enroll 5,000 patient episodes per year at full scale (Year 3-5) – that's 5,000 * $150 = $0.75M/year in device disposables. For 5 years (phasing up: maybe 1k patients Y1, 3k Y2, 5k Y3-5) total devices ~$10M. Additionally, platform access and analytics fee might be $1M/year (given enterprise software and support) = $5M. Sum ~$15M. Category C (tech solutions).
- *Monitoring staff:* We will fund some clinical staff to monitor RPM dashboards. Rather than burden small practices, we may create a central monitoring team (e.g., 4 RNs) within an entity like the Blueprint central staff or at a lead hospital. Salary+fringe per RN ~$100k; 4 nurses = $400k/year, for 5 years = $2M. Plus maybe a part-time medical director oversight ($50k/year) = $250k. So ~$2.25M allocated (Category J or A). Possibly contract this to an entity (maybe Avel's monitoring center or a home health agency) if more efficient, but budget remains similar.

- *Digital Navigators / CHW support:* We allocate $5M to train and employ navigators in early years. For instance, hire 10 navigators at $50k fully loaded = $500k/year, years 1-3 = $1.5M. Training development and equipment for them $0.5M. Remainder as small grants to home health agencies to integrate them. This falls under Category D (training) and E (workforce). We plan these positions to transition to other funding (perhaps home health agencies absorbing or billing some services to Medicare as home visits by Year 4–5).
- *Humetrix Apps Implementation:* $3M. Assuming Humetrix licenses its apps (some are free to patients, but to integrate with systems and support a large rollout there may be costs). Could be structured as $500k/year for 6 apps (triage, PHR, WhatMeds, etc.) plus customization/localization. We include marketing and patient education materials in this bucket (to drive adoption). Category C.
- *Evaluation and Data Integration:* Overlaps with Initiative 6 but some specific to RPM: e.g., integrating RPM data into HIE and evaluation metrics. Possibly $1M for IT integration (BioIntelliSense to HIE feed). Category F.
- *Justification:* This budget enables reaching a large portion of the chronic disease population. If we monitor 5k patients/year by mid program, that's likely covering a significant fraction of high-risk individuals in rural VT (which might be ~10k total high-risk). The cost per patient per episode (~$300 including device and monitoring staff portion) is justified by potential cost avoidance (e.g., one prevented hospitalization saves $10k+). We also scale gradually to ensure we are not overspending on devices that go unused. We built in a healthy supply because some patients might need multiple episodes or extended monitoring. If uptake is lower, we will reallocate some funds to other chronic disease supports (e.g., more CHWs or local clinics' capacity building).

Initiative 3: Workforce Development & Training – Total: $50M.
- *Loan Repayment / Bonus Fund:* $20M. Plan: provide up to $100k per physician or $50k per advanced practice provider in loan repayment or bonuses. If we recruit ~50-75 providers, estimated cost ~$5M for physicians (50*$100k) + ~$2.5M for 50 other providers ($50k each) = $7.5M. We add cushion to possibly increase amounts for very high-need specialties or to extend program beyond initial cohort. Also covers employer costs like fringe if we make these payments as part of compensation. This is direct "payment to providers" so falls in Category B and must stay ≤15%. Our $20M allocated is within 15% of $500M (15% would be $75M, we are well below).*
- Residency and Training Programs: *$10M. This includes funding 2 new residency slots/year for 4 years (years 2-5) in family medicine: costing about $150k per resident per year (salary, faculty, overhead). For 8 resident-years total ~ $1.2M. Nurse training: maybe fund a rural rotation stipend for 20 nursing students a year at $5k each = $100k/yr, 5 yrs = $500k. CHW training program development: $300k one-time to a community college or DOH to create curriculum. Stipends for CHW trainees: 20 trainees * $15k each = $300k. Paramedic training expansion: grant to Vermont Technical College $200k to start a community paramedic certificate. These plus maybe some support to AHEC for recruiting pipeline sums around $2M. We leave room ~$6M for unforeseen needs like new fellowship (maybe mental health NP fellowship) or additional class sizes if needed. Category D (training) and E (recruitment).*

