Request for Grant Applications (RFGA)

Application due 7/22/2026 at 5:00 p.m. MT

Department of Health & Human Services

Utah Rural Health Transformation Program

FAST 4.1 Support for Rural Providers to Transition to Value-Based Care (VBC) Models

Opportunity number: URHTP-2651-2026

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Table of contents

Section 1: Project Overview 3
- Background 3
- Purpose of Request for Grant Application (RFGA) 3
- Eligible Applicants 4
  - Minimum Mandatory Eligibility Requirements (Pass/Fail) 4
- Partners 5
  - Consortium Application Framework 5
- Completeness and Responsiveness Criteria 6
- Application Limits 7

Section 2: Funding Details 7
- Funding type: Grant agreement 7
- Agreement Period 7
- Cost Sharing 8
- Use of Funds 8

Section 3: Services and Deliverables 8
- Grantee Expectations 12

Section 4: Payments 13

Section 5: Application 13
- Application Questions 14

Section 6: Application Review 18
- Compliance and Eligibility Review Process 18
- Technical Review Committee 18
- Scoring for Applications 19
- Award timeline 24
- Disqualification 24

Section 7: Additional Resources 25

Apply by the application deadline:
July 22, 2026 at 5:00 p.m. Mountain Time (MT)

Section 1: Project Overview

Background

The Rural Health Transformation Program (RHTP) is a five-year federally funded initiative from the Centers for Medicare & Medicaid Services (CMS) designed to modernize and strengthen health systems within rural communities. In November 2025, the Utah Department of Health and Human Services (DHHS), acting as the state's lead agency, submitted a stakeholder-informed application to CMS. Consequently, Utah was awarded $195.7 million in federal funding for Year 1. While the program is anticipated to run through 2030, continued annual funding is contingent upon program outcomes, the availability of funds, and CMS discretion.

Utah's RHTP framework is built upon four strategic pillars: Making Rural Utahns Healthy, Workforce Development, Innovation and Access, and Technology Innovation. These pillars are operationalized through 24 key activities divided into seven integrated initiatives: PATH, RISE, SHIFT, FAST, LIFT, SUPPORT, and LINCS. These initiatives and activities aim to unite rural stakeholders to transform rural healthcare delivery, strengthen patient-centered care, and drive measurable improvements in health, coordination, and financial sustainability across rural Utah.

The Financial Approaches for Sustainable Transformation (FAST) initiative is a core component of Utah's RHTP plan. Aligned with the Sustainable Access and Innovative Care strategic goal, this initiative encompasses three key actions designed to address core financial and care delivery challenges that hinder rural healthcare viability in Utah. This specific funding opportunity is directly linked to key action 4.1: Support rural providers in transitioning to value-based care models and subactivities 4.A.-F.

Detailed eligibility criteria and program expectations are outlined in the subsequent sections of this application packet.

Purpose of Request for Grant Application (RFGA)

The purpose of this request is to select one Grantee via a competitive application to support rural health systems in transitioning to, or expanding existing value-based care (VBC) models through targeted technical assistance, training, and operational support. The selected Grantee will conduct a

comprehensive assessment of rural providers' readiness to adopt or enhance VBC and provide expert guidance on the implementation and operationalization of VBC models.

The Grantee will be responsible for developing financial models and establishing, maintaining, and continuously enhancing comprehensive education, training, onboarding, and technical assistance resources throughout the five-year agreement period. In addition, the Grantee will support the development of the capacity and infrastructure necessary to operationalize and expand VBC through sustainable improvements to data systems, interoperability, and care delivery capabilities. The Grantee will also continuously evaluate effective strategies and facilitate the long-term adoption of VBC models among rural providers.

As part of this effort, the Grantee will support entities implementing value-based payment models with at least two payers serving rural Utah communities. Consideration may also be given to the formation of a Clinically Integrated Network (CIN) as a strategy to support implementation and sustainability. The program will support activities necessary to achieve the benchmarks established by the RHTP FAST initiative. See Utah's RHTP plan at DHHS's RHTP website at dhhs.utah.gov/ruralhealth/. Click Utah's RHTP Full Project Narrative.

Questions regarding this RFGA should be addressed to the Utah RHTP team at ruralht@utah.gov. All questions and answers will be compiled and posted publicly in a continuously updated Q&A document located on Utah's RHTP funding opportunities website at dhhs.utah.gov/ruralhealth/funding-opportunities/. Applicants are encouraged to check the document regularly for updates. The final day to submit questions is **July 20, 2026 at 5:00 p.m. MT**, and the final Q&A document will be updated by **July 21, 2026 at 5:00 p.m. MT.**

Eligible Applicants

To ensure stewardship of federal funds and the highest quality project execution, applicants will be evaluated on two distinct tiers of criteria: Minimum Mandatory Eligibility Requirements (evaluated on a pass/fail basis) and Scored Technical Criteria (evaluated by reviewers based on the application proposal).

Minimum Mandatory Eligibility Requirements (Pass/Fail)

Applicants must meet all of the following minimum criteria to move forward to the technical review. Failure to meet any of these items will result in immediate disqualification.

