Foundation for Healthy Communities (FHC) Request for Application (RFA)
FHC Rural Primary Care Access (Updated 9/1/2026)

This GO-NORTH Request for Applications 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 $204,016,550.20 million 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.

The Governor's Office of New Opportunities and Rural Transformational Health (GO-NORTH), was established by Executive Order under Governor Kelly Ayotte, and is funded by the Rural Health Transformation (RHT) Federal program. GO-NORTH advances five strategic initiatives to improve the health and sustainability of rural New Hampshire.

Initiative 1: Population Health
Increase prevention, chronic disease management, and improved behavioral and maternal health.

Initiative 2: Access
Ensure sustainable access to care by strengthening rural hospitals, health centers, EMS, and telehealth services

Initiative 3: Workforce
Build and retain a skilled rural health workforce through education, training, and career pathways.

Initiative 4: Technology
Promote financial sustainability with innovative payment models and value-based care.

Initiative 5: Financial Sustainability
Promote financial sustainability with innovative payment models and value-based care.

GO NORTH delivers this work through five Hubs, each supported by a GO NORTH lead who provides coordination, guidance, and oversight to ensure alignment with statewide priorities. The 5 Hubs represent rural health experience and knowledge that will support our work together. [Program Overview | GO-NORTH]



Initiative #	☐1	☒2	☐3	☐4	☐5

At-a-Glance

Funding Overview	Rural primary care is the foundation of a high-functioning rural health system. This funding opportunity supports the transformation of rural primary care delivery in New Hampshire toward sustainable, team-based, technology-enabled, and community-connected models that improve health outcomes and strengthen long-term viability. Applicants are encouraged to propose integrated projects across four transformation domains through regional strategies rather than standalone interventions, with a clear plan for financial sustainability beyond the award period. FHC is expecting to award a total of approximately $15.5 million in funding.
Award Start Date	Execution of contract through September 30, 2027, multiple-year awards contingent on funding from GO-NORTH

Eligible Applicants	• Organizations that deliver primary care, such as:
	  ○ Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes
	  ○ Rural Health Clinics (RHCs), provider-based or independent
	  ○ Rural primary care practices
	  ○ Hospitals with a primary care clinic or rural health clinic
	• Organizations partnering with primary care practices to transform the delivery of primary care in rural New Hampshire.

Application Deadline	**Target Application Portal Opens:** Early September **Initial Application Deadline: October** 15th, 2026, at 5:00 PM ET **Notification of Award (initial cohort):** Late October Rolling Application acceptable while funds are available Award Notification (rolling cohort): within 45-60 days ---------- **Information Session: September 2nd 9:00am – 10:30am Register HERE**
Website	healthynh.org

Application Writing Support

To increase access and expand the pool of competitive applicants, the FHC will provide qualifying organizations with financial resources and direct support for project development and award application writing activities. Applicants may request this support ahead of completing their application.

To request application writing support, contact: GO-NORTH-FHC@healthynh.org

Note: Consultants engaged for award application writing support must be procured from FHC's list of pre-approved professionals or through an independent competitive procurement process in accordance with 2 CFR Part 200.

FHC Objective

The FHC's Year 1 investment strategy focuses on building foundational capacity for transformation through planning, stabilization, and initial program development across emergency medical services (EMS), oral health, primary care, and rural hospitals.

In subsequent years, the program shifts from foundation-building to implementation, scaling, and long-term sustainability, with continued funding contingent on demonstrated performance and GO-NORTH authorization.

Overview of Funding Opportunity

Rural primary care serves as the foundation of a high-functioning rural health system. The purpose of this funding opportunity is to support the transformation of rural primary care delivery in New Hampshire through investments that improve access to care, strengthen long-term operational and financial sustainability, reduce administrative burden, advance integration across services, and position rural providers for success under evolving value-based and population health-oriented payment models.

This funding opportunity is intended to support the transition from fragmented and volume-dependent care delivery toward sustainable, team-based, technology-enabled and community-connected models of care that improve health outcomes and strengthen rural health system sustainability over time.

Applicants are encouraged to propose integrated projects that address four transformation domains through cohesive regional strategies rather than isolated standalone interventions. Applicants should clearly describe how proposed investments will position organizations for long-term operational and financial sustainability beyond the award period, including through operational efficiencies, shared infrastructure, reimbursement strategies, participation in value-based payment (VBP) arrangements, or other sustainable financing mechanisms.

FHC is expecting to award a total of approximately $15.5 million in funding.

Who Is Eligible to Apply?

Primary Care Alignment

The applicant must be one of the following organization types **and** must demonstrate in the application narrative that the proposed project directly supports, expands, or integrates services that are integral to comprehensive primary care delivery in rural New Hampshire.

Eligible Lead Applicant Types

- ✓ Organizations that deliver primary care, such as:
  - Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes
  - Rural Health Clinics (RHCs), provider-based or independent
  - Rural primary care practices
  - Hospitals with a primary care clinic or rural health clinic
- ✓ Organizations partnering with primary care practices to transform the delivery of primary care in rural New Hampshire.

Multiple eligible organizations may collaborate on one application, and these partnerships are strongly encouraged. However, one organization must be designated as the lead applicant.

Primary Care Alignment Test

If the lead applicant is not an organization that delivers primary care, the applicant must clearly describe in the project narrative how the proposed project:

- Directly supports or expands primary care access, coordination, or delivery in rural communities
- Integrates the applicant's services into the primary care delivery model rather than operating as a standalone service

Applications that do not demonstrate a clear and meaningful connection to primary care access and transformation will be screened out as ineligible. An application does not satisfy the Primary Care Alignment Test if the application proposes the delivery of services through its existing channels and primary care only appears as a referral source or a recipient of notifications upon request of the primary care organization.

If the lead applicant is not an organization that delivers primary care, it must demonstrate integration of its services into the primary care delivery model by (i) providing a letter of commitment, Memorandum of Understanding (MOU), or letter of support from each named primary care partner, specifying role and scope; **and** (ii) demonstrating one of the following (1) clinical information flows back to the primary care organization – results, care plans, medication changes, etc. - through a defined mechanism, not only on request; (2) the primary care partner's workflow, panel management, or care team composition changes as a result of the project; or (3) shared or coordinated accountability for a defined patient population.