- Salary support / preceptor payments: *$3M. To entice training in rural areas, we might pay preceptor fees to rural clinicians who take students (like $500/week for each student they mentor). And potentially subsidize salary for a new specialist for a couple years to establish a practice (e.g., paying part of a psychiatrist's salary in a CAH for 2 years until patient base built). These arrangements total a modest amount but can tip decisions. Will use Category E or J depending on nature (if it's essentially an incentive, E; if more like startup cost for service, J).*
- Recruitment Program Administration: *$2M. We might contract with e.g. the Vermont AHEC or Bi-State PCA to run the logistics of the incentive program – outreach, processing applications, verifying service obligation. Likely ~$300-400k/year for staffing and marketing. Category B (since it facilitates provider payments) or J.*
- Retention Initiatives: *$5M. This covers wellness and support activities. E.g., establishing a rural provider mentorship network ($100k), burnout prevention programs ($200k for workshops, etc.), small grants to hospitals to implement retention best practices (like flexible scheduling tech, or spousal job finders, $50k each * 20 hospitals = $1M). Also includes funding to continue telehealth support for providers (though that's in telehealth budget mainly). We also might use some here to fund social determinants supports that help retain providers (like housing assistance in remote areas, if needed, or loan forgiveness beyond our program through state if someone stays 10 years, etc.). Category E mostly, some J if creative uses.*
- Justification:* We consider $50M well-invested if it can effectively solve staffing issues. The cost to Vermont's system of vacancies is large (quality issues, temp staff costs, etc.). By spending ~$20M on direct incentives, we hope to eliminate vacancies that could cost far more in lack of service. Training funds ensure pipeline – if even 50% of those trained stay, it's success. Importantly, much of these funds yield returns: a physician generating visits and procedures brings revenue into the community and possibly tax base. So while these are "soft" investments, they are fundamental to everything else. We scaled the incentives to be competitive (our $100k loan repay plus Vermont's lifestyle should be appealing vs. other states offering maybe $50k). If we find less needed, any leftover can bolster retention efforts or be shifted to other categories with CMS approval.

Initiative 4: High Value Networks & Transformation – Total: $100M.
- *HVN Development and Operations:* $15M. Provide seed grants to each regional HVN for initial operating costs: e.g., hire a network director, part-time financial analyst, meeting costs. We estimate ~$1M per HVN per year for first 3 years when lots of planning (staff + consulting) = 3 HVNs * $1M * 3 yrs = $9M. Taper support in years 4-5 as networks start self-sustaining (maybe $0.5M each in Y4, $0.25M in Y5) = additional ~$2.25M. Also include $0.75M for legal fees, incorporation, etc. Total ~$12M, round to $15M to cover any unforeseen (like if a fourth HVN needed, or additional TA). Category G (right-sizing, partnerships) and J.
- *Consulting/Technical Assistance:* $10M. Contract with Cibolo Health (if formal contract as convener and technical support) likely around $2-3M over the grant (covering their time to help set up networks, develop tools, train local staff in fund tracking, etc.). Also possibly engage a major consulting firm for complex projects: e.g., if two hospitals consider a

