Utah Department of Health and Human Services
&
NAME

Rural Health Transformation Program
PATH Initiative 1.5 Integrated Behavioral Health and Primary Care Services

Attachment B: SCOPE OF WORK

Article 1
DEFINITIONS

1.1 **Definitions.** In this agreement, the following definitions apply:

"**Behavioral Health Integration**" means the coordination of mental health, substance use, and primary care services to deliver comprehensive patient-centered care.

"**Budget Period**" means the 10-month period beginning on December 29, 2025, and ending on October 30, 2026, for Budget Period 1, and each 12-month period beginning on October 31 and ending on October 30 for Budget Periods 2 – 5.

"**CMS**" means the Centers for Medicare and Medicaid Services, the federal agency awarding the Rural Health Transformation Program (**"RHTP"**) funds.

"**EMR**" means Electronic Medical Record. a secure, digital, and longitudinal record of a patient's comprehensive health information, maintained over time by authorized clinicians and staff.

"**FQHC**" means Federally Qualified Health Center, a community-based health care provider that receives funds from the Health Resources and Services Administration Health Center Program to provide primary care services in underserved areas.

"**Grantee**" means the Subrecipient [ADD].

"**Grantee Subcontractor**" means an entity contracting with the Grantee to perform reimbursable work and receive funds for Utah RHTP 1.5 PATH Initiative activities originating from this agreement.

"**Integration**" means the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

"**NOA**" means Notice of Funding Award, the official CMS notifications to successful state grant applicants that indicate the grant start and end dates and allow the grant program work to begin. NOAs will be re-issued from CMS at each Budget Period as well as for any amendment or updated approved budget.

"**NOFO**" means Notice of Funding Opportunity, the formal public announcement soliciting applications from states for the RHTP cooperative agreements. It outlines funding availability, eligibility, goals, and programmatic and spending guidelines and parameters.

"**PATH Initiative**" means one of seven of Utah's RHTP broad initiatives focused on rural health through innovations in nutrition, physical activity, and built environments, establishing lifelong healthy behaviors to promote health.

"**RHTP Program Directives**" means the instructions promulgated by the Utah RHTP that describe required program operations.

"**Rural**" means an area located in one of Utah's 25 counties that meet the definition established by Utah Code § 26B-4-701 and § 17-60-104, (and not located in Davis, Salt Lake, Utah, or Weber counties).

"Safety Net Provider" means a healthcare entity that delivers care to patients regardless of their ability to pay.

"**Utah RHTP Plan**" means the specific section of Utah's RHTP application, submitted by DHHS and approved by CMS, detailing the strategic framework for program implementation. Utah's RHTP Plan includes but is not limited to: vision and goals; core initiatives and key actions; stakeholder engagement strategies; policy objectives; and all other associated activities required for RHTP execution.

Article 2
PURPOSE

2.1 **Purpose.** The Grantee shall work in Rural care settings. The Grantee shall implement a comprehensive Behavioral Health Integration model designed to bridge the gap between physical and behavioral health services in rural communities. The goal is to create Integration that improves assessment rates, clinical outcomes, and system efficiency. Sites may implement the Collaborative Care Model, Comprehensive Health Integration Framework or other evidence-supported models based on organizational infrastructure and community need. Central to this Integration is the transformation of traditional silos into cohesive, team-based environments.

Article 3
POPULATIONS SERVED

3.1 **Eligible Clients.** The Grantee shall provide services exclusively in eligible Rural counties.

Article 4
GRANTEE RESPONSIBILITIES

4.1 **Project Plan and Itemized Budget.** At a minimum, Behavioral Health Integration must incorporate at least three local service agencies with unique primary populations. The local service agencies must include physical health, mental health and substance use disorder treatment, prevention, and wellness services. At least one integrated network provider must be a recognized Safety Net Provider healthcare entity that primarily serves public assistance beneficiaries. The Grantee shall include a broad range of additional providers to enhance the local care landscape, ensuring all individuals served experience seamless entry and receive comprehensive support across the full continuum of care. This system must include:

(1) integrated workflows, which require:

(A) uniform assessment protocols using evidence-based assessment tools. If DHHS requests, the Grantee shall submit the assessment protocols to DHHS for review.

(B) development of a single shared treatment plan for patients that includes both physical and behavioral health treatment goals; and

(C) utilization of a shared HIPAA-compliant platform, interoperable EMR, or shared access to current EMR platforms to allow providers at different sites to view a patient's treatment plan and other pertinent details. Where full EMR

interoperability is in development, the Grantee shall implement a population health registry to track patient status, assessment scores, and referral completion.