Applicants may submit **only one application** as the lead applicant. However, lead applicants may also be partners in other applications in which their organization is not the lead applicant, provided that there is no duplication of funding. **Exception:** Lead applicants may submit a second application **only** if the second application proposes an **Occupational Health HUB Model** described under the **Innovative Care Models** focus area on page 16.

Who Is Not Eligible as a Lead Applicant Under This RFA?

Standalone specialty practices/organizations (e.g., ophthalmology, cardiology, orthopedics, mental health, dermatology) **-** that do not propose a project to integrate services into a primary care delivery model

Partner Organizations

Partners do not need to meet the primary care eligibility requirement but must have a defined scope of work and budget within the application. Partners may include hospitals, specialty practices, behavioral health providers, EMS agencies, oral health providers, community-based organizations, telehealth providers and other organizations whose participation directly supports the proposed primary care transformation project.

Where possible, a fully executed MOU or Letter of Commitment from each partner organization is preferred, and FHC reserves the right to require that the applicant delivers a fully executed MOU or Letter of Commitment at execution of an award. Please see more information on partnerships farther down in the RFA.

Applicant	Scenario	Eligible Applicant?	Why
FQHC	Team-based care integration	Yes	Primary care provider
Behavioral health community based organization (CBO)	Embedding clinicians into primary care practices	Yes	Although not a primary care provider, the proposed project integrates behavioral health into primary care delivery
Behavioral health CBO	Standalone therapy program	No	Not a primary care provider and project does not integrate applicant's services into a primary care delivery model
Pediatric mental health organization	Integrating early intervention into primary care screening and referral	Yes	Although applicant is not a primary care provider, the applicant is eligible because the proposed project integrates with or coordinates services with a primary care delivery model
Pediatric mental health organization	Standalone school-based therapy	No	Not a primary care provider and project does not integrate applicant's services into a primary care delivery model
Pediatric mental health organization	School-based therapy program integrated with local primary care organization	Yes	Although applicant is not a primary care provider, the applicant is eligible because the proposed project integrates with or coordinates services with a primary care delivery model

Hospital	Primary care transformation project	Yes	Primary care delivery
Ophthalmology practice	Screening equipment	No	Applicant is not a primary care provider, and project does not propose to integrate applicant's services into a primary care delivery model
Ophthalmology practice	Partner with FQHC on diabetic retinopathy screening in primary care	Yes	Although applicant is not a primary care provider, the applicant is eligible because the proposed project integrates or coordinates services with a primary care delivery model
Community Mental Health Center	CCBHC planning not connected to primary care	No	Application will be referred to NH Community Behavioral Health Association (CBHA)
Community Mental Health Center	Embedding behavioral health into FQHC primary care	Yes	Although applicant is not a primary care provider, the applicant is eligible because the proposed project integrates or coordinates services with a primary care delivery model Application may be referred to, or coordinated with, NH CBHA

Rural Test and Definition of Rural

Applicants must demonstrate that proposal qualifies as Rural by showing that the proposal qualifies through one of the following two pathways:

Pathway	Requirement
Path A –HRSA Rural Geographic Areas (Primary pathway)	Proposed project is directed at, and primarily, benefits individuals living in a HRSA-defined rural area of NH. Proposed project may indirectly benefit individuals living in non-rural areas, provided that, the focus and reason for the project is to benefit access to primary care services in Rural New Hampshire. Verify rurality through the HRSA Rural Health Grants Eligibility Analyzer. Rural Health Grants Eligibility Analyzer.
Path B -CMS Rural Facility Designation	Healthcare facilities defined as a "Rural Health Facility" under the CMS Rural Health Transformation Program as authorized by the One Big Beautiful Bill Act (Section 71401 of Public Law 119-21) such as RHCs and FQHCs

Award Period and Available Funding

Awards will be given to eligible organizations across New Hampshire through this funding opportunity. Awards are selected based on available funds and FHC reserves the right to provide partial funding.

Partial Funding Policy

FHC reserves the right to fund an award at less than the full amount requested. Partial awards may occur where:

→ An application scores well, but the requested budget exceeds available funds;
→ Specific budget line items fall outside the scope of allowable activities; or
→ FHC determines that a portion of the proposed work does not align with program priorities

The initial grant term runs from date of contract execution through September 30, 2027 (Year 1 project budget period). Applicants are encouraged to describe additional funding needs for multi-year projects. Awards issued under this RFA are eligible for non-competitive continuation funding in subsequent budget periods, contingent on GO-NORTH authorization and satisfactory annual performance review.

Project Structure

Applicants will select what best reflects the scope and structure of their proposed initiative. Both approaches are competitive and will be reviewed by the same criteria.

1. Single-Organization

For lead applicants proposing an initiative within their own organization, with partners playing a supporting or referral role only.

- One lead applicant
- Partners may be listed and are encouraged, but do not receive subaward funding through this application

2. Regional Partnership

For lead applicants proposing an initiative that directly involves and funds multiple sub-recipient organizations. The Regional Partnership is designed to reward collaboration, where each sub-recipient partner has a defined scope of work, a dedicated budget, and accountability for outcomes.

- One lead applicant who serves as the fiscal agent and primary point of contact with FHC
- Minimum of 2 additional organizations, each functioning as a funded subrecipient with a defined role, budget, and outcome responsibilities
- Each subrecipient must be identified in the application with a defined scope of work, budget, and designated organizational contact
- A letter of support is required from each subrecipient at the time of application based on the project stage. The letter of support must specify the organization's role, scope of work, and any financial or in-kind contribution to the initiative. Where possible, a fully executed Memorandum of Understanding (MOU) or Letter of Commitment is preferred, and FHC reserves the right to require that the applicant delivers a fully

executed Memorandum of Understanding (MOU) or Letter of Commitment at execution of an award.