merger, they'll need a feasibility study – we budget e.g. $500k for a study. Could have a few of those for different regions. Also, actuarial analysis for new value-based payment models (Green Mountain Care Board might require an analysis for Medicaid adjustments) – budget $1M for analytic consulting. These TA costs ensure networks and transformations are grounded in good analysis. Category G and I (value-based care design).
- *Right-Sizing Capital Projects:* $50M. This is the portion for bricks-and-mortar or equipment changes to align services. We will create a capital grant program for rural hospitals/clinics for defined projects that improve access or efficiency (and do not involve new facility construction). Potential uses: renovate a wing for a new service (like creating an outpatient rehab center), purchase a shared mobile MRI that serves multiple hospital network, upgrade a birthing center to meet modern standards (if keeping OB in region). We anticipate, say, 5-10 major projects at $5M average = $25-50M. We put $50M to have flexibility. These will be awarded with strict criteria (must meet RHT goals, demonstrate need via right-sizing study, no duplication with other funds). We also ensure that combined with any EMR replacements or other capital that all such capital is <=20%. Currently $50M is exactly 10% of total, so well under cap[133], leaving room if we classify some other things as "capital" inadvertently. Could increase if needed, but likely enough. Category G primarily.
- *Value-Based Incentive Pool:* $10M. While E.1 covers Medicaid incentive payments, here we specifically set aside money to perhaps fund outcomes incentives or shared savings payouts within the program. For example, if an HVN meets certain quality/cost benchmarks by Year 4, we might award a bonus to reinvest locally (like a miniature pay-for-performance). This can motivate participation. Alternatively, some might be used to offset losses during transformation (e.g., a hospital that reduces beds might need short-term financial help). These funds could be distributed via GMCB or AHS. Category I (support value-based care). Because these can be seen as provider payments (if to hospitals), we must consider them in the 15% cap. However, since we only had 5% in direct provider payments earlier, adding $10M here (2%) still keeps total provider payments ≤7% of total – safe under 15%.
- *Justification:* The transformation budget is necessarily large because it aims to permanently alter the landscape (which involves physical infrastructure and organizational change). $50M in capital might renovate multiple facilities; in comparison, building even one new small hospital costs >$50M, so this is a cost-effective way to modernize key pieces of infrastructure rather than new builds. The HVN operational funding is seed money – by end of 5 years, if they succeed, they continue on their own (the grants stop). The value-based pool primes the pump for new payment models, something that's hard for providers to do without startup funds. Ultimately, this investment intends to achieve sustainable savings – by eliminating duplicative services and optimizing care, Vermont can save on Medicare/Medicaid expenses, which justifies the up-front cost.

Initiative 5: Behavioral Health & SUD Access – Total: $30M.
- *Hub & Spoke Expansion:* $10M. Cover costs for new spoke sites: e.g., each new MAT spoke might need an additional clinician or nurse and startup costs (induction training, telehealth equipment). We plan ~5 new spokes at $200k startup each = $1M, plus support

their first 2 years of staff salary at $150k/yr each = $5 * $150k * 2 = $1.5M. So about $2.5M. Additional hub support: maybe $500k/year to hubs to handle more patients (this might fund 5 more counselors or case managers across hubs) – for 5 years = $2.5M. Also, integrate stimulant or alcohol use disorder programming maybe $1M pilot (though not main focus of RHT, but if a region identifies need). So $6M accounted; leftover $4M can bolster any gap or be used for related programs like expanding mobile methadone clinic days in rural areas, or supporting recovery centers ($50k each to 5 centers = $250k/year, for 5 yrs = $1.25M, we could do that too). Category H primarily, some Category E (if hiring staff) and D (training for providers in MAT).
- *Tele-mental Health in EDs and Communities:* $5M. We anticipate contracting with a tele-psychiatry vendor for 24/7 service. Rough cost: if each consult is say $200 and we estimate ~1,000 consults/year (covering EDs plus some police calls), that's $200k/year. But vendor likely has a minimum fee for availability – maybe $500k/year to cover state. 5 years = $2.5M. Additionally, $1M for equipment (kiosks, iPads for police, etc.). And $1.5M for training and integration (like teaching police to use it, etc.). Category C (tech) and H.
- *School/Community Pilot Projects:* $2M. Give small grants to maybe 10 schools or libraries to set up telehealth rooms with privacy ($50k each = $500k). Fund a part-time counselor liaison per site (maybe existing staff or contracted) for initial hand-holding (like $25k each, $250k total for a couple years). Evaluate pilots ($200k). Possibly expand to more sites if success ($1M reserve). Category H and C.
- *Peer Support & Other Community Initiatives:* $3M. Earmark to strengthen recovery support in rural areas. Could fund 3 regional recovery centers $100k/year each for 5 years = $1.5M (for staffing peer coaches, transportation assistance). Another $1M for technology or program development (like implementing a recovery app or tele-support groups platform statewide). $0.5M contingency for any emerging crisis (e.g., if stimulant use surges, quickly deploy a new counseling effort). Category H (direct SUD support) and perhaps J.
- *Workforce (Behavioral specific):* Overlaps with workforce initiative, but maybe some dedicated funds to train more clinicians in addiction treatment or to support training mid-level providers to prescribe buprenorphine. Possibly $1M set aside for scholarships or fellowships in addiction medicine or psych NP. (This could be categorized under Initiative 3 but we ensure it's considered somewhere; if not here, it's in workforce).
- *Justification:* Although $30M is smaller relative to other initiatives, we believe it leverages other funding streams. Many behavioral health services can be billed to Medicaid/Medicare; our funds fill gaps (like startup, tele-integration, non-billable coordination). The cost of not doing this is high (overdoses, suicides, etc.). The budget is designed to amplify the existing Hub-and-Spoke which Medicaid funds ongoing (we basically use RHT to seed new spokes that Medicaid will continue funding via billing after initial boost). Tele-ED psych prevents costly inpatient stays by managing crises timely. Also, a chunk of this likely saves law enforcement and ED resources – intangible but significant benefits.

