Department of Health & Human Services

Utah Rural Health Transformation Program

SHIFT 3.2 Rural Health Provider Networks

Opportunity number: URHTP-2892-2026

CMS Disclaimer: This Rural Health Transformation Program is 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 $195,743,566.29 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.

Table of Contents

Glossary 3
Section 1: Project Overview 4
- Background 4
- Purpose of Request for Grant Application (RFGA) 4
- Eligible RFGA Applicants 5
  - Minimum Mandatory Eligibility Requirements (Pass/Fail) 5
  - Scored Technical Criteria (Evaluated via RFGA Application) 6
- Partners 8
- Completeness and Responsiveness Criteria 8
- RFGA Application Limits 9

Section 2: RFGA Funding Details 9
- RFGA Agreement Period 9
- Cost Sharing 10
- Use of Funds 10

Section 3: Services and Deliverables 10
- Grantee Expectations 13

Section 4: Budget 13
Section 5: RFGA Application 15
- RFGA Application Questions 16

Section 6: RFGA Application Review 21
- Compliance and Eligibility Review Process 21
- Technical Review Committee 21
- Scoring for RFGA Applications 21
- Award timeline 27
- Disqualification 27

Section 7: Budget Period Timeline 28
- Allotment Process 28

Section 8: Additional Resources 29

Apply by the application deadline:

August 14, 2026 at 5:00 p.m. Mountain Time (MT)

Glossary

Core Program & Procurement Terms

1. **CMS (Centers for Medicare & Medicaid Services):** The federal agency within the U.S. Department of Health and Human Services (HHS) providing the $195.7+ million financial assistance award that entirely funds Utah's Rural Health Transformation Program.
2. **DHHS (Utah Department of Health and Human Services):** The state's lead health and human services agency acting as the primary recipient and administrator of the federal CMS funds, responsible for issuing and managing the sub-grant agreements.
3. **I/T/U Providers:** A collective acronym representing the tripartite framework of Indigenous healthcare delivery: Indian Health Service facilities, Tribal health programs, and Urban Indian organizations.
4. **Minimum Mandatory Eligibility Requirements:** The baseline legal and operational criteria that an applicant must satisfy to be considered for funding. These are evaluated on a strict Pass/Fail basis; failing to meet a single requirement results in immediate disqualification before the technical proposal is scored.
5. **NOA (Notice of Award):** The official, legally binding document issued by CMS to Utah DHHS that formalizes the funding amount, reporting periods, and specific fiscal restrictions.
6. **NOFO (Notice of Funding Opportunity):** The initial federal solicitation document issued by CMS that sets the global rules, baseline expectations, and permissible use guidelines for the overarching grant.
7. **RFGA (Request for Grant Application):** A formal, competitive solicitation document issued by a state agency (in this case, Utah DHHS) inviting eligible organizations to submit structured proposals for funding. It outlines the project's scope of work, compliance rules, funding limits, and evaluation criteria.
8. **RHTP (Rural Health Transformation Program):** Utah's five-year, federally funded framework built across four strategic pillars to modernize rural health systems, build workforce capacity, and optimize technological innovation in rural communities.
9. **Technical Review Committee:** An impartial panel of experts assembled by DHHS to evaluate, score, and rank compliant grant applications based on the Scored Technical Criteria before making final award recommendations.

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 3.2: Expand services and resources through rural health provider network and subactivities 3.B-C.

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 up to 6 Grantees to establish or expand integrated rural health provider networks. These networks will pool resources, expand local services, reduce duplication of efforts, streamline administrative functions through shared service models, and lower operational costs across rural Utah.

Target Networks: Funding may be used to develop distinct types of networks, including but not limited to:

- Rural Health Clinic Networks
- Pediatric Trauma Networks
- Maternal Health Networks
- Oral Health Networks
- Clinically Integrated Networks
- Hospital and EMS Partnerships
- Expanding Existing Hospital/Clinic Alliances

The program will support activities necessary to achieve the benchmarks established by the RHTP SHIFT 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 **August 12, 2026 at 5:00 p.m. MT**, and the final Q&A document will be updated by **August 13, 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.

- **Must be a recognized Utah based entity:** Utah-based non-profit 501(c) entities, for-profit organizations, Government or Public Entities, or formal health networks/consortiums. This includes established networks with documented histories in rural healthcare coordination, as

well as newly forming or emerging networks demonstrating a clear intent and framework to establish such coordination.