- **Legal Entity Status and State Vendor Registration:** Open to Utah-based non-profit 501(c)(3) entities, Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), or professional healthcare consulting firms/consortiums with documented, direct operational histories in value-based care architecture.
- **Operational History Check:** The lead applicant, or their core technical partners/subcontractors, must demonstrate a minimum of three consecutive years (as of January 2026) actively managing network governance, executing clinical/financial integration strategies, or building multi-facility data reporting platforms. Compliance must be verified by submitting at least two of the following items:
    - Official participation records in the CMS Medicare Shared Savings Program (MSSP) or commercial VBC programs or proof of participation for the applicant's managed healthcare networks/CINs.
    - Three consecutive years of corporate tax returns or audited financial statements.
    - Executed network participation agreements showing multi-year facility management.
- **Federal and State Standing:** The applicant must not be debarred, suspended, or otherwise excluded from receiving federal or state funding.

Partners

Consortium Application Framework

DHHS highly encourages applications from unified consortiums, alliances, or joint ventures. For example, a recognized state-level healthcare collaborative, regional health network, or non-profit convener may apply as the lead applicant, provided they formally partner with specialized technical subcontractors (e.g., healthcare data engineering firms, actuarial consulting groups, or established VBC management networks). In these arrangements, the collective experience of the entire proposed project team and partners will be evaluated together to satisfy technical and operational history requirements.

Only the organization that submits an application (lead applicant) can be the primary recipient of the award. Applicants may sub-award or contract RHTP funds to partners for various activities. However, these partners are not co-applicants. The Grantee responsible to DHHS will be the lead applicant that submitted the application and was awarded funding.

Scored Technical Criteria (Evaluated via Application)

Reviewers will score the quality, depth, and feasibility of the application based on the following technical competencies:

- **Outreach, Training, and Technical Assistance:** The applicant must provide evidence of successfully designing and executing outreach campaigns and hands-on technical training for diverse healthcare stakeholders. Applications must demonstrate how training adapts to shifting provider capacities.
- **Readiness Assessment and Identification:** Demonstrated expertise evaluating an organization's current financial, technological, and operational capabilities to determine their baseline preparation for implementing VBC. This includes the capacity to establish a unified baseline master directory to track the grant's core performance metric across rural healthcare providers.
- **Strategic Approach:** Demonstrate a strategic approach to drive collaboration, financial modeling, data infrastructure, and sustainability. Applicants must demonstrate how their data strategy will measurably raise the core performance metric (percentage of equipped facilities per county).
- **Analysis and Evaluation:** Demonstrated ability to conduct comprehensive analysis and evaluation of value-based payment models. Evaluation frameworks must capture clinical and financial outcomes across the multi-payer pilot structures to drive ongoing strategic program decisions.
- **Operationalization:** A proven track record of successfully assisting rural providers with transitioning to VBC models. This includes the capacity to operationalize Clinically Integrated Networks (CINs) and establish long-term pathways that transition pilot structures into permanent, self-sustaining programs.
- **Experience and Qualifications:** Exceptional capacity to coordinate, align, and drive consensus among various rural healthcare providers, health systems, insurers, and state regulators in rural communities. Under the allowed consortium framework, the collective experience of lead conveners and technical subcontractors will be scored together to evaluate this capacity.
- **Budget:** The applicant must provide a total budget which is within the maximum award amount including line items that are relevant and justifiable within scope of the RFGA project.

Completeness and Responsiveness Criteria

DHHS will review the application to make sure it meets the requirements set forth in this RFGA document.

DHHS will not consider an application that:

- is from an organization that does not meet all Minimum Mandatory Eligibility Requirements;
- is submitted after the deadline;
- is not submitted via the provided application link; and
- does not include all of the components required in the application.

Application Limits

DHHS will accept only one formal application per entity. In the event that multiple completed applications are received from the same entity, only the final submission recorded prior to the application deadline will be considered for review, and all preceding versions will be disqualified.

Section 2: Funding Details

Funding type: Grant agreement

Maximum funding available for Year 1: Up to $6,000,000.00

Maximum funding available for the agreement: Up to $15,000,000.00 over a 5 year period, contingent on the availability of funds.

Expected total number of awards: Up to one.

Grant extensions and terminations are determined by availability of funds, grantee performance, and the discretion of CMS and DHHS.

Agreement Period

The agreement period is anticipated to begin **September 8, 2026** and end on **September 30, 2031**. All funds related to project implementation must be expended for each Budget Period by the end of the following federal fiscal year (September 30 of the following year). Failure to expend funds by the end of each following federal fiscal year will result in funds recouped by DHHS to return to CMS.

Cost Sharing

This RFGA has a no cost-sharing requirement, meaning applicants are not required to contribute to the costs of this project.