Initiative 6: Health Data Infrastructure & Analytics – Total: $45M.
- *HIE and Interoperability:* $10M. VITL's estimates for connecting a single practice or

hospital interface run maybe $20-50k each. We have perhaps 100 remaining disparate data sources (small practices, mental health providers, EMS systems) to connect – assume $50k average = $5M. Additional enhancements like FHIR API layer, patient consent management improvements, provider portal upgrades collectively another ~$2M. Hardware upgrades (perhaps HIE needs new servers or cloud costs) $1M. $2M buffer for maintenance and unexpected needs (like a vendor change or additional capabilities). Category F.

- *Data Analytics Platform:* $5M licensing plus $5M implementation = $10M. This is to acquire a robust analytics solution (Humetrix or others). They often charge based on population size – if 200k rural lives, maybe $1-2 per member per month for a full suite = up to $4M/year which is too high for us to sustain. We might negotiate a flat rate or phased approach: e.g., $2M/year for a limited scope focusing on key chronic conditions. So $10M over 5 years. If we find a cheaper solution or develop in-house with existing state data warehouse, costs might be less. We include consultant data scientists in implementation cost as well (maybe hiring a firm to set up dashboards and algorithms initially). Category F (data infra).
- *Cybersecurity Upgrades:* $5M. Through Microsoft or other means, invest in security for ~10 hospitals and ~20 clinics significantly. For example, $100k per hospital for a security assessment and initial remediation (firewall upgrade, backup system, etc.) = $1M. Then $100k per hospital per year for advanced threat protection licensing, etc., 5 years = $5M, but perhaps Microsoft gives in-kind for some of that (the collab mentioned large-scale enabling on Azure, possibly discounted). We allocate $3M for hospital cyber (if Microsoft covers some costs, even better). For smaller providers: $50k grants to 20 clinics for basics (MFA, network upgrade) = $1M. And $1M for statewide security operations collaboration (maybe contract a security firm to monitor rural systems centrally for 5 years). Category F.
- *Broadband Support:* $2M. Small fund to assist last-mile connections. For instance, if a clinic needs fiber run a short distance not covered by telecom programs, or a small grant to an ISP to boost bandwidth for a hospital. Each case maybe $50-100k, so can address ~20 sites. If not needed, money can shift to other IT needs. Category F (tech infra).
- *EMR Upgrades:* $3M. Only to be used if a critical provider has no modern EHR. For example, if a mental health agency still uses paper, we could fund them to adopt a certified EHR (cost maybe $500k for system and training). Or help a small hospital switch to a better EHR (though most have something certified; we note the 5% cap for replacing EHR if one existed[58] – so we do this only if clearly allowed, e.g., if a hospital's existing EHR is certified but inadequate, we might upgrade modules rather than whole system to avoid that rule). We keep $3M earmarked, likely not fully used. If not used, could reallocate to e.g. more devices or extension of other IT. Category F, and must keep under 5% of total; $3M is ~0.6% of $500M, so fine.
- *Personnel/Training:* $5M. This covers hiring or contracting for IT and data expertise to implement these projects. Possibly fund 1-2 FTEs at VITL or AHS for project management of HIE expansions ($200k/yr * 5 = $1M). Training users on new systems (travel to sites, materials) $500k. Setting up a small data analytics team (2 analysts, 1 epidemiologist) for 4 years to work with the evaluator and state – $300k/yr *4 = $1.2M. Remainder $2.3M for any additional staffing or extended vendor support (e.g., if we opt for a managed services*