(2) cross agency collaboration, which requires:

(A) completion of shared policies and procedures for warm handoffs within the community by the end of Budget Period 1;

(B) implementation of shared warm handoff protocol that prioritizes in-person or video instructions and applies reciprocally from all project partners by the end of Budget Period 1; and

(C) by the end of Budget Period 3, either:
i. cross-agency access to EMRs for real time appointment availability; or
ii. implement a cross-agency referral dashboard to track real-time appointment availability.

(3) sustainable workforce, which requires:

(A) maximizing the Rural workforce (e.g., a Health Department Nurse working in a behavioral health setting, or a clinician working at the FQHC) supported by formal Memorandums of Understanding ("**MOU**") defining treatment roles and clinical supervision across agency lines. MOUs cannot limit a patient's freedom to choose their own provider, whether that provider is within the integrated system or another external provider;

(B) utilization of teleconsultation when appropriate to provide rural primary care providers with access to psychiatric or other behavioral health expertise;

(C) implementing standardized billing workflows to ensure billing codes are utilized effectively and can be sustained long-term; and

(D) completion of Grantee identified training on available billing codes.

(4) additional activities, which require:

(A) participation in technical assistance sessions regarding integrated system components and standardized Integration measurement tools; and

(B) development of data collection and capacity for required reporting and quality improvement.

4.2 **Community Tailored Enhancement.** The Grantee shall implement Integration components tailored to the needs of the community as included in the grant application. Such enhancements may include:

(1) a second primary care site;

(2) addressing dental or vision needs;

(3) collaboration with emergency medical systems;

(4) utilization of community health workers; and

(5) partnerships with local hospitals.

4.3 **Project Management and Fiscal Oversight.** The Grantee shall:

(1) within 30 days, provide a complete description and cost breakdown for each Grantee Subrecipient in writing to DHHS upon selection;

(2) obtain prior written approval from DHHS for Grantee proposed changes to the pre-approved purchase of goods or services;

(3) ensure Grantee Subcontractors comply with all CMS and DHHS terms as outlined in the NOFO, NOA, CMS FAQs and other guidance, Program Directives, and this agreement;

(4) require reports on a quarterly, annual, and a final basis from all Grantee Subcontractors according to budget and reporting timelines. See Article 10 Timelines;

(5) conduct site visits with each Grantee Subcontractor at least once during the agreement period or more frequently as needed;

(6) facilitate and participate in interagency communications and activities that overlap with or complement this RHTP initiative as opportunity and capacity allows;

(7) participate in program evaluation activities requested by DHHS and/or its contractor(s); and

(8) participate in and facilitate regular desk and in-person contract compliance monitoring conducted by DHHS.

4.4 **Budget Adjustments.** The Grantee shall seek written preapproval from DHHS:

(1) for any transfers between subcategories;

(2) reimbursing clinical services (as outlined in NOFO Category B); and

(1) replacing an EMR system if a previous HITECH certified EMR was in place as of September 1, 2025.

4.5 **Public Materials.** In adherence with the Stevens Amendment referenced in the NOA p.14, when issuing statements and public facing materials resulting from activities supported by this agreement, the Grantee shall include an acknowledgement of federal assistance using the following or a similar statement:

(1) for public facing materials utilizing 100% of funds from this agreement:
This [project/publication/program/website, etc.] [is/was] supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $XX with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

(2) for public facing materials partially utilizing funds from this agreement:
This [project/publication/program/website, etc.] [is/was] supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $XX with XX percentage

funded by CMS/HHS and $XX amount and XX percentage funded by non-government source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

(3) additional requirements on the prior approval of public materials, presentations, and high-visibility content, and rules for using the RHTP federal logo, will be provided in RHTP Program Directives.

Article 5
OUTCOMES

5.1 **Outcomes.** The overall outcome for this agreement is that individuals in Rural communities will achieve better health outcomes by accessing integrated physical and behavioral care. Each outcome measure must be reported as aggregate data.

(1) Measure. Number of unduplicated patients served.

(2) Measure. Number of patients screened for behavioral health at the primary care clinic.

(A) number of patients identified with a behavioral health need via screening who then receive behavioral health interventions with the same clinic;

(B) number of patients with a positive screen who then receive a referral for physical health services at another clinic or agency; and
i. reason for external referrals made to include referral services and agency;
ii. number of referral follow-ups completed; and
iii. average number of days from initial request for treatment to first scheduled appointment.