Use of Funds

The Grantee agrees to use all funds received under this agreement only for the permissible uses defined in the CMS Notice of Funding Opportunity (NOFO) and Utah's initial Notice of Award (NOA). These uses are governed by Federal statute: Pub. L. No. 119 21, § 71401 (July 4, 2025) (codified at 42 U.S.C. § 1397ee(h)) ("Rural Health Transformation Program"). Use of funds categories may not be applicable to specific project tasks or to all phases of project implementation. Descriptions of Use of Funds categories are outlined in the NOFO p. 11, 12 and NOA p. 9-12.

The Grantee shall not use funds provided under this agreement for any unallowable costs. Prohibited expenditures under CMS guidelines and the federal RHTP may not be applicable to specific project tasks or to all phases of project implementation. Unallowable costs are outlined in the NOFO p.18-20 and the NOA p. 9-12.

Section 3: Services and Deliverables

This section describes the expected activities and deliverables of the Grantee to support rural providers and networks with initiating, expanding, and/or implementing sustainable VBC models in rural Utah. The following milestones and benchmarks should be incorporated into the description and approach in the application.

Foundational and Ongoing Activities — Assess, Educate, Train, and Identify. At a minimum:

1.1. Assess and build rural providers' VBC readiness.

- Conduct an immediate, comprehensive assessment of VBC readiness, participation interest, and implementation needs across rural hospitals, certified outpatient clinics, and rural healthcare providers.
- Convene commercial payers, health system executives, and state regulators to establish standardized, non-competing VBC participation protocols.

- Provide ongoing education, training, and strategic communication to build baseline awareness about VBC models, in alignment with existing federal VBC models as appropriate.

Foundational Deliverables:

- A county-by-county master directory of rural hospitals, certified outpatient clinics, tribal health (I/T/U) facilities, and local behavioral health authorities in Utah. This document serves as the official baseline denominator for the grant's core performance metric, explicitly identifying which facilities currently have VBC data infrastructure in place and which do not. Since providers and facilities may decline to participate in the baseline assessment or subsequent programming, performance metrics will track progress solely among actively engaged sites.
- A summary report identifying sites that are ready to immediately receive support.
- A signed organizational charter or document establishing a formal, Rural VBC Steering Committee. This asset demonstrates that the commercial payers, health system executives, and state regulators have formally met, established a governance structure, and approved a year 1 project roadmap to standardize rural VBC quality metrics.

Developmental Activities — Strengthen VBC infrastructure in rural Utah. At a minimum:

2.1. Build and strengthen capacity and infrastructure to operationalize and expand VBC.

- Build financial models that sustain operational capabilities
  - Develop detailed financial models and long-term sustainability analyses for interested or participating rural providers.
  - Develop sustainability plans that advance actionable strategies for achieving operational stability, improving care coordination, and maximizing participation in value-based payment models over time.
- Strengthen data infrastructure that enhances data collection, analytics, and reporting capabilities
  - Directly advance progress toward the grant's core performance metric (percentage of rural health facilities in each rural county with data infrastructure in place for value-based payment) by expanding data infrastructure across the rural healthcare ecosystem.
  - Support the development of a robust data infrastructure designed to enhance quality measurement, reporting, and performance monitoring in preparation

for participation in value-based payment models. This infrastructure should advance data capabilities, such as data collection, interoperability, analytics, and reporting necessary to track outcomes, identify care gaps, and meet payer reporting requirements.

- Deliver comprehensive VBC education, training, onboarding, and technical assistance throughout the five-year agreement period. Support will be dynamically tailored to the shifting progress, readiness, and capacity of participating rural providers. Technical assistance pathways will be informed by provider assessments and may encompass core VBC capabilities as appropriate, including but not limited to:
  - Financial & Strategic Modeling: Understanding risk-bearing arrangements and payer negotiations.
  - Data & Interoperability Infrastructure: Enhancing technical capabilities for data sharing, interoperability, and timely insurance data availability.
  - Network & Administrative Scaling: CIN operationalization/expansion and the integration of centralized administrative services.
- Proactively identify and address any operational challenges in preparation for the successful implementation of new or expanded VBC pilots.

Developmental Deliverables:

- A formalized procurement log detailing the bulk purchase and distribution of data analytics software licenses, EHR interface bridges, and performance-monitoring tools for Phase 1 priority facilities.
- A technical system blueprint delivering standardized data collection architecture, outcome-tracking workflows, and care-gap reporting protocols designed to meet multi-payer data requirements.
- Aggregated and synthesized report on the selected VBC models and alignment with existing federal VBC models.
- Report on tailored technical assistance to participating rural providers and networks.

Implementation Activities — Pilot new or expanded existing VBC models. At a minimum:

3.1. Support the implementation of new or expanded VBC pilots.

- Assist at least two rural providers with launching or expanding VBC models. Monitor the initial performance of the pilots, using the enhanced data infrastructure to track quality reporting and patient outcomes.

3.2. Payer onboarding.

- Facilitate and finalize VBC contracts with at least two primary payers serving rural Utah.

3.3. Alignment with RHTP outcomes

- Design VBC education, technical assistance, and pilot financial models that explicitly track and drive progress toward Utah's RHTP federal commitments. While pilots should be scalable across a comprehensive range of clinical outcomes, they must, at a minimum, deploy care coordination pathways and financial tracking that address the following key program outcomes:
  i. Access & Stability: Improving appointment wait times (Metrics B.2) to safeguard rural facilities against closure or service reductions (Metric B.1).
  ii. For additional key program outcomes and measures refer to Utah's Rural Health Transformation Plan.