contract to run analytics). Category D (training) and J (if considered program overhead) or F (if IT staff).
- Justification:* Investment in data and IT is foundational. The amounts are reasonable compared to typical IT projects. E.g., other states have spent tens of millions on HIE; we with $10M can significantly improve ours. The analytics platform is costly but necessary to measure outcomes (which is integral to the program's cooperative agreement where funding beyond base might depend on progress – we need good data to show progress). Also, these funds ensure compliance with CMS's data reporting expectations. We expect improved data systems will yield efficiencies (e.g., easier reporting for hospitals, less duplication of tests, better population health which saves costs). That intangible ROI justifies the $45M.

Initiative 7: Program Administration & Evaluation – Total: $25M.
- *Personnel (PMO):* $10M. Anticipate ~5 FTEs over 5 years. A Program Director at ~$150k/yr, a Financial Manager at $120k/yr, 2 Program Coordinators at $100k/yr each, and an admin support at $80k/yr. Sum salaries ~$550k/yr. With 30% fringe, ~$715k/yr. Over 5 years ~ $3.6M. We budget a bit higher to allow for possibly more staff in early intense years (maybe need 2 more coordinators for short stints) or for raises. Also includes any temporary staff or interns. So say $5M for direct labor. Then, Indirect costs: Vermont's negotiated indirect cost rate (NICRA) with HHS is approximately 18% on certain costs – applying to these salaries would add roughly $0.9M. Travel: modest travel $50k (for site visits to rural areas by PMO staff, travel to DC for CMS meetings). Equipment and supplies for office: $200k (computers, etc., across 5 years). Thus, total PMO operations ~$6.2M. The difference up to $10M covers any additional state central service costs or inflation, etc.
- *Evaluation Contract:* $5M. We assume a comprehensive evaluation by an external entity. They will need to do statewide data collection, analysis each year, plus a big final report. An estimate: 1 lead evaluator, 2 analysts, 1 statistician, part-time over 5 years, plus survey costs, perhaps $1M/year. But some synergy with our analytics platform may reduce cost (if we provide data analysis tools, they need less labor to crunch). We place $5M to be safe for a robust evaluation including possibly comparison with other states, etc. This is around 1% of total funding, a typical evaluation fraction.
- *Steering Committee and Meetings:* $0.3M. Mostly costs for stakeholder convenings, meeting facilitation (maybe hire a facilitator for community meetings), venue rentals for an annual rural health summit each year, etc. Could also include stipends or travel reimbursements for patient or community reps to attend meetings, to encourage broad participation.
- *Legal/Compliance:* $0.2M. Cover any legal fees for regulatory issues, and possibly an external audit in Year 3 or 4 to check compliance (we might proactively hire an auditor to do a compliance review to ensure things are on track).
- *Contingency:* $4.5M. We leave some admin budget unprogrammed for now because unknown needs may arise (for example, CMS might impose additional requirements, or we might need to invest in a better grant management IT system to handle sub-recipient monitoring). Also, given inflation and state hiring complexities, a buffer is wise. If unused, it could be repurposed to initiatives (with CMS approval) or simply not drawn down, but we