- FHC will execute a single award agreement with the lead applicant; the lead applicant is responsible for subaward agreements with each subrecipient and for all financial and programmatic compliance across the partnership

Award amounts will be determined based on the overall merit, scope, feasibility, and potential impact of the proposed project. In determining the appropriate award amount, consideration may be given to factors such as the number, quality, and strength of committed partnerships; the project's potential to achieve meaningful and transformative outcomes for rural communities; the extent to which the project addresses documented rural health needs, challenges, and disparities; the potential for long-term sustainability beyond the grant period; and the degree to which the proposed budget is reasonable and aligned with project goals, activities, and anticipated outcomes. Additional proposal characteristics and funding consideration may also be taken into account as part of the review and award determination process.

Defining Partnership for Regional Partnership Structure

Organizations participating in a partnership will be identified using a Unique Entity ID and/or Tax ID or Employer Identification Number (when applicable).

Partnership must be structural, not performative. A genuine partnership must demonstrate at least one structural characteristic:

1) Shared back-office infrastructure (multiple organizations jointly investing in a common operational system - such as a shared revenue cycle management platform, centralized billing, or common electronic health record (EHR) - that scales once across all partners rather than each organization building and maintaining its own, resulting in lower per-organization fixed costs and greater sustainability beyond the award period);
2) Shared service delivery (multiple organizations contributing distinct but interlocking clinical or community-based services to a single patient population, where the patient experiences one coordinated model of care and the partners share accountability for outcomes); or
3) Shared risk and VBP readiness (multiple organizations entering a joint or aligned VBP arrangement, accepting collective financial accountability for cost, quality, and outcomes across a shared patient population - aligned with New Hampshire's active transition to VBP.

Partnership under Regional Partnership structures is not just a letter of support, a referral relationship, or a list of named organizations with no budget, scope, or accountability. Applicants must be prepared to provide information on each partner including a defined scope of work, budget and designated organizational contact.

Application Timeline & Initial Close

Initial Application Deadline: October 15th, 2026, at 5:00 PM ET

FHC will review and evaluate all applications received by the initial deadline as a single cohort. Applications submitted by this date will receive priority for funding consideration.

Rolling Applications - Initial Close

FHC will keep this application open on a rolling basis following the initial deadline. Applications submitted after the initial deadline will be reviewed and evaluated in the order received, subject to remaining funding availability. FHC reserves the right to close the application period at any time once remaining funds are fully committed, or to pause the rolling window between review periods.

Applicants are strongly encouraged to submit by the initial deadline to ensure the fullest consideration for funding. Submitting after the initial deadline does not guarantee review - funding may be fully allocated from the initial cohort.

Key Dates

- **Target Application Portal Opens:** Early September
- **Initial Application Deadline:** October 15th, 2026, at 5:00 PM ET
- **Notification of Award (initial cohort):** Late October
- Rolling Application acceptable while funds are available
- Award Notification (rolling cohort): within 45-60 days

Detailed Breakdown of Funding Opportunity

The GO-NORTH Rural Health Transformation Program is designed to support lasting improvements in rural primary care, not isolated projects or short-term solutions. Successful transformation requires organizations to strengthen multiple aspects of care delivery simultaneously.

Rural Primary Care Goals

Goals for Rural Primary Care investments in NH's Rural Health Transformation Program include:

1. Transform how primary care is delivered in rural New Hampshire through the adoption of integrated team-based care.
2. Expanded access to comprehensive primary care services including preventive care, chronic disease management, behavioral health, and oral health integration
3. Support structural changes to rural primary care operations to support long-term financial sustainability and achieving NH's GO-NORTH goals.

To achieve these goals, all applicants must demonstrate how their proposed project integrates and advances each of the following Rural Primary Care focus areas. Together, these focus areas provide a framework for developing projects that improve patient care, strengthen organizational capacity, increase financial sustainability, and position rural primary care practices for long-term success**:**

Focus Area 1: Adoption of innovative care models
Focus Area 2: Adoption of technology with a demonstrated return on investment

Focus Area 3: Transition to value-based care (VBC)
Focus Area 4: Financial stability and operational efficiency

The Rural Primary Care Focus Areas descriptions and example activities can be viewed starting on page 14.

Provider Funding Priorities and Allocation Framework

FHC recognizes that rural health organizations across New Hampshire are at different stages of organizational readiness, and that a one-size-fits-all approach to award design will leave many providers behind. The RHTP is not designed exclusively for the most sophisticated applicants- it is designed to meet organizations where they are and move them forward.

To ensure equitable access across the full spectrum of rural provider capacity, FHC has structured its RFA portfolio around three program stages: Project Development, Preparatory Investments, and Program Ready. Each stage reflects a distinct level of organizational readiness and a distinct type of investment. Applicants should identify which stage best describes their organization's current state and propose a project scope that is appropriate to that stage.

Awards will be made across all three stages. FHC does not require applicants to be at the Program Ready stage to be competitive. Organizations at earlier stages that demonstrate a clear, credible pathway toward transformation are equally encouraged to apply.

Stage 1 - Project Development

Project Development awards support organizations with a promising project concept but need structured investment to assess their current state, build the partnerships required for sustainable change, and develop a credible project roadmap before committing to larger programmatic investments. Applicants proposing Project Development projects should articulate a defined problem, an identified set of partners and stakeholders, a clear description of the gap or barrier being addressed, and a concrete set of outputs the award will produce.

FHC expects Project Development awards to result in actionable deliverables - not studies that sit on a shelf. Funded activities should advance the organization to the Preparatory Investments or Program Ready stages in a future cycle. Proposals that lack a clear connection between the planning work and a defined next step will not be considered competitive at this stage.

Eligible activities include but are not limited to stakeholder convenings and coalition building, community health needs assessments, regional partnership development and governance planning, feasibility studies for shared services or new care delivery models, and early-stage workforce pipeline planning.

If your project concept is not yet fully developed and requires additional research, planning and identification of partners, we encourage you to apply for a GO-NORTH Planning Grant.