- **Collaboration & Facility Diversity Verification:** The lead applicant must demonstrate formal, active collaboration with rural healthcare partners. To encourage comprehensive cross-functional integration, the application must include a minimum of 3 different facilities within the partnership structure to be considered for funding. Eligible facility and network types include, but are not limited to:
    - Critical Access Hospitals (CAHs)
    - Rural Emergency Hospitals (REHs)
    - Certified Rural Health Clinics (RHCs)
    - Indian Health System (I/T/U) Providers
    - Federally Qualified Health Centers (FQHCs)
- **Mandatory Verification Evidence:** The lead applicant must demonstrate compliance with the multi-facility collaboration mandate by submitting at least two of the following validation items at the time of application:
    - Executed Memoranda of Understanding (MOUs) or formal partnership agreements confirming active multi-facility collaboration.
    - Documentation of joint clinical or operational initiatives involving at least two rural healthcare partners.
    - Official letters of support or attestation from the leadership of the participating rural facilities.
- **Federal and State Standing:** The applicant must not be debarred, suspended, or otherwise excluded from receiving federal or state funding.

Scored Technical Criteria (Evaluated via Application)

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

- **Network Governance and Operational Readiness:** The applicant must demonstrate the capacity to establish formal governance structures, shared administrative protocols, and centralized operational frameworks that optimize resource pooling and eliminate administrative redundancies across rural networks. Applications will be evaluated on the depth of their clinical service needs evaluation and the clarity of their short- and long-term plans for introducing new service lines.
- **Care Model Design and Resource Mapping:** Demonstrated ability to develop a comprehensive, region-specific directory of physical and behavioral healthcare services

containing data on capacity and access points. Applicants must provide a strategic plan for integrating innovative care delivery models, specifically outlining how paraprofessionals (such as community health workers or peer support specialists) will be utilized to mitigate provider strain and streamline longitudinal care.

- **Program Execution and Service Activation:** A proven track record or a highly feasible operational roadmap for launching clinical services within designated rural service boundaries. This includes the ability to deploy paraprofessional roles directly into active care coordination pathways and successfully activate newly expanded clinical service lines to meet emerging community needs.
- **Performance Metrics, Tracking, and Evaluation:** Demonstrated capability to maintain operational logs that continuously track core network metrics, specifically: the number of new services made available to the community and the total number of patients receiving services from network members. Evaluation frameworks must clearly outline how these statistics will be synthesized into comprehensive technical summary packages for review by Utah DHHS to guide ongoing adjustments.
- **Financial Sustainability and Strategic Expansion:** Demonstrated expertise in designing forward-looking financial models focused on long-term viability through billing, coding, and reimbursement optimization. Applicants must provide operational mechanisms detailing how network activities will transition from initial grant funding into self-sustaining delivery systems capable of permanently expanding clinical capacity.
- **Experience and Qualifications:** Exceptional capacity to coordinate, align, and drive consensus among various rural healthcare providers, clinics, health systems, and community stakeholders. The collective experience of lead network conveners, member clinics, and technical partners will be scored together to evaluate the applicant's readiness to manage a complex rural health network infrastructure.
- **Budget and Cost Justification:** The applicant must provide a comprehensive, detailed budget that falls within the eligible funding range ($250,000 to $1,200,000). Line items must be clear, cost-effective, and explicitly justified to support the operationalization and execution of the five core deliverables within the project scope.
- **Special Priority Scoring Note:** To encourage equitable care access and strengthen tribal health infrastructure within Utah, the review committee will award up to 5 additional bonus points to any application that includes at least one verified Tribal Health Entity (such as an Indian Health Service facility or a Tribally Operated Health Program) as a formal, active partner within their network structure. These points will be applied to the applicant's final score.
    - **Pre-Application Engagement Requirement (For Non-Tribal Lead Applicants):** To qualify for these bonus points, applicants must connect with the respective tribal

community leadership prior to submitting the application. The proposal must explicitly demonstrate how tribal feedback was gathered and integrated to address the community's self-identified network and health needs.

- **Community Alignment (For Tribal Lead Applicants):** If the primary applicant is a verified Tribal Health Entity or active I/T/U provider, the proposal must demonstrate how internal community health needs assessments, membership feedback, or tribal leadership recommendations directly informed the network's design, service expansions, and priorities.

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.

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;

- includes a budget that exceeds the maximum allowable award amount;
- is not submitted via the provided application link; and
- does not include all of the components required in the application.

RFGA Application Limits

DHHS will accept only one formal RFGA 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: RFGA Funding Details

Funding type: Grant agreement

Maximum funding available for Year 1: Up to $2,500,000.

Maximum funding available for the agreement: Up to $18,500,000 over a 5 year period, contingent on the availability of funds.

Expected total number of awards: Approximately 6 awards.