(3) Measure. Number of patients screened for physical health in a non-primary care setting, and behavioral health at the primary care clinic:

(A) number of patients with a positive screen who then receive physical health interventions with the same clinic;

(B) number of patients with a positive screen who then receive a referral for physical health services at another clinic or agency; and
i. reason for external referrals made to include referral services and agency;
ii. number of referral follow-ups completed; and
iii. average number of days from initial request for treatment to first scheduled appointment.

(4) Measure. Total number of times an approved, uniform evidence-supported screening tool was administered across the integrated provider network.

(5) Measure. Aggregate scores using the established assessment tool, including:

(A) baseline scores;

(B) interval scores; and

(C) percentage of patients improving.

(6) Measure. Participation in Medication-Assisted Treatment ("**MAT"**) for patients with an identified behavioral health need for whom MAT is appropriate:

(A) percentage of participation in MAT at 90 days; and

(B) percentage of participation in MAT at 180 days.

(7) Measure. Percentage of patients with a diagnosed chronic condition (e.g. diabetes or hypertension) who show measurable clinical improvement (e.g. controlled HbA1c or blood pressure).

(8) Measure. Change in number of emergency department visits.

(9) Measure. Change in number of physical health hospitalizations.

(10) Measure. Change in number of behavioral health hospitalizations.

(11) Measure. Standardized social determinants of health assessment scores.

Article 6
REPORTING AND MEETING REQUIREMENTS

6.1 **Reporting.** The Grantee shall submit reports that reflect progress made during the designated reporting period. See reporting timelines in Article 9 Timelines.

(1) **Quarterly reports**. The Grantee shall submit quarterly progress reports to DHHS in the format provided by DHHS. The reports:

(A) are due on or before the 10th day of the month following the end of each quarter. If the due date falls on a weekend or holiday, it is due the next business day; and

(B) must include outcome measures as specified, number of people served, spending data broken down by use of funds, milestone progress, sustainability planning, and success stories.

(2) **Annual reports**. The Grantee shall submit annual reports to DHHS in the format provided by DHHS. The reports are due on or before the 15th day of the month following the end of each reporting period.

(3) **Final report**. The Grantee shall submit a one-time final report to DHHS in the format provided by DHHS. The report:

(A) is due on or before December 30, 2030 after the project period; and

(B) must be cumulative of all activities completed during the entire performance period.

6.2 **Required Meetings.** The Grantee shall:

(1) attend all check-in meetings scheduled by DHHS for project management and implementation;

(2) attend quarterly progress meetings scheduled by DHHS;

(3) facilitate site visits with Grantee Subcontractors for DHHS, as needed;

(4) attend CMS or DHHS related conferences, trainings, or meetings, as needed;

(5) facilitate and/or participate in interagency communications and meetings that overlap with or complement this RHTP initiative as opportunities and capacity allows; and

(6) participate on Utah RHTP Stakeholder Engagement Committees.

Article 7
DHHS RESPONSIBILITIES

7.1 **DHHS Responsibilities.** DHHS shall:

(1) provide the Grantee with quarterly, annual, and final reporting and project plan templates;

(2) provide budget and invoice submission guidance;

(3) submit Grantee project plans to CMS for review and approval;

(4) review submitted reports and provide necessary technical assistance;

(5) communicate any changes to the RHTP budget or Utah RHTP Plan mandated by CMS;

(6) facilitate interagency communications and activities that overlap with or complement this RHTP initiative as opportunity and capacity allows;

(7) provide written pre-approvals according to the timeline agreed upon by both parties;

(8) provide funding allocation letters as funding changes occur;

(9) update and provide current RHTP Program Directives;

(10) upon request, provide technical guidance to facilitate tribal engagement and allocation requirements throughout the appropriation process; and

(11) define the frequency and scope of contract compliance monitoring

Article 8
INVOICES, REIMBURSEMENT AND FUNDING

8.1 **Invoicing.** The Grantee shall submit monthly invoices for services through the electronic billing system. The Grantee shall only submit allowable costs, as described in Attachment D: Funding Allocation, Rate Table, and Budget. The Grantee shall include the following on each invoice:

(1) a detailed description of the services rendered;

(2) dates services rendered;

(3) agreement number;

(4) uniquely identifiable invoice number;

(5) Grantee name;

(6) Grantee’s address for payment;

(7) Grantee’s phone number;

(8) Grantee's signature; and

(9) expenses incurred as indicated by the line items in the attached budget.

(10) Invoices submitted without the required information will not be paid and will be returned to the Grantee for revision.