Stage 2 - Preparatory Investments

Preparatory Investments awards fund one-time, non-recurring investments that remove a specific operational barrier, close a defined infrastructure gap, or establish a critical organizational

capability that is prerequisite to longer-term transformation. These awards are designed for organizations that have identified a clear need and are ready to act - but require a targeted, time-limited investment to build the foundation from which transformation can follow.

Applicants proposing Preparatory Investments projects should clearly describe the barrier or gap being addressed, the specific investment proposed, and how that investment will position the organization to advance toward VBC, financial sustainability, workforce sustainability, population health improvement, or rural access expansion in subsequent award budget periods. One-time investments that do not connect to a longer-term transformation goal will not be considered competitive.

Eligible activities include but are not limited to: one-time software and technology purchases, EHR upgrades and optimization, population health management tool acquisition and implementation, revenue cycle assessment and improvement tools, and shared service early implementation.

Stage 3 - Program Ready

Program Ready awards are the intended destination of FHC's multi-year investment strategy - and the category where the most significant transformation outcomes are expected. Organizations at the Program Ready stage have completed foundational planning, established committed partnerships, and are prepared to implement a well-defined project with clear goals, measurable outcomes, and a realistic multi-year budget.

Applicants proposing Program Ready projects should demonstrate that the core elements of successful implementation are already in place: partners are identified and committed, a gap analysis has been completed and its findings are understood by the applying organization, and a detailed project plan with defined goals, objectives, milestones, and a realistic budget has been developed. Proposals that assert Program Ready status but cannot demonstrate these foundational elements will be evaluated as Project Development or Preparatory Investments proposals.

Eligible activities include but are not limited to: fully designed care transformation programs with committed implementation partners, multi-organization regional care models with defined governance structures and shared accountability frameworks, and VBP initiatives with defined payer partnerships and measurable performance targets.

How FHC Will Apply This Framework

Applications will be reviewed in the context of the program stage the applicant self-identifies and proposes. FHC reviewers will assess whether the proposed project scope, budget, and deliverables are appropriate and credible for the identified stage. Applicants are not penalized for being at an earlier stage- they are evaluated on whether their proposal is the right investment for where they are right now, and whether it creates a clear pathway toward transformation.

Expectations for Applicants

Funding is designed to support the transformation of rural primary care over a five-year period. In addition to describing the work you will complete during the initial funding period, applicants must demonstrate how their proposed activities fit into a broader, long-term transformation strategy.

Before preparing your application, consider the following:

1. **This is a transformational program, not a sustaining award**. Funded projects should describe structural changes to how care is delivered, financed, or sustained - not incremental improvements or continuation of existing services.
2. **You must address each of the Rural Primary Care focus areas**. Your application should describe how your project incorporates each of the four Rural Primary Care focus areas, 1- Adoption of innovative care models. 2- Adoption of technology with a demonstrated return on investment. 3- Transition to VBC. 4 - Financial stability and operational efficiency.
3. **Metrics matter**. Your application should include specific, measurable metrics for each focus area. These metrics will be tracked and reported throughout your award period and will factor into funding continuation decisions.
4. **Sustainability is required**. You must describe how the changes funded through this RFA will be sustained beyond the award period. Projects that create dependency on continued award funding without a path to financial sustainability are not competitive.
5. **Partnerships strengthen proposals.** Projects that leverage partnerships across providers, sectors, and service areas - particularly those that share infrastructure or coordinate care across organizations - are more competitive than single-organization proposals operating in isolation.
6. **Technology investments must demonstrate Return on Investment (ROI)**. Technology funding is available for investments that produce a demonstrable return. Applicants must articulate the expected return- whether through reduced costs, increased revenue, improved efficiency, or enhanced clinical capacity.

Rural Primary Care Focus Areas

How it Works:

Step 1. Select your primary Innovative Care Model.

Choose the innovative care model under **Focus Area 1** that best represents the primary focus of your proposed project.

FHC recognizes that many projects incorporate elements of multiple care models. However, applicants may submit **only one application** as the lead applicant and should select the single innovative care model that best aligns with the project's primary objective. **Exception:** Lead applicants may submit a second application **only** if the second application proposes an **Occupational Health HUB Model** described under the **Innovative Care Models** focus area on page 16.

Note: Lead applicants may also be partners in applications in which the organization is not the lead applicant, provided that there is no duplication of funding.

Step 2. When you complete your application, be sure to describe how your project incorporates and addresses all four focus areas.
Although your project will be organized around one innovative care model, your application must also explain how it incorporates and advances the remaining Rural Primary Care Focus Areas:

- Adoption of technology with a return on investment
- Transition to value-based care
- Financial sustainability

Applications should clearly describe how the proposed activities across all four focus areas work together to improve care delivery and support the long-term transformation and sustainability of rural primary care.

Long-Term Objectives:
Applicants are strongly encouraged to also describe their anticipated long-term approach for the remainder of the RHT Program (**October 1, 2027–September 30, 2031**).* This should include:

- Long-term project objectives
- Anticipated activities and key milestones
- Expected evolution or expansion of the project
- A high-level budget and anticipated use of funds

The long-term plan is intended to demonstrate how the proposed project will build on the initial implementation and support sustainable transformation beyond Budget Period 1. Applicants are not expected to provide the same level of operational detail for the later years as they do for Budget Period 1.

** Please note that funding beyond September 30, 2027 is contingent upon the availability of funding through GO-NORTH as well as each recipient's progress toward achieving established goals, milestones and performance metrics. See Appendix B for more details on budget periods.*

Rural Primary Care Focus Area Descriptions

Focus Area 1: Adoption of Innovative Care Models

Applicants should describe how they will adopt or expand team-based care, adopt or expand integrated care models that improve health outcomes, enhance patient experience, and increase access to rural populations. Proposals should demonstrate how these models represent a significant change from current practice - not a continuation or modest expansion of existing operations.