Maximum Year 1 Award Amount: Recipients can apply for award amounts from $250,000 up to $1,250,000 dependent upon project scale and network complexity.

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 21, 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.

Budget Period "Year"	Beginning date	End date	Budget Period funds must be expended by end of the following fiscal year
1	Agreement start date	October 30, 2026	September 30, 2027
2	October 31, 2026	October 30, 2027	September 30, 2028
3	October 31, 2027	October 30, 2028	September 30, 2029
4	October 31, 2028	October 30, 2029	September 30, 2030
5	October 31, 2029	October 30, 2030	September 30, 2031

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. The intent of this activity is to fund sustainable Health Provider Network projects in rural Utah that establish or strengthen clinical service lines, expand access to care, and streamline operational infrastructure through shared administrative models**.** It is designed to enable

networks to meet emerging community needs through sustainable service expansion and economies of scale—pooling resources across members for legal, IT, billing, and procurement functions. By reducing individual administrative overhead and provider burden, networks reinforce long-term financial viability alongside future billing and reimbursement."

The following milestones and benchmarks should be incorporated into the description and approach in the application.

SHIFT: Sustaining Health Infrastructure for Transformation

3.2 Expand services and resources through rural health provider networks including but not limited to a rural health clinic network, pediatric trauma network, or community health worker network.

Grantees must incorporate the following milestones into their project implementation:

1. Network Governance & Clinical Needs Assessment

- **Network Operationalization:** Establish the formal governance structures, shared administrative protocols, and centralized operational frameworks necessary to optimize resource pooling and eliminate administrative redundancies across the network.
- **Clinical Service Needs Evaluation:** Conduct a comprehensive evaluation of the clinical service needs of the proposed rural provider network service area. Identify measurable short and long-term plans for bringing new service lines to the service areas.

2. Directory Development & Care Model Integration Planning

- **Resource Directory Development:** Grantees must develop a comprehensive, region-specific directory of physical and behavioral healthcare services. This directory must provide granular data on service capacity, access points, and availability to facilitate enhanced patient navigation and inter-provider coordination.
- **Integration of New Care Models:** Provide a detailed strategic plan for the integration of innovative care delivery models. This includes the utilization of community health workers, peer support specialists, or other paraprofessional roles designed to mitigate provider strain and streamline longitudinal care coordination.

3. Program Execution & Service Launch

- **Model Deployment:** Operationalize the detailed strategic coordination framework by integrating dedicated care coordination or navigation roles directly into patient care pathways to bridge gaps in rural health delivery.
- **Service Line Activation:** Execute the short-term plans created to introduce and deliver newly expanded clinical service lines inside the designated rural service boundaries.

4. Metrics Tracking & Evaluation Logging

- **Implementation Logging:** Maintain detailed operational logs tracking network service delivery and system expansion results directly caused by the development and execution of the rural health provider network. Grantees must continuously track:
    - # of new services available to a community
    - # of patients that receive services from members of a rural health network
- **Continuous Reporting:** Synthesize logged performance statistics into complete technical summary packages for review by Utah DHHS to guide ongoing adjustments and long-term programmatic sustainability.

5. Sustainability Modeling & Strategic Expansion

- **Financial Sustainability Framework:** Design and implement a comprehensive financial model focused on long-term viability through billing, coding, and reimbursement optimization. Grantees must establish clear operational mechanisms to transition network activities from initial grant funding to self-sustaining models capable of adapting to emerging clinical demands.
- **Clinical Capacity Expansion:** Formulate actionable strategies to establish, strengthen, and scale essential clinical service lines. This planning must explicitly detail how the network will expand physical or programmatic access to care, ensuring the permanent enrichment of health delivery systems within the designated rural service area.

6. Shared Administrative Infrastructure & Economies of Scale

- **Shared Services Needs Assessment & Model Design:** Conduct a targeted administrative assessment across network members to identify shared operational vulnerabilities and opportunities for resource pooling (e.g., shared legal counsel, centralized billing/coding

services, shared IT departments, compliance management, joint purchasing arrangements, etc.). Design a formal shared services framework that enables participating providers to pool financial resources and leverage economies of scale while preserving local institutional governance and independence.

- **Joint Contracting & Administrative Burden Alleviation:** Identify opportunities for and begin operationalizing shared administrative mechanisms through joint vendor contracting, pooled purchasing agreements, or centralized administrative staffing across participating network facilities. Implement streamlined administrative workflows designed to directly lower operating overhead, eliminate redundant administrative costs, alleviate provider administrative burden, and reinforce long-term financial sustainability.

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.
- Collaborate with DHHS to ensure support of tribal health priorities.

Section 4: Budget

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 8% of the total amount requested. This 8% 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.