(11) Payments will be made through the State of Utah, Department of Administrative Services, Division of Finance Electronic Funds Transfer ("**EFT**") system. Submit within 30 days following the end of each month.

(12) Prior to the submission of invoices, the Grantee shall ensure it is enrolled in the EFT system. DHHS will provide the Grantee with instructions to enroll in the EFT system. The Grantee shall ensure that their EFT approval is maintained and shall notify DHHS of any change to the EFT status contractor's address for payment.

(13) Failure to enroll in the EFT system will result in a delay of all payments until EFT is established.

(14) All payments made will be made in the name of the Grantee as it appears on the cover page. Any change must be submitted in writing to the DHHS Administrative Services Director.

(15) State Fiscal Year-End Billings. The state fiscal year is from July 1st through June 30th. The Grantee shall submit all billings for services performed on or before June 30th of a given fiscal year by July 14th of the following fiscal year, regardless of the Grantee's billing period or the expiration or termination date of this contract. DHHS may delay or deny payment for services performed in a given fiscal year if it receives the Grantee's bill for those services after July 14th of the following fiscal year.

(16) Funding Allocation, Budget, and Rate Table Attachment D. If the Grantee is a Utah governmental entity, a funding allocation, budget, and rate table attachment issued by DHHS subsequent to this contract constitutes an amendment to this agreement. DHHS may issue a funding allocation, budget, and rate table attachment on its own initiative without need for the Grantee's signature and it may likewise issue a funding, budget, and rate table attachment in response to a request from the Grantee. Funding allocation, budget, and rate table attachments may increase or decrease the funding available to the Grantee and will be issued by DHHS and sent to the Grantee. Funding allocation, budget, and rate table attachments may reference and contain federal terms that apply to specific federal funding provided pursuant to this agreement. If the Grantee is not a Utah governmental entity, this paragraph does not apply.

(17) Lapsing Funds: Any funds not expended by the end of the funding period for which they were allocated will lapse and the Grantee shall have no further claim to the funds.

8.2 **Reimbursement.** DHHS shall reimburse the Grantee for invoiced and approved products and services in accordance with the approved budget up to the maximum award per Budget Period. Payments may be suspended or declined by DHHS or CMS based on insufficient project progress and availability of funds.

(1) **Expenditure deadline.** The Grantee shall:

(A) ensure all funds related to project implementation are expended for each Budget Period by the end of the following federal fiscal year (September 30 of the following year); and

(B) obligate funds for Budget Period 1 no later than December 31, 2026, for Budget Periods 2-5, no later than June 30 of the respective Budget Period, to ensure all expenditures adhere to the regulatory guidance and deadlines specified in Article 10 Timelines. Failure to timely obligate and expend funds will result in funds recouped by DHHS to return to CMS.

8.3 **Continued Funding.** Continued funding is conditional on the availability of appropriated funds from CMS, satisfactory Grantee performance, and compliance with the agreement.

(1) Continued funding will be issued in increments as CMS awards funding at the start of each Budget Period.

(2) Satisfactory performance includes progress in implementing approved activities; progress on applicable performance metrics; adherence to the implementation plan; accurate, complete, and timely submission of progress reports and invoices; and quality and timely communication and responses. Progress will be measured both qualitatively and quantitatively.

8.4 **Annual Recalculation of Funds.** Based on annual CMS rescoring and awarding, funding will be recalculated and reissued at the start of each Budget Period. Funding will be issued to the Grantee through DHHS funding allocation letters.

Article 9
USE OF FUNDS AND FUNDING RESTRICTIONS

9.1 **Use of Funds.**

(1) **Budget Period and activities**. Funds may only be used for costs incurred within the defined Budget Periods and for activities expressly authorized under this agreement.

(2) **Use of funds**. The Grantee agrees to use all funds received under this agreement only for the permissible uses defined in the NOFO and NOA. These uses are governed by Federal statute: Pub. L. No. 11921, § 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. Contact the DHHS Contact with questions regarding an RHTP Use of Funds before an expense is incurred. Descriptions of Use of Funds categories are outlined in the NOFO p. 11, 12 and NOA p. 9-12.

(A) Prevention and chronic disease

(B) Provider payments

(C) Consumer tech solutions

(D) Training and technical assistance

(E) Workforce

(F) IT advances

(G) Appropriate care availability

(H) Behavioral health

(I) Innovative care

(J) Capital expenditures and infrastructure

(K) Fostering collaboration

9.2 **Funding Restrictions.** The Grantee shall not use funds provided under this agreement for any unallowable costs. The items listed below represent a non-exhaustive list of prohibited expenditures under CMS guidelines and the RHTP and may not be applicable to specific project tasks or to all phases of project implementation. Contact the DHHS Contact with questions regarding an RHTP expense before the expense is incurred. Unallowable costs are outlined in the NOFO p.18-20 and the NOA p. 9-12.