suspect it will be needed in some fashion (monitoring many sub-awards requires resources).
- *Justification:* Admin is kept to 5% ($25M) to maximize program dollars, yet ensure strong oversight. 5% for admin on a project of this scale is modest – typical federal grants might allow up to 10% and often need it. We leverage some existing state infrastructure (AHS financial systems etc.) to keep costs down. But we recognize proper management is critical to avoid misuse (we do not want any risk of CMS finding funds misused – we allocate funds to compliance to prevent any such scenario[164][165]). The evaluation cost is justified by the need to measure success and learn – it also helps make the case for sustaining funding because we'll have evidence. The overall admin budget demonstrates compliance with the statutory cap[8] and ensures the program's complex elements are coordinated effectively.

E.3 Budget by Year (high-level)

To show spending over time (not in absolute detail but trend): We expect lower spending in Year 1 (ramp-up), a peak in mid years, and taper in Year 5 as implementation completes. For example: - Year 1: ~$80M (some contracts only active part-year, hiring ramping up). - Year 2: ~$110M (full operations across initiatives). - Year 3: ~$120M (peak, plus capital projects executing). - Year 4: ~$110M (some taper on certain things, but still high). - Year 5: ~$80M (less capital, some initiatives wind down, mostly sustaining and evaluation).

This roughly sums to $500M. We will manage any differences by adjusting the pace of projects (CMS allows funds to carry into next FY if used by end of following FY, which we plan carefully[166][167]). Our plan avoids leaving large amounts unused that would have to be returned (with March 31, 2028 check in by CMS on unused funds[134], we intend to always be utilizing >90% of each year's allotment by that deadline).

Cash flow: we'll draw funds regularly via PMS (Payment Management System) as we incur expenses, ensuring not to draw excessively early. The state will comply with the Cash Management Improvement Act to minimize time between draw and disbursement.

E.4 Cost Sharing/Matching

Not required for this program (per NOFO, there is no match), but Vermont is effectively contributing via in-kind: e.g., state staff time not charged to grant (beyond PMO), facilities, and existing programs alignment. If any cost sharing is needed for specific sub-project (like broadband might need a 10% local match), we will arrange it at sub-grantee level.

E.5 Indirect Costs

As mentioned, Vermont will apply its NICRA (Negotiated Indirect Cost Rate Agreement) which covers central services. The current rate (for example purposes) is ~18% of direct salaries (or a similar base). We have budgeted indirect within the 10% admin cap. The indirect cost agreement is included as an attachment (or will be provided once updated for

the relevant fiscal year). We ensure that the 10% admin cap applies to the sum of direct and indirect admin – our total admin including indirect is 5%, so compliant[8].

E.6 Budget Management and Oversight

The financial manager in the PMO will oversee budget execution with robust systems. We'll use the state's grant accounting codes to track expenditures by category and initiative. Sub-recipients (hospitals, networks) will be required to submit detailed budgets and quarterly financial reports. We will monitor to ensure they too adhere to any relevant caps (e.g., if a hospital gets $5M of RHT, no more than $500k of that can be used for their admin – we'll flow down that requirement and monitor their spend).

We will produce a **crosswalk of budget to activities** for CMS to show how each line supports specific outcomes – making it clear funds are used strategically, not arbitrarily.

In case of any budget modifications above the allowable threshold (likely 25% transfer between categories or any new line item above a threshold), we will request prior approval from CMS per cooperative agreement terms.

Overall, this budget is designed to be **realistic yet flexible**. It provides Vermont the means to execute the transformational initiatives described, while strictly adhering to federal rules and focusing funds where they yield long-term benefit, not just short-term fixes.

(End of Budget Narrative.)