Category J Funding Definition: As outlined in the Notice of Funding Opportunity (NOFO) Program Requirements and Expectations, Category J funds are specifically designated for capital investments in existing rural healthcare facility infrastructure. Allowable expenditures under this category include minor building alterations, renovations, and equipment upgrades designed to align long-term overhead and upkeep costs with current patient volumes. To be permissible, these expenditures must be integrated into a comprehensive initiative that demonstrates a clear linkage to overarching program goals, subject to all stated NOFO funding policies and limitations.

Rural Health Networks Category J Restriction: Category J funds are strictly prohibited and unallowable for use within or in support of the Rural Health Networks Activity.

Category B Funding Definition: As outlined in the Notice of Funding Opportunity (NOFO) Program Requirements and Expectations, Category B funds are specifically designated for provider payments for clinical services not reimbursed by insurers or other programs. To be permissible, these payments must tie directly to the strategic goals of the Rural Health Transformation Program (RHTP) and support

initiatives described in the State's Rural Health Transformation Plan, focusing on workforce recruitment, sustainable access to care, and technological innovation. Allowable expenditures include payments for performance in alternative payment models and services supporting specific RHTP initiatives, provided they are not otherwise billable or linked to clinicians under non-compete agreements.

Rural Health Networks Category B Eligibility: Applicants are eligible to request Category B funds to support clinical services and must directly advance the goals of the Rural Health Provider Networks activity. ***Utilization of these funds is strictly limited to an overall 15% cap of Utah's total awarded $195,593,767.19.*** Applicants must provide detailed information regarding Year 1 funding requirements and a strategic plan for fund distribution and long-term sustainability.

- **What is Covered:**
  - Outcome-based payments for alternative care models.
  - Clinical services supporting the RHTP Rural Health Provider Networks activity that are not billable to Medicare, Medicaid, or private insurance.
- **What is Not Covered:**
  - Standard "billable" services or uncompensated care unrelated to the RHTP Rural Health Provider Networks activity.
  - Salaries for clinicians who are subject to non-compete agreements.
- **Your Application Must Include:**
  - The specific dollar amount requested for **Year 1**.
  - A detailed plan explaining how these funds will be used and how the initiative will remain sustainable after the grant ends.

Section 5: RFGA Application

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

- Application link: Utah RHTP SHIFT 3.2 Rural Health Provider Networks Application
- Budget template link: Rural Health Provider Networks RFGA Budget Template_Final

The application must be submitted by August 14, 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.

1. **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 grant agreement:
    a. Utah-Based Non-Profit Organization / 501(c)
    b. For-Profit Business / Organization
    c. Government or Public Entity
    d. Formal Health Network / Consortium
2. **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 network partnership.
3. **[Collaborative Entity] Partner Breakdown:** List the legal names, facility types, and primary locations of all core rural healthcare partners or subcontractors involved in this application.
4. **Facility Diversity Verification:** To encourage comprehensive cross-functional integration, your partnership network must include a **minimum of three (3)** different facilities. Please check all facility types represented in your application structure:
    a. Critical Access Hospital (CAH)

b. Rural Emergency Hospital (REH)
c. Certified Rural Health Clinic (RHC)
d. Indian Health Service (IHS) Facility
e. Tribally Operated Health Program
f. Federally Qualified Health Center (FQHC)
g. Other (if other please specify)

5. **Mandatory Verification Evidence Selection:** Please select the appropriate verification document(s) you will be uploading to demonstrate your multi-facility collaboration mandate. You must select and upload at least **two (2)** of the following items:
    a. **Executed Memoranda of Understanding (MOUs):** Formal partnership agreements confirming active multi-facility collaboration.
    b. **Joint Initiative Documentation:** Documentation of active joint clinical or operational initiatives involving at least three rural healthcare partners.
    c. **Official Letters of Support:** Formal attestations signed by executive leadership from the participating rural facilities.
6. **Mandatory Verification Document Upload:** Please upload the appropriate verification documents selected above. *(Maximum 1 upload — please combine/compress these documents into a single PDF file before uploading.)*
7. **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:

    "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 agree and attest.