Implementation Deliverables:

- Log of technical assistance and operational guidance to enable rural providers to successfully pilot new or expanded VBC models.
- A finalized master training schedule, onboarding packets, and multi-channel educational modules covering the mandatory concepts (financial modeling, data infrastructure, payer negotiations, timely insurance data availability, CIN operationalization, and centralized administrative services), accompanied by a 5-year deployment schedule.
- Delivery of the baseline, repeatable financial modeling templates and long-term sustainability analysis frameworks developed for participating hospitals and certified clinics.
- Delivery of finalized agreements with at least two primary payers, alongside an operational readiness report documenting participating providers, baseline data parameters, and pilot workflows.

Evaluation Activities — Critically evaluate VBC pilots. At a minimum:

4.1. VBC Evaluation.

- Conduct a comprehensive evaluation of the value-based payment model pilots across the payer partnerships to assess clinical, operational, and financial performance. Identify measurable successes and areas of mid-course correction to guide key decision-making.

Evaluation Deliverables:

- Comprehensive evaluation report.

Operationalization and Sustainability Activities — Ensure the VBC model remains sustainable. At a minimum:

4.2. Transition from pilot to program.

- Assist rural providers with transitioning the evaluated pilot program into a permanent, fully integrated VBC model. Assistance may include:
    i. Ensure all expanded technical capabilities for interoperability and quality reporting are permanently sustained and compliant with data-sharing regulations.
    ii. Ensure CINs are fully operationalized and/or expanded for sustainable functionality.

Operationalization and Sustainability Deliverables:

- A comprehensive strategy document outlining the permanent transition of rural providers from the initial pilot phase into a fully integrated, long-term VBC model. This asset must explicitly detail:
    - Operational protocols to ensure all expanded technical capabilities for interoperability and quality reporting are permanently sustained and fully compliant with state and federal data-sharing regulations after federal grant funding phases out.
    - A structural roadmap ensuring that Clinically Integrated Networks (CINs) are fully operationalized and/or expanded for sustainable functionality, relying on performance-based revenues and shared savings rather than future State of Utah financial obligations.

Grantee Expectations

The Grantee will be expected to adhere to the following:

- Meet at least monthly with the Utah RHTP team to coordinate activities, provide updates about findings and progress of activities, and ensure all contractual requirements are met.
- Provide monthly reimbursement requests/invoices of expenses in accordance with State Contracting processes.
- Attend all RHTP trainings related to the project.
- Provide all services and deliverables described in the agreement.
- Participate in the DHHS evaluation process.

- Timely delivery of reports to Utah DHHS as outlined in the Grantee agreement.

Section 4: Payments

Utah RHTP shall reimburse the Grantee based on the negotiated budget, not to exceed the funding available for this agreement. Expenses shall be reimbursed based on actual expenditures with appropriation documentation. Expenditures must follow the guidelines described below. The categories defined below are the only expenditures allowed under this agreement.

Grantees must submit reimbursement invoices of expenses monthly in accordance with State Contracting processes. Payment(s) may be withheld until the services and deliverables defined in this agreement are completed. These funds are not to be used for purchasing meals. The only exception is for per diem reimbursement for authorized personnel while traveling.

Categories	Rate/allowable costs*
Personnel: salaries/fringe	Personnel working on project implementation
Administration of funding	Up to 6% of the total amount requested. This 6% limit applies to administrative costs for your entire budget, including indirect and direct costs.
HITECH Certified EMR System	No more than 5% of total State funding in a given budget period can support funding the replacement of an EMR system if a previous HITECH certified EMR system is already in place as of September 1, 2025.
Project implementation	Expenses to create and execute project and agreement requirements
Travel	Mileage/meal reimbursement (per diem)
Supplies	Purchases under $10,000.00
Other	Other costs (e.g., software licenses, data sources, etc.)

*See the CMS NOFO for full information on allowable and unallowable costs.

Section 5: Application

To be considered for this RFGA, interested applicants must submit an application and budget using the following linked forms:

- Application link: utahdhs.iad1.qualtrics.com/jfe/form/SV_4SGJZRPv6E3D5DE
- Budget template link: docs.google.com/spreadsheets/d/1JZ_Si2LjV4RL8CknzhcNwD_Vf_E6LyDNsveaSDJsJdk/edit?usp=sharing

The application must be submitted by July 22, 2026 at 5:00 p.m. MT. Late applications will not be considered.

Application Questions

The application questions are detailed below for reference. To ensure a smooth application submission, applicants are encouraged to prepare responses to the following sections before using the application link. Please note that character limits apply to certain responses.

Part 1: Organization Information

1. Organization Name
2. Organization Website (if applicable)
3. Organization Contact Name
4. Organization Contact Title
5. Organization Contact Email Address
6. Organization Contact Phone Number

Part 2: Minimum Mandatory Eligibility Criteria (Pass/Fail)
Please provide objective confirmation of your organization's legal and operational eligibility. Note: False statements will result in immediate disqualification from the application process.