Innovative Care Models	Example Activities
Investments to develop and establish comprehensive team-based care including	Expansion and/or establishment of a team-based care model to maximize efficiency, improve health outcomes and enhance patient experience.

primary care prevention, chronic disease management, behavioral health, substance use prevention and treatment and oral health.	"Team-Based Care" is defined as a collective mix of professionals (primary care providers, behavioral health clinicians, care coordinators, social workers, community health workers, peer coaches, pharmacists, oral health, home health care professionals and specialists) who share the responsibility of delivering care and improving health outcomes for individuals in their shared patient panel populations, and / or individuals living within shared service catchment areas. Activities may include: • Embedding of community health workers into the team-based care model. • Enhanced wellness visits and utilization of the NH Medicaid Primary Care and Prevention Model of Care • Identification and rectification of gaps in preventive care or chronic disease management • Screening for health-related social needs (HRSN) • Lifestyle counseling and education including nutrition, physical activity and other lifestyle programs • Connecting patients to social services, community wellness programs and disease management programs • Assisting patients with transition of care, pre-visit planning, post hospitalization coordination and assistance with patient self-management of chronic disease. • Continuous patient monitoring • Specialized medication management and pharmacist integration • Communication and information sharing between care team, patients and specialists or ancillary services • Expanded MA, LNA, Pharmacist, CHW roles Note: Some services may be provided by practice-based personnel directly, or by partner organizations who coordinate with the primary care practice.
Virtual-first Primary Care Models	Collaborative projects that: • Expand access to primary care via telehealth by establishing the technology and creating the systems needed for patients to conduct visits with practice staff using video telehealth modality in lieu of or in addition to an in-person patient encounter. • After hours or weekend visits through telehealth and/or in person • Telehealth enabled access points
Expanded access to specialty care via telehealth	Collaborative projects that: • Expand access to specialty care via telehealth After hours or weekend visits: in person or telehealth visits

Pilot occupational health HUB model, bringing occupational health services into rural primary care settings to get residents back to work following injury, illness, or disability faster and safely.	One award will be awarded that pilots an occupational health hub and spoke model. Efforts can include: • Embed multidisciplinary occupational health team into the primary care practice • Workflows and systems to facilitate referrals from primary care providers to occupational health team members • Work to ensure prompt and accurate documentation of patient work capacity and to embed work planning into patient treatment plans. Lead applicants may submit **only one application** as the lead applicant. However, a lead applicant may submit a second application **if the second application proposes an Occupational Health HUB Model** described here.
Innovative models that support an individual accessing home and community-based services, aimed at delaying institutionalization (NF care)	Community Health Worker Programs: • Health coaching and chronic disease support • Care coordination • Health related social needs (HRSN) screening • Connecting Individuals to community resources • Home visits and follow-up after hospitalization Place-Based Care: • Community Paramedicine or MIH: o Post discharge follow-up o Medication reconciliation o Chronic disease monitoring o Fall risk assessments o Coordination with primary care • Home-based Primary Care: o Community-based nursing visits o Routine primary care visits including acute illness evaluation and treatment, preventive care, preventive screening o Chronic disease management o Remote patient monitoring o Telehealth visits o Medication management and reconciliation o Health related social needs screening o Care planning o Coordination with specialists • Hospital at Home o Nursing visits o Remote monitoring o Laboratory and imaging services o Pharmacy support o Physical therapy

Innovative Care Models Example Metrics

- Number of community health workers embedded in primary care;
- Increased team-based care utilization;
- New workflows established to support a virtual first primary care model;
- Reduced appointment wait times;
- Increased preventive care utilization;
- Increased telehealth utilization;
- Increased number of rural patients served;
- Reduced missed appointments;
- Increased patient panel capacity per care team.
- Decreased emergency department (ED) utilization
- Decreased re-admissions

Focus Area 2: Technology Adoption with a Return on Investment

Funding under this focus area supports technology investments that produce a demonstrable return on investment by modernizing care delivery and strengthening the operational and financial sustainability of healthcare organizations. Competitive projects will demonstrate how technology investments will improve patient care while reducing administrative burden, lowering costs, increasing clinical productivity and enhancing revenue cycle performance.

One-time technology purchases with no clear connection to operational or financial improvement are not competitive under this RFA. Applicants will need to outline at least one technology adoption below they plan to leverage in their application.

Technology Adoptions	Example Activities
Technology that supports enhanced clinical efficiency or productivity	• Technology that reduces administrative waste, streamlining processes (pre-authorization, referrals, etc.). • Real time or near real time claims management and denial tracking • Technology and AI enhancements that enable ambient listening into documentation, predictive modeling for risk, clinical decision support, evidence-based clinical reference tools, etc. • Robotics, technology-enabled clinical services • Technical training and assistance

Projects that enhance Revenue Cycle Management, billing and coding	• The capture of currently lost revenue for billable services in primary care for delivering evidence-based preventive health services and care coordination (Annual Wellness Visits, Chronic Care Management, Transitional Care Management, Behavioral-health Integration, and Collaborative of Care Models, etc.). • Technology that enables real time or near real time claims management and denial tracking; • Training and technical assistance
Technology to support shared services	• Interoperable EHRs • E-Consults: Allow primary care providers to message specialists securely for rapid treatment advice without an in-person referral (cardiology, dermatology, endocrinology, nephrology, etc.). • Shared video and chat tools that enable remote patient visits and multi-provider case reviews. • Shared care plans • Centralized billing systems • Aggregated analytics: Dashboards that track regional health trends, resource allocation, and preventive care gaps across a shared patient base.

Technology or EHR Enhancements that supports team-based care or enhanced care coordination (e.g. CLR)	• Integration of new EHR and tech innovations into the system of practice
	• Patient technology; remote patient monitoring
	• Training and technical assistance for staff
	• Population Health Infrastructure:
	  ○ Create shared patient registries for diabetes, hypertension, behavioral health and/or high-risk patients
	  ○ Develop shared dashboards that allow teams to monitor preventive care, quality measures, care gaps, hospital utilization, etc.
	  ○ Use predictive analytics to identify patients needing proactive outreach
	• Enhanced EHR functionality, integrated with the NH Care Connections Closed Loop Referral System (CLRS) or any other CLRS, to refer patients to community-based services.