8. **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?
    a. Yes
    b. No

Part 3: Network Governance and Operational Readiness

1. **Governance Framework and Protocols:** Describe your planned approach to establish formal governance structures, shared administrative protocols, and centralized operational frameworks. Explain how these frameworks will optimize resource pooling and eliminate administrative redundancies across your rural provider network. *(3,000 characters)*
2. **Clinical Needs Evaluation:** Detail your methodology for conducting a comprehensive evaluation of the clinical service needs within your proposed rural service area. How will your findings directly inform the identification of new clinical service lines? *(2,000 characters)*
3. **Service Line Expansion Planning:** Outline your measurable short-term and long-term plans for bringing these newly identified service lines into the target rural service areas. *(2,000 characters)*

Part 4: Care Model Design and Resource Mapping

1. **Resource Directory Development:** Describe your strategy to build a comprehensive, region-specific directory of physical and behavioral healthcare services. Specify how you will gather and maintain granular data regarding service capacity, access points, and provider availability to facilitate patient navigation. *(2,000 characters)*
2. **Innovative Care Model Integration:** Provide a detailed strategic plan for integrating innovative care delivery models into your network. Explicitly detail how your network will utilize community health workers (CHWs), peer support specialists, or other paraprofessional roles to mitigate rural provider strain and streamline longitudinal care coordination. *(3,000 characters)*

Part 5: Program Execution and Service Activation

1. **Model Deployment Execution:** Explain how you will operationalize your strategic coordination framework to deploy active paraprofessional roles (CHWs, peer support specialists, etc.) directly into your network's care coordination pathways. *(3,000 characters)*
2. **Service Line Activation Roadmap:** Detail the concrete operational actions, milestones, and timelines you will execute to successfully launch and deliver your newly expanded clinical service lines inside the designated rural service boundaries. *(3,000 characters)*

Part 6: Performance Metrics, Tracking, and Evaluation

1. **Implementation Logging Methodology:** Detail your operational logging framework to continuously track and verify network service delivery and system expansion results. Explicitly outline how you will accurately capture and log:

a. The number of new services made available to the community.
b. The number of unique patients receiving services from members of the rural health network. *(2,000 characters)*

2. **Continuous Reporting & Technical Summary Synthesis:** Describe your process for synthesizing logged performance statistics into complete technical summary packages. How will these packages be utilized to guide ongoing programmatic adjustments and demonstrate long-term viability to Utah DHHS? *(2,000 characters)*

Part 7: Financial Sustainability and Strategic Expansion

1. **Financial Sustainability Framework:** Detail the design and implementation of the financial model you will use to focus on long-term viability. Address how your network will utilize billing, coding, and reimbursement optimization to create sustainable revenue. *(3,000 characters)*
2. **Grant-to-Sufficiency Transition Mechanisms:** Specify the exact operational mechanisms your network will deploy to transition activities away from initial grant funding into a fully self-sustaining model. How will this model dynamically adapt to future emerging clinical demands while permanently enriching health delivery systems in rural Utah? *(4,500 characters)*

Part 8: Shared Administrative Services & Economies of Scale:

1. Detail your plan to identify and execute shared administrative services (e.g., joint legal contracting, pooled IT/billing, group purchasing) among network providers. Explain how your network will pool financial resources to achieve economies of scale, reduce individual administrative costs, and alleviate operational burden while maintaining local provider governance. (3,000 characters)

Part 9: Experience and Qualifications

1. **Consensus Building and Collaboration Past Performance:** Detail your organization's specific past performance in coordinating, aligning, and driving consensus among diverse rural healthcare providers, clinics, health systems, and local stakeholders. *(3,000 characters)*
2. **Relevant Project Overview:** Highlight one (1) past or ongoing network project relevant to rural health infrastructure scaling. Include specific details regarding historical governance outcomes, service line expansions, and financial/operational improvements achieved. *(4,000 characters)*

3. **[Single Entity] Project Lead & Key Personnel Qualifications:** Identify the Project Lead and up to two additional key personnel, describing their professional qualifications and specific roles in executing this project. *(3,000 characters)*
4. **[Collaborative Entity] Roles & Operational Governance:** Describe the operational relationship between the Lead Applicant and all proposed network partners or technical subcontractors. Delineate who is responsible for high-level stakeholder convening versus hands-on operational deployment and financial modeling. *(3,000 characters)*
5. **Resumes/CVs Upload:** Upload the Resume or Curriculum Vitae (CV) for the Project Lead and two key personnel named in the previous questions. *(Limit of 4 pages per CV. Maximum 1 upload — please combine/compress these documents into a single PDF file before uploading).*
6. **Tribal Community Engagement & Feedback Integration:** Select the path below that aligns with your application structure and provide the requested details.
    a. **Path A [Tribal Lead Applicant - Up to 18 Points]:** Describe how your internal community health needs assessments, membership feedback, or tribal leadership directives directly informed the design, clinical service expansions, and priorities of this proposed rural health provider network. *(2,000 characters)*
    b. **Path B [Established Tribal Partner Network - Up to 9 Points]:** Describe your organization's past capacity working with tribes and detail the pre-application consultation process conducted with tribal leadership. Explicitly demonstrate how tribal feedback was actively gathered and directly integrated into your proposed network design. *(2,000 characters)*
    c. **Path C [Work-Plan Consultation Commitment - Up to 3 Points]:** Describe your formal plan and commitment to conduct meaningful consultation with tribal leadership during the project's initial work-planning phase, detailing how tribal input will be gathered to shape upcoming clinical and operational activities. *(2,000 characters)*
    d. **Standard Network:** Please enter "N/A - Standard Network" in the application process.