7. **Organization Legal Structure:** Select your organization's primary legal framework. If applying as a joint venture, alliance, or consortium, select the legal structure of the Primary Applicant designated to execute the agreement:
    a. Utah-Based Non-Profit Organization / 501(c)(3)
    b. Clinically Integrated Network (CIN)
    c. Accountable Care Organization (ACO)
    d. For-Profit Healthcare Consulting Firm / Corporation / LLC

8. a. **Applicant Entity Structure:** Which of the following best describes your entity structure for this application?
    a. Single Entity: Applying as a standalone organization.
    b. Collaborative Entity: Applying as a unified consortium, alliance, or joint venture.

    8.b. [Collaborative Entity] List the legal names, states of incorporation, and primary functions of all core technical partners or subcontractors.

    9.a. **Legal Status Documentation:** The Lead Consultant, or their core technical partners/subcontractors, must demonstrate a minimum of three consecutive years (as of January 2026) actively managing network governance, executing clinical/financial integration strategies, or building multi-facility healthcare data reporting platforms.

    Please select the appropriate verification document(s) you will be uploading, based on your organization's legal structure. For CIN or ACO, select at least two of the following documentation.

    - **Regulatory and Program Participation Records:** Official documentation showing active participation in the CMS Medicare Shared Savings Program (MSSP) or equivalent commercial value-based care tracks, or documentation of MSSP and/or commercial VBC participation for managed networks.
    - **Corporate and Tax Filings:** Articles of Incorporation, state registration records, and three consecutive years of corporate tax returns.
    - **Audited Financial Statements:** Three consecutive years of independent, third-party financial audits.
    - **Network Agreements:** Executed Network Participation Agreements or Affiliation Agreements demonstrating the longevity of the participating providers and the established CIN/ACO governance structure.
    - **Quality and Claims Data:** Historical reports submitted to regulatory bodies or commercial payers that demonstrate multi-year tracking of population health outcomes and quality metrics.
9. b. **Legal Status Documentation Upload**: Please upload the appropriate verification document based on your selections in question 9.a. (Maximum 1 upload — please combine/compress these documents into a single file before uploading.)
10. **Eligibility & Intent to Register as a State Vendor:** Disbursements for this project can only be made to entities registered with the Utah Division of Purchasing (via the U3P/Jaggaer system). Please review the following attestation and check the box to confirm compliance:
    a. “I certify that my organization is eligible to register as a vendor with the State of Utah and, if selected for an award, agrees to fully complete and submit our Utah State

Purchasing vendor registration within 14 business days of receiving the Notice of Intent to Award. I understand that failure to complete this registration in a timely manner may result in the forfeiture of the award."

   i. I agree and attest.

11. **Federal and State Standing:** Do you certify that your organization is in good standing and is not currently debarred, suspended, or otherwise restricted from participating in federal or state grant programs? [Yes / No]

Part 3: Instructional Delivery

12. **Ongoing Training Approach:** Describe your planned approach to deliver and maintain comprehensive education and training on VBC over the five-year agreement period. (3,000 characters)
13. **Ongoing Training Approach Scope:** The specific scope of the training content and the types of activities you will use (e.g., webinars, workshops, 1-on-1 coaching). Specify the scope of the content and associated activities. (1,000 characters)
14. **Technical Assistance Approach:** Describe your strategic and technical assistance approach to support rural providers in piloting new or expanded VBC models, as well as proactively identifying and addressing operational challenges to ensure a successful implementation of new or expanded VBC pilots. (2,000 characters)

Part 4: Readiness Assessment and Identification

15. **Assessment:** Explain your approach and methodology to broadly assess rural Utah providers' readiness to transition to or expand VBC. (3,000 characters)

Part 5: Strategic Approach

16. **Stakeholder Collaboration Strategy:** Describe your strategy to effectively initiate and facilitate VBC collaboration and coordination among rural Utah providers, commercial payers, health system executives, state regulators, and other relevant stakeholders, including engagement of a multi-stakeholder Steering Committee to provide governance and oversight for VBC implementation. (3,000 characters)
17. **Financial Modeling Strategy:** Specify how you would develop tailored financial models and long-term sustainability analyses for interested or participating rural providers. Detail key components. Explicitly outline your team's actuarial approach to establishing standardized, non-competing reimbursement frameworks and your negotiation strategy to secure finalized VBC risk-contracts with at least two primary commercial payers. (4,500 characters)

18. **Data Infrastructure Strategy:** The grant's core performance metric is the percentage of rural health facilities in each rural county with data infrastructure in place for value-based payment. Detail your strategy to systematically identify, track, and equitably upgrade smaller or under-resourced rural facilities to raise this county-level percentage. (4,500 characters)
19. **Sustainability Model Strategy:** Specify how you would develop sustainability plans for interested or participating rural providers. Detail the key components. Your response must explicitly demonstrate how these plans align with the funding principles of H.J.R. 101 (prioritizing non-recurring "One-time Projects" and establishing market-driven revenue models that create no future financial obligations for the State of Utah). (4,500 characters)