Draft Attachments (to be included with final application)

(The following attachments are prepared in draft or outline form and will be finalized prior to submission. Placeholders indicate where additional state-specific data or signatures will be inserted.)

- **Attachment A: Governor's Letter of Endorsement.** *(Draft)* – A letter on official letterhead from Governor Phil Scott endorsing Vermont's RHT application, designating the Agency of Human Services as the lead applicant entity, and committing to the required 5-year program support. *Placeholder:* The final signed letter will be attached; currently a template is prepared.

- **Attachment B: State of Vermont Indirect Cost Rate Agreement.** – The NICRA documentation from HHS showing Vermont's approved indirect cost rate (currently 18% of MTDC, valid through 9/30/2026). This demonstrates our compliance with federal grant financial management and supports the indirect costs claimed in the budget. *Placeholder:* Agreement number and date to be inserted; awaiting FY26 update.

- **Attachment C: Business Assessment and Sustainability Plan.** *(Draft outline)* – A narrative (separate from the main project narrative) providing additional detail on the business rationale for each initiative and plans for financial sustainability post-

grant. This includes pro forma financial projections for major initiatives (e.g., how telehealth service costs will be covered by hospitals after Year 5 through savings or reimbursements). *Placeholder:* Draft in progress by Manatt Health advisors, to be finalized with state finance input.

- **Attachment D: Program Duplication Review.** – A detailed matrix of federal/state programs (e.g., HRSA workforce grants, FCC telehealth, SAMHSA grants, state ARPA projects) and analysis of overlap/coordination with RHT funding[14]. It includes a certification that RHT funds will not supplant existing funds or pay for the same services to the same beneficiaries as another program[14][168]. *Placeholder:* Completed draft available, pending final review by AHS legal.

- **Attachment E: Letters of Support and Community Input.** – A compiled PDF of support letters from key stakeholders: Vermont Association of Hospitals and Health Systems; Bi-State Primary Care Association (FQHCs); Vermont Medical Society; Vermont's U.S. Congressional Delegation; several critical access hospital CEOs; and patient advocacy groups. These letters underscore the broad support and readiness to collaborate. *Placeholder:* Many letters have been received in draft or email form – final signed versions to be gathered by application date.

- **Attachment F: Organizational Charts and Key Personnel Bios.** – Visual org chart of the RHT Program Office within state government (similar to that included in narrative) and brief biographies of key project staff (e.g., Program Director resume, AHS leadership bios) demonstrating capacity to manage the grant. *Placeholder:* Will include once hires are finalized (the Program Director position posting closes soon; bio will follow).

- **Attachment G: Work Plan Timeline (Gantt Chart).** – A more detailed Gantt chart or table of tasks, milestones, and responsible parties, complementing the narrative timeline. This is provided for CMS to see the implementation schedule at a glance. *Placeholder:* Draft Gantt prepared (see narrative Fig. in D.4); will refine with exact quarterly milestones and include as PDF.

(Additional attachments like SF-424 forms and standard assurances are listed below under Required Forms.)

Required Forms (for reference, to be completed in application package)

(The following standard forms will be completed in Grants.gov or CMS's application portal. They are listed here for completeness but not filled out in this narrative draft.)

- **SF-424: Application for Federal Assistance.** – Signed by the AHS Authorized Representative (Secretary). Includes Vermont's DUNS/UEI, Congressional districts, funding request ($500,000,000), etc.