(1) New construction and major renovation are not allowable. Renovations or alterations, as described in Category J in the NOFO Use of Funds section, are allowed if they are clearly linked to program goals.

(2) Supplanting funding for in-process or planned construction projects or directing funding towards new construction build is not allowable.

(3) Payment for clinical services that could be reimbursed by insurance is not allowable. Direct clinical health services must be justifiable as filling a coverage gap or not already reimbursable.

(4) Clinician salaries or wage support for facilities that subject clinicians to non-compete contractual limitations are not allowable.

(5) Funding received or provided under this agreement may not be used for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law.

(6) Social Security Act Section 2105(c) (42 U.S.C. 1397ee), paragraphs (1),(7), and (9) apply as funding limitations. These limitations are related to general limitations, limitations on payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.

(7) Using funds in a manner inconsistent with activities described in Utah RHTP program plan, on activities explicitly limited in the Limitations and Program-specific limitations sections outlined in the RHTP NOFO or Notice of Award, or on activities that have not been approved by DHHS or CMS is not allowed.

(8) Funds may not be used towards initiatives similar to the Rural Tech Catalyst Fund Initiative as described in the NOFO appendix.

Article 10
TIMELINES

10.1 **Timelines.**

(1) **Budget Periods**. DHHS shall issue funding according to the CMS five Budget Periods. For each Budget Period, the Grantee will have until the end of the following federal fiscal year (September 30 of the following year) to spend awarded funding.

(A) Budget Period 1: Agreement start date to October 30, 2026

(B) Budget Period 2: October 31, 2026 to October 30, 2027

(C) Budget Period 3: October 31, 2027 to October 30, 2028

(D) Budget Period 4: October 31, 2028 to October 30, 2029

(E) Budget Period 5: October 31, 2029 to October 30, 2030

(2) **Reporting periods**. The Grantee shall report progress on activities in this agreement according to the following reporting periods.

(A) ANNUAL REPORT #1: First annual reporting period will be from March 30, 2026 through July 31, 2026.

(B) Quarterly reporting period 1: August 1 to October 30, 2026

(C) Quarterly reporting period 2: October 31, 2026 to January 30, 2027

(D) Quarterly reporting period 3: January 31, 2027 to April 30, 2027

(E) ANNUAL REPORT #2: Second annual reporting period will be from August 1, 2026 through July 31, 2027. This annual report will include quarterly progress for May 1, 2027 to July 31, 2027.

(F) Quarterly reporting period 4: August 1, 2027 to October 30, 2027

(G) Quarterly reporting period 5: October 31, 2027 to January 30, 2028

(H) Quarterly reporting period 6: January 31, 2028 to April 30, 2028

(I) ANNUAL REPORT #3: Third annual reporting period will be from August 1, 2027 through July 31, 2028. This annual report will include quarterly progress for May 1, 2028 to July 31, 2028.

(J) Quarterly reporting period 7: August 1, 2028 to October 30, 2028

(K) Quarterly reporting period 8: October 31, 2028 to January 30, 2029

(L) Quarterly reporting period 9: January 31, 2029 to April 30, 2029

(M) ANNUAL REPORT #4: Fourth annual reporting period will be from August 1, 2028 through July 31, 2029. This annual report will include quarterly progress for May 1, 2029 to July 31, 2029.

(N) Quarterly reporting period 10: August 1, 2029 to October 30, 2029

(O) Quarterly reporting period 11: October 31, 2029 to January 30, 2030

(P) Quarterly reporting period 12: January 31, 2030 to April 30, 2030

(Q) ANNUAL REPORT #5: Fifth annual reporting period will be from August 1, 2029 through July 31, 2030. This annual report will include quarterly progress for May 1, 2030 to July 31, 2030.

(R) Quarterly reporting period 13: August 1, 2030 to October 30, 2030

(S) Final report period: entire project period.

10.2 **Adherence.** In addition to the standard terms and conditions, DHHS, Grantees, and Grantee Subcontractors, are subject to the terms and conditions set forth by CMS for the RHTP in the NOFO and the NOA. CMS may add or otherwise amend the terms and conditions as necessary at any point during the RHTP period of performance. CMS retains the final approving authority for any and all activities related to this agreement as outlined in the NOFO and NOA.