Part 10: Budget

1. **Proposed Funding Request Amount:** State your total proposed budget request for the project period. *(Must fall within the eligible range of $250,000 to $1,250,000).*
2. **Itemized Budget Sheet Upload:** Upload a comprehensive, itemized budget sheet using the template provided. Ensure all line items are clear, cost-effective, and explicitly justified to support the operationalization of the five core deliverables. *(Maximum 1 upload).*

Section 6: RFGA 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) entity, for-profit business/corporation/LLC, Clinically Integrated Network (CIN), Accountable Care Organization (ACO), or Government/Public entity (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:

Special Priority Scoring Note: To encourage equitable care access and strengthen tribal health infrastructure within Utah, the review committee will award up to 18 additional bonus points to applications that are led by tribal entities, demonstrate verified partnerships, or commit to tribal consultation and engagement. Bonus points will be added to the applicant's final score on a tiered scale according to the criteria detailed below.

RFGA Scoring Outline

01. Network Governance and Operational Readiness (28 points available)

a. Governance Framework and Protocols (12 points)
   i. **Fail:** No formal governance structure, administrative protocols, or operational frameworks are provided.
   ii. **Satisfactory:** A governance structure is outlined, but it lacks clear administrative protocols or fails to show how resource pooling and administrative redundancies will be managed across network members.
   iii. **Excellent:** Establishes an airtight, formalized governance structure with clear shared protocols and centralized operational frameworks optimized to maximize resource pooling and eliminate operational redundancies.

b. Clinical Needs Evaluation (6 points)
   i. **Fail:** No evaluation methodology or plan to assess clinical service needs in the rural service area is provided.
   ii. **Satisfactory:** A clinical needs evaluation is mentioned, but the methodology is vague or fails to gather granular data on the specific needs of the target rural population.
   iii. **Excellent:** Details a comprehensive, data-driven methodology to evaluate the clinical service needs of the proposed rural service area to accurately identify gaps in care.

c. Service Line Expansion Planning (10 points)
   i. **Fail:** No measurable plans for bringing new service lines to the service areas are provided.
   ii. **Satisfactory:** Mentions short- or long-term service expansion, but plans lack clear timelines, measurable benchmarks, or alignment with the clinical needs evaluation.
   iii. **Excellent:** Outlines clear, highly measurable short- and long-term action plans for successfully introducing and scaling new clinical service lines within the target service areas.

02. Performance Metrics, Tracking, and Evaluation (10 points available)

a. Implementation Logging Methodology (5 points)
   i. **Fail:** No framework for monitoring operations or building an implementation log is provided.
   ii. **Satisfactory:** Plans basic operational logs, but fails to provide a clear methodology to continuously and accurately isolate and track the core metrics (number of new services and number of unique patients served).
   iii. **Excellent:** Outlines a rigorous logging framework capable of continuously and accurately tracking system expansion results, specifically capturing the number of new services available and the total volume of patients served by network members.

b. Continuous Reporting & Technical Summary Synthesis (5 points)
   i. **Fail:** No plan to synthesize data or report back to Utah DHHS is outlined.
   ii. **Satisfactory:** Performance statistics are collected, but the method for synthesizing these into technical packages is poorly defined or fails to outline how data will guide ongoing adjustments.
   iii. **Excellent:** Outlines a clear process for synthesizing logged statistics into comprehensive technical summary packages for review by Utah DHHS to drive data-informed program adjustments and long-term sustainability.

03. Financial Sustainability and Strategic Expansion (34 points available)

a. Financial Sustainability Framework (16 points)
   i. **Fail:** Omits specialized long-term financial modeling or relies entirely on permanent grant funding.
   ii. **Satisfactory:** Financial sustainability is mentioned, but the underlying models are vague and fail to outline specific mechanisms for billing, coding, and reimbursement optimization.
   iii. **Excellent:** Delivers a highly sophisticated financial architecture focused heavily on long-term viability through meticulous billing, coding, and reimbursement optimization.

b. Grant-to-Sufficiency Transition Mechanisms (18 points)
   i. **Fail:** No operational plan to transition network activities away from grant funding is provided.
   ii. **Satisfactory:** A transition plan is present, but it lacks clear operational boundaries to shift away from temporary grant capital, or fails to prove how the model will adapt to future clinical demands.
   iii. **Excellent:** Establishes explicit, realistic operational mechanisms to seamlessly transition network activities from initial grant reliance to a fully self-sustaining delivery system that permanently enriches rural healthcare infrastructure.