Part 6: Analysis and Evaluation

20. **Pilot Performance Analysis:** Detail how you plan to monitor pilot performance. Explain how you would leverage initial performance findings to drive key decisions. (2,000 characters)
21. **Evaluation Methodology:** Detail your plan for a comprehensive evaluation of the value-based payment model pilots. Identify measures of success and strategies for improving operations. (2,000 characters)

Part 7: Operationalization

22. **CIN Operational Plan:** Describe how your organization will operationalize and expand a clinically integrated network (CIN), that supports centralized billing, IT, credentialing, and advanced care. (3,000 characters)
23. **Operationalization Plan:** Outline a five-year operationalization plan, including necessary milestones, actions, and timelines you will execute to ensure rural Utah providers transition evaluated pilot programs into permanent, fully integrated VBC models. (4,500 characters)

Part 8: Experience and Qualifications

24. **Organizational Expertise:** Detail your organization's specific past performance with supporting rural providers in VBC implementation or expansion. (3,000 characters)
25. **Relevant Project:** Highlight one relevant VBC past project and include details on clinical outcomes, financial modeling, and data infrastructure. (4,000 characters)
26. a. [Single Entity] **Project Lead & Key Personnel Qualifications:** Identify the Project Lead and up to two additional key personnel and describe their roles in supporting VBC implementation. (3,000 characters)
    b. [Collaborative Entity] **Roles & Operational Governance:** Describe the operational relationship between the Primary Applicant and all proposed partners or technical

subcontractors. Delineate who is responsible for high-level stakeholder convening versus hands-on data infrastructure engineering and financial/actuarial modeling. (3,000 characters)

27. **Resumes/CVs Upload:** Upload the Resume or Curriculum Vitae (CV) for the Project Lead and two key personnel named in the previous question (Limit of 4 pages per CV. Maximum 1 upload — please combine/compress these documents into a single file before uploading).

Part 9: Budget

28. **Proposed Budget:** What is your proposed budget for this project?
29. Upload an itemized budget sheet using the template provided.

Section 6: Application Review

Compliance and Eligibility Review Process

Each application submitted by the due date and time will first be reviewed by DHHS for completeness and compliance with the requirements provided in this RFGA. All applications that fail to address all requirements shall be deemed incomplete and shall receive no further consideration.

Compliance Criteria

- Organization meets all minimum mandatory eligibility requirements (Pass/Fail)
- Application submitted by the deadline (Pass/Fail)
- Application submitted via the provided application link (Pass/Fail)
- Application includes all of the components required in the application (Pass/Fail)

Minimum Mandatory Eligibility Requirements

- Applicant provides documentation of legal operational status as a recognized Utah-based non-profit 501(c)(3) entity, a Clinically Integrated Network (CIN), an Accountable Care Organization (ACO), or a for-profit healthcare consulting firm / corporation / LLC (Pass/Fail)
- Applicant agrees and attests to their eligibility and intent to register as a state vendor. (Pass/Fail)
- Applicants certifies the organization is in good standing and is not currently debarred, suspended, or otherwise restricted from participating in federal or state grant programs. (Pass/Fail)

Technical Review Committee

DHHS will conduct a comprehensive, fair, and impartial review of applications received as a result of this RFGA. The Technical Review Committee will review the applications, rank them according to the scoring system described below, and meet as a group to compare evaluations. The committee will then make award recommendations to DHHS.

Scoring for Applications

Applications are scored on a maximum 160 point scale. Reviewers will score each section using a 0–5 point scale, which is then multiplied by each criteria's assigned weight to determine the total score. Maximum point values and evaluation criteria for each section are as follows:

1. **Instructional Delivery (30 points available)**
    a. Ongoing training approach (12 points)
        i. Fail: No multi-year training or educational delivery model is provided.
        ii. Satisfactory: A training plan is included but lacks localized delivery methodologies or fails to clearly address all seven of the grant's mandatory technical concepts.
        iii. Excellent: Delivers a comprehensive, 5-year training roadmap that adapts to shifting provider capacity.
    b. Ongoing Training Approach Scope (7 points)
        i. Fail: Does not specify the scope of the training content or fails to outline the types of activities (e.g., webinars, workshops, 1-on-1 coaching) that will be utilized.
        ii. Satisfactory: Identifies the scope of the training content and lists learning activities, but lacks key strategies for engaging participants at various levels of VBC understanding.
        iii. Excellent: Clearly defines a comprehensive content scope paired with a robust mix of blended learning activities (such as webinars, hands-on workshops, and individualized 1-on-1 coaching) directly mapped to the training goals, demonstrating a cohesive strategy for participant engagement and mastery.
    c. Technical assistance approach (11 points)
        i. Fail: No structured planning approach for hands-on technical assistance or pilot execution is provided.
        ii. Satisfactory: Technical assistance is mentioned, but the timeline is vague or lacks proactive strategies to identify and solve facility operational challenges

before pilot deployment.

iii. Excellent: Outlines a realistic, turn-key technical assistance model designed to support rural providers through the pilot phase. The strategy includes proactive diagnostic troubleshooting and a clear path to assist facilities in executing contracts and tracking initial performance metrics.