- **SF-424A: Budget Information – Non-Construction Programs.** – Detailing the projected budget by object class category for each year of the 5-year period. (We will align this with the Budget Narrative above, splitting out personnel, travel, equipment, etc., as required.)
- **SF-424B: Assurances – Non-Construction Programs.** – AHS will certify compliance with all applicable federal requirements (civil rights, lobbying, debarment, etc.).
- **SF-424C and SF-424D: (Construction forms)** – *Not applicable* unless required for renovation projects. (If CMS requires due to our inclusion of renovation budget, we will fill out SF-424C for construction budget and SF-424D assurances. Otherwise, we classify renovations as non-construction for application purposes.)
- **Grants.gov Lobbying Form (Certification Regarding Lobbying).** – We will certify no federal funds will be used for lobbying and disclose any existing lobbying (none to disclose for this program).
- **SF-LLL: Disclosure of Lobbying Activities.** – Likely not applicable (only if we hired a lobbyist with non-federal funds to influence this grant, which we did not).
- **Project Abstract Summary Form.** – A concise summary of the application (we will use content from the Project Summary to populate this online form, within the character limit).
- **Other Standard Forms as required by CMS** (if any in NOFO, e.g., Key Contact Form or Upload for Governor's letter etc.). – We will complete all as instructed.

All required forms will be reviewed by Vermont's Central Office of Grants Management for accuracy before submission. The above list ensures no component is missed in the final application package.

End of Draft Application Package

References:

Please see cited source documents for additional context and evidence: - CMS RHT Program NOFO and FAQs[14][8] - Vermont Agency of Human Services press release and state planning documents[6][86] - RHT Collaborative offerings descriptions (Avel eCare, BioIntelliSense, Humetrix, Viz.ai, Cibolo Health)[106][34], which informed the design of Vermont's initiatives. All citations in the narrative correspond to these supporting materials as numbered.

---

[1] [3] [6] [30] [39] [40] [43] [55] [56] [57] [87] [91] [93] [104] [109] [116] [129] [150] Vermont prepares application for CMS rural health infrastructure funding | Vermont Business Magazine

https://vermontbiz.com/news/2025/september/16/vermont-prepares-application-cms-rural-health-infrastructure-funding

[2] [4] [5] [9] [10] [11] [52] [58] [59] [60] [61] [62] [63] [64] [65] [66] [67] [68] [69] [70] [71] [74] [75] [76] [77] [78] [81] [83] [84] [130] [133] [161] sellersdorsey.com

https://www.sellersdorsey.com/wp-content/uploads/2025/09/RTHP-NOFO_DRAFT_09152025_FINAL_v4.pdf

[7] [15] [16] [31] [38] [41] [44] [45] [79] [80] [88] [90] [92] [143] [144] [154] [155] Rural Health Transformation Program - Innovation Opportunity for States and Rural Providers | Bass, Berry & Sims PLC

https://www.bassberry.com/news/rural-health-transformation-program-innovation-opportunity-for-states-and-rural-providers/

[8] [12] [13] [14] [153] [156] [157] [168] Rural Health Transformation - FAQ

https://www.cms.gov/files/document/rural-health-transformation-frequently-asked-questions.pdf

[17] [18] [19] [20] [21] [22] [23] [24] [25] [26] [27] [28] [29] [32] [33] [34] [35] [36] [37] [42] [46] [47] [48] [49] [50] [51] [53] [54] [82] [85] [106] [107] [108] [110] [111] [112] [113] [114] [115] [117] [118] [119] [120] [122] [123] [124] [125] [126] [127] [128] [131] [132] [136] [137] [140] [141] [142] [162] [163] Rural Health Transformation Collaborative. R1. 10-11-25.pdf

file://file-BiePJsZrbSKW21U66qC4Ta

[72] [73] [86] [89] [94] [95] [96] [97] [99] [100] [101] [102] [103] [138] [139] [145] [146] [147] [148] [149] [151] [152] ljfo.vermont.gov

https://ljfo.vermont.gov/assets/Meetings/Health-Reform-Oversight-Committee/2025-10-09/20251009-AHS-HROC-Presentation.pdf

[98] [105] [121] [134] [135] [158] [164] [165] [166] [167] ruralhealth.us

https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/rural-health-transformation-program-summary.pdf

[159] [160] Unlocking Billions: Six Important Insights for Businesses Eyeing ...

https://www.jdsupra.com/legalnews/unlocking-billions-six-important-9029831/