04. Care Model Design and Resource Mapping (15 points available)

a. Resource Directory Development (6 points)
   i. **Fail:** No strategy to create a regional healthcare service directory is provided.
   ii. **Satisfactory:** Plans a basic resource directory, but it lacks granular data on service capacities, distinct access points, or availability to truly support patient navigation.
   iii. **Excellent:** Delivers a robust strategy to build a comprehensive, region-specific directory of physical and behavioral healthcare services featuring granular data on capacity, access points, and real-time availability to optimize inter-provider coordination.

b. Innovative Care Model Integration (9 points)
   i. **Fail:** No plan for integrating innovative care delivery models or utilizing paraprofessional roles is outlined.
   ii. **Satisfactory:** Mentions utilizing community health workers or peer support specialists, but lacks a detailed strategic plan for how these roles will mitigate provider strain or integrate into longitudinal care.
   iii. **Excellent:** Provides a highly strategic plan for integrating innovative care delivery models, explicitly demonstrating how community health workers, peer support specialists, or other paraprofessionals will be systematically deployed to eliminate provider strain and streamline longitudinal care.

05. Program Execution and Service Activation (14 points available)

a. Model Deployment Execution (6 points)
   i. **Fail:** No plan to operationalize the coordination framework or integrate paraprofessionals into active care pathways is provided.
   ii. **Satisfactory:** Paraprofessional roles are defined, but the active care coordination pathways are vague, creating risks for operational bottlenecks.
   iii. **Excellent:** Outlines a seamless operationalization strategy that integrates active paraprofessional roles directly into the core care coordination pathways from day one.

b. Service Line Activation Roadmap (8 points)
   i. **Fail:** No operational roadmap or timeline for launching clinical services within the designated rural boundaries is provided.
   ii. **Satisfactory:** A service launch plan is included, but it lacks concrete operational actions, milestone timelines, or feasibility within the grant period.
   iii. **Excellent:** Delivers an outstanding, turn-key operational roadmap detailing clear milestones, actions, and timelines to successfully launch and deliver newly expanded clinical service lines inside the designated rural boundaries.

06. Experience and Qualifications (22 points available)

a. Consensus Building and Collaboration Past Performance (12 points)
   i. **Fail:** The applicant provides no history of coordinating or driving consensus among rural healthcare stakeholders.
   ii. **Satisfactory:** Explains general network management, but lacks proof of successfully aligning diverse, independent clinics or health systems with potentially competing interests.
   iii. **Excellent:** Demonstrates an exceptional track record of consensus-building, highlighting a proven ability to align diverse rural providers, clinics, health systems, and community stakeholders toward shared goals.

b. Relevant Project Overview (12 points)
   i. **Fail:** No relevant past case study or project narrative is provided.
   ii. **Satisfactory:** Highlights a past project, but omits specific details regarding service line expansion, governance outcomes, or financial sustainability metrics achieved.
   iii. **Excellent:** Details a highly successful, directly relevant past project that explicitly demonstrates a proven track record in rural health network design, governance execution, and expanded health service lines.

07. Applicant Structure and Personnel (9 points)

(Note: Applicants will be scored on either the single entity criteria or the collaborative criteria below for a maximum of 9 points).

a. Option A: Single Entity Applicants: Project Lead & Key Personnel Qualifications
   i. **Fail:** The proposed personnel lack the technical credentials or specialized experience needed to execute the scope of work.
   ii. **Satisfactory:** The proposed team has general healthcare skills but lacks an equitable balance of specialized experts in rural clinical expansion and billing/reimbursement structures.
   iii. **Excellent:** Key personnel possess premier technical expertise in rural healthcare coordination, clinical service operations, and sustainable financial modeling.

b. Option B: Collaborative Entity Applicants: Roles & Operational Governance
   i. **Fail:** Response fails to provide any meaningful description of operational relationships, roles, or division of labor.
   ii. **Satisfactory:** A governance structure is included, but the response lacks clear delineation between high-level stakeholder convening and hands-on operational deployment.
   iii. **Excellent:** Delivers a comprehensive governance roadmap that clearly defines roles, decision-making frameworks, and explicit operational boundaries across stakeholder convening, data sharing, and execution.