2. Readiness Assessment and Identification (10 points available)

a. Readiness assessment (10 points)

i. Fail: The applicant provides no methodology to assess rural provider baseline readiness.

ii. Satisfactory: A baseline assessment plan is provided, but it uses a slow implementation timeline or misses critical, under-resourced provider types across the designated counties.

iii. Excellent: Details a highly efficient, turn-key diagnostic strategy capable of immediately auditing readiness across hospitals, clinics, and other rural provider categories to establish the official baseline denominator for the core performance metric.

3. Strategic Approach (40 points available)

a. Stakeholder collaboration strategy (8 points)

i. Fail: No strategy for initiating collaboration or consensus-building among rural stakeholders is provided.

ii. Satisfactory: The strategy is generic and does not account for the diverse, sometimes competing interests of independent hospitals and clinics.

iii. Excellent: The strategy demonstrates advanced consensus-building mechanics, detailing clear methods to align participating and non-participating providers toward a unified goal of establishing standardized, non-competing VBC protocols.

b. Financial modeling strategy (10 points)

i. Fail: The proposal omits specialized actuarial or long-term multi-payer financial modeling.

ii. Satisfactory: Financial modeling is mentioned, but the underlying frameworks are vague or fail to account for the unique data criteria needed to safely transition rural providers away from traditional fee-for-service.

iii. Excellent: Delivers a clear actuarial architecture to design tailored financial models and long-term sustainability frameworks for local providers..

c. Data infrastructure strategy (14 points)

i. Fail: The applicant fails to prioritize data infrastructure improvements or quality reporting structures.

ii. Satisfactory: Plans basic data tracking upgrades, but lacks a sophisticated

strategy to resolve multi-EHR system silos or expand interoperability capabilities to meet multi-payer metrics.

iii. Excellent: Details a highly technical data integration strategy designed to expand system capabilities (collection, analytics, interoperability, and reporting) across the healthcare ecosystem to directly advance the grant's core performance metric: maximizing the percentage of rural health facilities in each rural county with VBC data infrastructure in place.

d. Sustainability model strategy (8 points)

i. Fail: No operational sustainability plan is provided, or the model relies on recurring state-funded support.

ii. Satisfactory: Financial sustainability plans are provided but present long-term feasibility concerns or lack clear boundaries separating temporary capital injections from ongoing state operational liabilities.

iii. Excellent: Outlines an airtight long-term sustainability plan that completely mirrors the principles of H.J.R. 101. Proves that all funding targets non-recurring upgrades ("One-time Projects") and establishes an operational path where networks rely entirely on performance-driven market revenues over time.

4. Analysis and Evaluation (15 points available)

a. Pilot performance analysis (9 points)

i. Fail: No framework for monitoring initial performance or building analytics reporting tools is provided.

ii. Satisfactory: Mentions performance tracking but provides no concrete blueprint for a VBC dashboard, or fails to show how early performance data will be used to drive mid-course operational adjustments.

iii. Excellent: Outlines a comprehensive performance monitoring framework and details the critical components of a VBC evaluation strategy. Clearly demonstrates how initial performance findings will be leveraged to drive key strategic decisions.

b. Evaluation methodology (6 points)

i. Fail: No plan for a comprehensive evaluation of the value-based payment model pilots is outlined.

ii. Satisfactory: An evaluation plan is present but lacks clear measures of success, third-party vetting parameters, or defined strategies for improving long-term pilot operations.

iii. Excellent: Details a rigorous, highly auditable evaluation methodology to assess clinical, financial, and operational performance across the multi-payer pilot structures, isolating clear measures of success to guide final contract adjustments.

5. Operationalization (15 points)

a. CIN operational plan (6 points)
   i. Fail: The applicant fails to describe how they will operationalize or expand a Clinically Integrated Network (CIN).
   ii. Satisfactory: Addresses CIN expansion but omits critical elements like centralizing billing, technical IT integration pathways, or shared credentialing services across independent network members.
   iii. Excellent: Outlines a highly scalable operational framework to expand and stabilize the CIN, delivering a clear blueprint to establish centralized, shared administrative services (billing, IT, and credentialing) that reduce facility-level provider burnout.

b. Five-year operationalization plan (9 points)
   i. Fail: No multi-year transition timeline or long-term operationalization plan is provided.
   ii. Satisfactory: A plan is provided but fails to detail critical operational milestones, presents feasibility concerns within the 5-year grant lifecycle, or fails to detail technical compliance continuity.
   iii. Excellent: Outlines a realistic 5-year operational roadmap detailing the milestones, timelines, and actions necessary to transition pilots into permanent, fully integrated VBC models that ensure long-term data compliance and network solvency independently of state support.