Interoperability among providers participating in comprehensive team-based primary care	Technology that facilitates and/or improves:
	• EHR interoperability between providers, including real-time notifications for hospital admissions, discharges and transfers, ED visits
	• The secure, bidirectional exchange of:
	  o Screening results, treatment/care plans, medication lists, problem lists, allergies, HRSN and immunizations
	  o Laboratory, imaging and consulting reports
	• The implementation of shared care plans with the ability to update by multiple providers
	• Incorporates the adoption and utilization of a closed-loop referral system
	• Team based communication tools such as:
	  o Secure messaging across organizations
	  o Electronic referral management systems
	  o Electronic consultations
	  o Supports virtual multidisciplinary case conferences
	  o Shares tasks and follow up responsibilities electronically
	• Population Health Infrastructure:
	  o Create shared patient registries for diabetes, hypertension, behavioral health and/or high-risk patients
	  o Develop shared dashboards that allow teams to monitor preventive care, quality measures, care gaps, hospital utilization, etc.
	  o Use predictive analytics to identify patients needing proactive outreach

Enhancing administrative efficiency	Centralizing key services such as payer contracting, revenue cycle management, and related administrative functions
Technology Adoption with a Return on Investment Example Metrics • Closed loop referral system adopted • Technology investment plan developed • Technology adopted to support shared services, team-based communication. • Shared patient registry developed for patients with diabetes. • Reduced provider documentation time; • Reduced prior authorization turnaround times; • Reduced no-show rates; • Increased patient portal utilization; • Increased telehealth completion rates; • Reduced staff time spent on administrative tasks;	

- Increased automation of administrative workflows.

Focus Area 3- Transition to Value Based Care (VBC)

Proposals should include details on what VBC arrangements the organization currently participates in, and a readiness and transition plan to adopt VBC. RHT funds can be used to support that transition (e.g. population health data analytics, risk identification, tracking and interventions, chronic disease management / remote patient monitoring, etc.)

Transitions to Value Based Care	Example Activities

Projects that build the operational, financial and clinical infrastructure aimed at improving readiness for Value Based Payment (VBP) and/or Accountable Care Organization (ACO)	• Assessment of organizational clinical, financial, data and operational readiness to participate in VBP or ACO arrangements
	• Evaluation of opportunities to participate in Medicare and other ACO/VBP care models
	• Consulting, technology, staffing, and training to prepare for and support the transition to value-based care, including:
	  ○ Developing and implementing value-based contracting strategies;
	  ○ Redesigning clinical and operational workflows to support value-based care;
	  ○ Population health analytics;
	  ○ Improving performance on ACO and payer quality measures;
	  ○ Strengthening clinical documentation, cost accounting, and risk-adjustment practices;
	  ○ Building and strengthening care management infrastructure and capabilities;
	  ○ Facilitating participation in existing ACOs or a collaborative model.
	• Financial performance and shared-savings analysis
	• Procuring or leveraging technology and data analytics solutions to support predictive risk modeling and population health management
	• Implementation coaching and technical assistance for VPM and ACO transitions
	• Digital health infrastructure
	• Enhanced interoperability and data exchange with payers and other care partners
	• Capture, analysis and reporting of quality, utilization and cost measures

Shift to Value Based Care Example Metrics	

- VBP/ACO readiness assessment completed.
- Number of strategic partners engaged in VBP/ACO planning or implementation
- Completion of a shared VBP/ACO strategy or implementation plan
- Technology /data infrastructure implemented
- Number of cross-organizational workflows or care pathways developed
- Shared-savings methodology/dashboard developed
- Contracting/participation milestones achieved
- Number of shared quality, utilization and cost measures established across participating organizations.
- Increased participation in VBP arrangements;
- Increased percentage of revenue tied to alternative payment models;
- Increased attributed patient populations under value-based arrangements.

Focus Area 4 - Financial Sustainability

Funding under this focus area supports projects that strengthen the financial and operational performance of rural primary care practices. Proposed activities should reduce administrative burden, improve operational efficiency, strengthen long-term financial sustainability, and demonstrate a clear return on investment.

Financial Sustainability	Example Activities

Projects that implement operational improvements designed to reduce administrative burden, streamline practice operations, strengthen revenue cycle performance, and leverage shared infrastructure to improve efficiency and long-term sustainability.	• Implement technology that reduces administrative burden by streamlining processes such as prior authorization, referrals, scheduling, and other administrative workflows.
	• Enhance claims management through real-time or near real-time claims monitoring and denial tracking.
	• Improve revenue capture for billable primary care services, including evidence-based preventive services and care coordination.
	• Share infrastructure, services, or administrative functions among rural providers to improve efficiency and reduce costs.
	  o Centralized billing systems
	  o Care coordination and population health management
	  o Patient safety and quality improvements
	  o Share best practices that improve financial, operational and clinical performance
	• Provide workforce training to improve operational performance and adopt more efficient business practices.
	• Investments to reduce the long-term operating costs and, where applicable, a plan to sustain such investments
	• Support operational and payment model changes that advance the transition to VBC.

Financial Sustainability Example Metrics

Administrative Burden:

- Average time to complete prior authorizations or referrals
- Provider time spent on documentation after clinic hours ("pajama time")
- Reduction in administrative costs.

Operational Efficiency:

- Time from referral to completed appointment
- Number of patients seen per provider or care team

Revenue Cycle Management:

- Clean claims rate
- Claims denial rate
- Days in accounts receivable (A/R)
- Average reimbursement per visit

Financial Sustainability:

- Cost per patient visit
- Revenue generated from preventive services or care coordination
- Annual operating cost savings
- Return on investment for technology or process improvements
- Percentage increase in billable services captured

Shared Infrastructure:

- Cost savings from shared infrastructure
- Reduction in duplicated services
- Number of shared staffing or administrative functions implemented

Application Questions (Written Narrative Response)

The application portal will include the following prompts/questions for candidates to complete during submission. Use these as a guide when preparing your application.