08. Shared Administrative Infrastructure & Economies of Scale (15 points available)

a. Shared Administrative Needs Assessment & Governance (7 points)
   i. **Fail:** No framework or methodology to identify shared administrative needs or assess operational redundancies across network members is provided.
   ii. **Satisfactory:** Identifies potential shared administrative services, but lacks a structured assessment process or clear governance framework for multi-facility resource pooling.
   iii. **Excellent:** Outlines a comprehensive, structured approach to evaluate administrative vulnerabilities across member facilities and establish clear governance protocols for pooled operational resources.

b. Joint Contracting & Administrative Cost Reduction (8 points)
   i. **Fail:** No plan to execute joint contracting, shared operational mechanisms, or administrative cost-reduction strategies across network providers is provided.
   ii. **Satisfactory:** Mentions shared administrative services, but lacks concrete plans for joint contracting, shared legal/IT/billing mechanisms, or clear cost-reduction strategies.
   iii. **Excellent:** Outlines a clear, highly feasible framework to conduct shared needs assessments, execute joint vendor contracting, pool financial resources, and reduce operational overhead while preserving local provider governance.

09. Budget and Cost Justification (15 points available)

a. Proposed Funding Request Amount (1 point)
   i. **Fail:** Budget request sits outside the mandatory $250,000 to $1,200,000 range.
   ii. **Excellent:** Proposed budget falls strictly within the allowable $250,000 to $1,200,000 range.

b. Relevance and Scope Alignment (7 points)
   i. **Fail:** Budget contains unallowable costs or line items unrelated to the core deliverables.
   ii. **Satisfactory:** Line items are generally relevant, but funding leans heavily on temporary operational staffing rather than structural mechanisms that foster long-term billing sustainability.
   iii. **Excellent:** Every line item is highly relevant, falls within scope, and directly maps to the operationalization and execution of the core deliverables.

c. Clear and Rational Justifications (7 points)
   i. **Fail:** Budget lacks transparent itemized cost calculations or rationales.

ii. **Satisfactory:** Justifications are included but are generic or fail to show clear math connecting spending blocks to physical deliverables.
iii. **Excellent:** Demonstrates a completely transparent, logical cost justification for each operational section, cleanly linking proposed spending directly to verifiable network deliverables.

10. Priority Bonus Points (up to 18 points available)

a. Tribal Health Entity Integration Bonus (18 points)
   i. **No Bonus (0 pts):** The applicant's network structure does not contain a verified Tribal Health Entity or any of the below approaches.
   ii. **Consultation Planning Bonus (3 pts):** The applicant demonstrates a formal commitment to conducting tribal consultation during the work-planning phase, but lacks documented evidence of established partnerships or prior engagement.
   iii. **Tribal Partner Network Bonus (9 pts):** The Lead Applicant is an outside organization that demonstrates a proven capacity for working with tribes, provides documented proof (via Part 2 MOUs or Letters of Support) of an active partnership with a tribe/tribal health organization, and explicitly details in Part 8 a meaningful pre-application consultation process where tribal feedback directly shaped the proposed network services.
   iv. **Full Tribal Lead Bonus (18 pts):** The Lead Applicant is a verified Tribal Health Entity or active I/T/U provider in rural Utah, and their Part 8 response clearly outlines how community-specific health demands and tribal leadership directives directly informed the network's design.

Total Points: 180 points
Required technical point threshold: 80 points. Base scores below 80 points will not qualify for funding.

Award timeline

DHHS anticipates notifying all RFGA applicants of the award decision by **August 31, 2026**. Upon award, DHHS will initiate the State of Utah contracting process. DHHS may negotiate modifications with the selected Grantees 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 selected Grantees. DHHS determination regarding any questions of conflict of interest shall be final.

Section 7: Budget Period Timeline

CMS issues funding based on the following Budget Periods timelines. Per federal Rural Health Transformation mandates, failure to expend funds for each Budget Period by the end of the following fiscal year (September 30 of the following year) will result in funds recouped by DHHS to return to CMS.

CMS Budget Periods

Budget Period "Year"	Beginning date	End date	Budget Period funds must be expended by end of the following fiscal year
1	Agreement start date	October 30, 2026	September 30, 2027
2	October 31, 2026	October 30, 2027	September 30, 2028
3	October 31, 2027	October 30, 2028	September 30, 2029
4	October 31, 2028	October 30, 2029	September 30, 2030
5	October 31, 2029	October 30, 2030	September 30, 2031

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

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 8: Additional Resources

- CMS Rural Health Transformation Service Commitment Fact Sheet: outlines the 5 year service commitment criteria. cms.gov/files/document/5-year-service-commitment-fact-sheet.pdf
- 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