6. Experience and Qualifications (35 points)

a. Organizational expertise (12 points)
   i. Fail: The applicant or consortium provides no demonstrable history supporting healthcare providers through VBC transitions or system alignment.
   ii. Satisfactory: Explains general healthcare management experience, but the technical track record is vague or not directly applicable to localized clinic or hospital settings.
   iii. Excellent: The proposed applicant demonstrates an ideal blend of expertise seamlessly mapping out clear governance structures between the lead convener and technical subcontractors to deliver VBC architecture.

b. Relevant project (12 points)
   i. Fail: No relevant past case study or project narrative is provided.
   ii. Satisfactory: Highlights a past project, but omits specific technical details regarding clinical quality outcomes, financial tracking metrics, or multi-facility data infrastructure.
   iii. Excellent: Details a highly successful, relevant past project that explicitly demonstrates a proven track record in VBC design, clearly outlining the scope of clinical outcomes, financial risk modeling, and integrated data

networks achieved.

c. Applicant Structure and Personnel (11 points)
    i. (Note: Applicants will be scored on either the single entity criteria or the consortium criteria below for a maximum of 11 points).
        1. Option A: Single Entity Applicants: Project lead and key personnel, Resume/CV Upload (11 points)
            a. Fail: The proposed personnel lack the technical credentials or specialized experience needed to execute the scope of work.
            b. Satisfactory: The proposed team has general healthcare skills but lacks an equitable balance of specialized experts in technical health informatics, data engineering, or actuarial contract negotiations.
            c. Excellent: The proposed personnel possess premier technical expertise across all core areas to meet all grant requirements.
        2. Option B: Consortium Applicants: Roles & Operational Governance (11 points)
            a. Fail: Response fails to provide any meaningful description of operational relationships, roles, or division of labor.
            b. Satisfactory: A governance structure is included, but the response lacks clear delineation between high-level stakeholder convening, hands-on data infrastructure engineering, and financial/actuarial modeling responsibilities.
            c. Excellent: Delivers a comprehensive governance roadmap that clearly defines roles, decision-making frameworks, and explicit operational boundaries across stakeholder convening, data engineering, and financial modeling.

7. Budget (15 points)

a. Total budget is within the maximum award amount (1 point)
    i. Fail: The proposed budget exceeds the maximum available funding caps for either Year 1 ($6,000,000.00) or the overall contract lifecycle ($15,000,000.00).
    ii. Excellent: The proposed budget is fully compliant and sits within the maximum award caps for both Year 1 and the multi-year cumulative agreement period.
b. Budgeted items are relevant and within scope of the RFGA project (7 points)
    i. Fail: Proposed lines contain unallowable expenditures or items detached from the scope of work.

ii. Satisfactory: Proposed items are generally relevant and within scope, but the spending model leans heavily into recurring operational staffing costs rather than technical assets. iii. Excellent: Every proposed line-item is highly relevant, falls within the scope of work, adheres strictly to the 10% administrative overhead limit, and is logically structured to map cleanly to the non-recurring capital infrastructure goals of the grant. c. Budget includes clear and rational justifications for each section (7 points) i. Fail: The budget submission lacks itemized specific justifications or transparent cost-rationale. ii. Satisfactory: Includes basic section-level justifications, but the underlying cost calculations or resource rationales are vague or generic. iii. Excellent: Demonstrates a transparent, clear, and logical financial justification for each operational section, cleanly linking proposed spending blocks directly to physical technical assets, software licenses, or verifiable data deliverables.
Total 160 points Required technical point threshold: 80 points. Scores below 80 points will not qualify for funding.

Award timeline

DHHS will notify all applicants of the award decision by **August 4, 2026**. Upon award, DHHS will initiate the State of Utah contracting process. DHHS may negotiate modifications with the Grantee during contract implementation and funding cycle.

Disqualification

DHHS reserves the right to cancel an award if, in its sole discretion, any interest disclosed from any source could give the appearance of a conflict or cause speculation as to the objectivity of the program/project developed by the grantee. DHHS determination regarding any questions of conflict of interest shall be final.

Allotment Process

DHHS may:

- Fund projects in whole or in part.

- Fund projects at a lower amount than requested.
- Choose to fund no applications under this RFGA.

Section 7: Additional Resources

- CMS Notice of Funding Opportunity (NOFO): Provides CMS guidance on program scope, permissible use of funds, and unallowable cost. dhhs.utah.gov/wp-content/uploads/NOFO-RHTP-2.pdf
- Utah's RHTP website: Updates on Utah's implementation and publicly available resources, including most of those listed here. dhhs.utah.gov/ruralhealth/
- Utah's RHTP Full Project Narrative: Utah's original application which guides implementation. dhhs.utah.gov/wp-content/uploads/Rural-Health-Transformation-Plan.pdf
- Notice of Award (December 29, 2025): Initial notice of funding award that also outlines budget restrictions, reporting periods, and other guidelines aligned with the NOFO. dhhs.utah.gov/wp-content/uploads/NOA_RHTCMS332051-01-00.pdf
- CMS Frequently Asked Questions (FAQs): Responses from CMS regarding inquiries from states. cms.gov/files/document/rural-health-transformation-frequently-asked-questions.pdf