1. Transformational Impact

Part 1: Project Rationale

Describe the need for your proposed project and how it will transform rural primary care. Your response should include: (Limited to 600 words)

- The challenge, opportunity, or gap the project is designed to address.
- What is new, different, or innovative about the proposed approach compared to current practice.
- The evidence-based practices, care models, or research that support your proposed approach.

Part 2: Rural Primary Care Focus Areas

Please outline how your proposal addresses and integrates each Rural Primary Care focus area using the below questions. See examples in Appendix A. (Limited to 1200 words)

- Describe the specific transformation the project will achieve and how activities in the focus areas will support it (care delivery, payment models, operational efficiency, workforce, population health, access to care, or technology infrastructure).
- Why is the change important for your organization and community?
- Describe how the adoption of new/updated technology will generate measurable value, operational improvement, financial sustainability, improved health outcomes, and/or readiness for future VBC participation.
- Long–term change: Describe the expected long-term organizational or system-level change that will result from this investment.

2. Project Plan & Milestones

Describe your project, your implementation approach, and your organization's capacity to successfully deliver it. (Limited to 2000 words).

Your response should include:

a. **Project Plan & Milestones**
   a. Major project activities
   b. Partners involved in project
   c. Key milestones and deliverables.
   d. Timeline for implementation
   e. Critical dependencies, risks and mitigation strategies
   f. How the project will maximize the impact of GO-NORTH funding

b. **Organizational Capacity**
   a. Relevant organizational experience implementing similar initiatives
   b. Existing staffing structure and governance
   c. How this project fits within your current strategic priorities and portfolio of work
   d. Project champion(s), including their role in securing organizational, community, and stakeholder support
   e. Key personnel responsible for implementation and their responsibilities
   f. Designated administrative lead who will serve as the primary point of contact with FHC

c. **Data & Reporting Capacity**
   a. Describe your ability to collect, manage, analyze, and report project data. Identify existing data your organization currently collects and reports that could be leveraged to develop and track program metrics.
   b. Describe systems, staff, and processes that will support required reporting and performance monitoring

d. Future Implementation:

Applicants are strongly encouraged to also describe their anticipated long-term approach for the remainder of the RHT Program (**October 2027–September 30, 2031**).* This should include:

   a. Long-term project objectives
   b. Anticipated activities and key milestones

c. Expected evolution or expansion of the project

** Please note that funding beyond September 30, 2027 is contingent upon the availability of funding through GO NORTH as well as each recipient's progress toward achieving established goals, milestones and performance metrics. See Appendix B for more details on budget periods.*

3. Projected Impact on Rural Communities

Describe how this project will improve health, access, sustainability, or wellbeing in rural communities. (Limited to 400 words).

Your response should include:

- Estimated number of individuals impacted.
- Expected impact on access to care, population health, workforce capacity, financial sustainability, care quality, or other rural health priorities.
- Expected short-term and long-term benefits.

4. Partnerships & Collaboration

Describe how this project will strengthen partner relationships, create and improve collaboration in rural communities, and how this collaboration will support successful implementation. (Limited to 500 words)

Your response should include:

- Organizations participating as partners in the project.
- Each partner's scope of work, including role and responsibilities.
- How partnerships support implementation, coordination, and sustainability.
- Description of regional collaboration, where applicable.
- Status of partnership commitments (e.g., discussions, letters of support, MOUs, operational agreements).
- How you will measure success of partnership(s)(e.g., number of partners engaged, formal agreements established, shared workflows developed, data sharing connections implemented, or partnership milestones completed).

5. Ambition of Measurable Outcomes

Describe the outcomes your project is expected to achieve and how you will measure success. (Limited to 800 words)

Your response should include:

- The key outcomes the project is expected to achieve.
- Why these outcomes are ambitious yet achievable based on your organization's readiness and the proposed scope of work.
- How the outcomes support the long-term transformation changes described in your project.
- Clear, specific performance metrics that will be used to monitor progress. Please ensure these metrics are tied to GO-NORTH Key Performance Metrics.

- The applicant must articulate specific dollar projections where cost savings are expected (e.g., current denial rate is 12%; target is 6%, recovering approximately $X in previously denied claims)
- Baseline data (where available) and project-period performance targets.
- The data sources and methods that will be used to collect and report performance data.
- How performance data will be tracked, reported and used to inform continuous improvement.

6. Sustainability & Long-Term Value

Describe how the project and the benefits of this investment will be sustained beyond the award period. (Limited to 500 words).

Your response should include:

- How project activities, services, infrastructure, or outcomes will continue after award funding ends.
- Ongoing operational requirements.
- Funding, reimbursement, revenue, or cost-savings strategies that will support continuation.
- Organizational commitments that support long-term success.
- Risks to sustainability and plans to mitigate those risks.

Include the rationale for why external funding will no longer be needed, and outline the operational, financial, and organizational strategies that will allow the initiative to sustain long-term. If continued funding is required to support ongoing transformation efforts, describe your plan for securing long-term sustainability through payer and/or funder engagement. Include evidence of payer participation, commitments from long-term funding partners, or other demonstrated support for continuation after the award period ends.

7. Budget Alignment

Explain how the requested funding supports the proposed project: (Limited to 400 words)

Your response should include:

- How requested funds directly support project activities.
- Why proposed costs are reasonable and cost-effective.
- How the budget supports both implementation and long-term sustainability.
- Resources or matching investments that will contribute to project success.

Note: If you plan to fund direct health care services, you must justify why those health care services are not already reimbursable, how the payment will fill a gap in care coverage, and/or how they transform the current care delivery model.

Additional Required Attachments

The following attachments will be required with your submission:

1. Workplan of Milestones and Timeline (Template will be provided)
2. Project Budget (Template will be provided)
3. Letters of Support or MOUs (as applicable)

a. Please include letters of support from key partner organizations indicating their role and responsibilities in the project

4. Documentation demonstrating the organizations payer mix (as applicable)

Allowable Use of Funds

All funded activities must be allowable, allocable, reasonable, and necessary in accordance with 2 CFR Part 200. Applicants are responsible for ensuring that all proposed costs meet these standards and for providing written justification for every budget line item. The following describes allowable uses of funds under this RFA.

General Allowable Cost Categories

- **Personnel Costs:** Salaries, wages, and fringe benefits for staff directly engaged in project implementation. Personnel must be clearly tied to specific project activities. Costs must be proportional to the time spent on award-funded work and supported by time-tracking records. Certain restrictions may apply - applicants will need to identify whether they plan to fund personnel time for payments to healthcare providers for the provision of clinical care not paid by insurers and/or other programs.
    - Funds may not be used for clinical salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations.
    - None of the funds shall be used to pay the direct salary of an individual at a rate in excess of Executive Level II determined by the Office of Personnel Management. Awardees may pay salaries at a rate higher than the Executive Level II if the amount beyond the salary cap is paid with non-FHC funds. Since the Executive Level II rate and HHS Appropriations Act citation changes each year, awardees should refer to the most recent information posted on the Office of Personnel Management. **Note:** The salary cap limitation only applies to using FHC GO-NORTH RHT funds to directly fund an individual's salary.
- **Clinical Supplies:** GO-NORTH funds the incremental clinical supplies needed to launch, expand, or redesign an RHT-supported service for a defined startup period including:
    - Supplies for start-up of service or expansion of service
    - Supplies to test a new model of care

  This includes items such as diagnostic test kits, wound care supplies, clinical consumables, PPE, and other medical expendables used in the course of award-funded services. Bulk or standing supply orders must be proportional to the scope and duration of the funded project.
- **Equipment Purchases:** Subject to CMS prior approval medical, clinical, or technological equipment necessary to carry out the proposed project. Equipment is means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost that equals or exceeds the lesser of the capitalization level established by the recipient or subrecipient for financial statement purposes, or $10,000. *See* 2 CFR §200.1. *See also* the definitions of capital assets, computing devices, general purpose equipment, information technology systems, special purpose equipment, and supplies in 2 CFR §200.1. See below for information that must be provided to FHC to obtain approval for Equipment purchases or reimbursement.

- **Outreach & Engagement**: Costs related to patient outreach, consent coordination, referral management, and care navigation activities that support access to proposed activities.
- **Health Information Technology:** Technology investments, software licensing, and IT infrastructure costs directly required to support program implementation or program delivery, including hardware required to run approved systems. Investments can include but are not limited to those that support interoperability, telehealth, AI documentation tools, population health platforms, and data systems. Projects proposing to replace a HITECH certified electronic health records require the prior approval of GO-NORTH.
- **Data Collection & Evaluation:** Costs associated with collecting, managing, and reporting program data, establishing baseline metrics, and fulfilling reporting obligations to FHC and GO-NORTH.
- **Quality Improvement:** Activities designed to improve program performance, clinical outcomes, or operational efficiency, including participation in quality improvement collaboratives and process redesign efforts.
- **Training & Continuing Education:** Training for existing staff that is directly related to the proposed project, including initial onboarding and follow-up training associated with implementation of an EHR system. Individuals receiving funding for education and training programs that provides a structured pathway to a new degree, certification, license, or clinical workforce career opportunity must commit to serving a designated rural community for a minimum of five years following the completion of the funded education or training. Out-of-state travel for professional development directly related to the project is allowable with justification; in-state meeting travel is allowable.
- **Consultants:** Contracted consultants providing specialized expertise in support of the project. All consultant procurement must comply with 2 CFR Part 200 procurement standards. Consultants may be procured from FHC's list of pre-approved professionals, which is still in development.
- **Partnership & Regional Collaboration:** Costs associated with building regional partnerships, coordinating care across organizations, and participating in shared service planning or communities of practice aligned with RHT priorities.
- **Sustainability Planning:** Activities focused on building long-term program sustainability, including engagement with health systems, payers, and funders to develop reimbursement models and ensure program continuity beyond the award period.
- **Indirect Costs:** Consistent with 2 CFR §200.332, FHC will apply one of the following to each subaward, with respect to indirect costs:
    - **Federally Negotiated Rate.** If the applicant has a current federally negotiated indirect cost rate, FHC will honor that rate and apply it to the base specified in the applicant's federally negotiated indirect cost rate agreement (NICRA). Applicants must submit a copy of the NICRA with their application.
    - **De Minimis Rate**. An applicant without a current federally negotiated rate may elect the de minimis indirect cost rate of 15% of modified total direct costs (MTDC) under 2 CFR §200.414(f). No documentation or justification of the rate is required, but the election must be stated in the application budget and applied consistently across all federal awards. MTDC is defined at 2 CFR §200.1 and excludes equipment, capital expenditures, rental costs, participant support costs, and the portion of each subaward exceeding $50,000.

    - **Negotiated rate**. FHC and the applicant may negotiate a rate specific to the subaward.
    - FHC's administrative and indirect costs, and the administrative and indirect costs of FHC's subrecipients and contractors, are capped under the federal award at 10% of FHC's total award. FHC reserves the right to cap an applicant's administrative and indirect costs.
- **Administrative costs:** Direct administrative costs are allowable, such as costs associated with managing, administering, overseeing, accounting for, reporting on, or complying with the RHT grant, rather than carrying out the substantive approved RHT activities within the scope of the grant contract with FHC. Examples include, but not limited to, evaluation and data reporting cost, financial reporting, budget monitoring, contract administration, grants management, and general legal services.
- **Other Operational Costs:** Other reasonable and necessary operational costs directly associated with project implementation not captured above. Applicants must provide a written justification for any cost listed under this category.
- **Health care services that ARE NOT ALREADY REIMBURSEABLE**. If you plan to fund direct health care services, you must justify why those health care services are not already reimbursable, how the payment will fill a gap in care coverage, and/or how they transform the current care delivery model. **See Appendix C for additional clarity**.

Equipment Purchases

Any proposed purchase of equipment, as defined in 2 CFR §200.1, requires prior written approval from CMS before the cost may be reimbursed by FHC. Prior approval is not needed to include equipment in your application. Applicants must identify all such equipment in their budget submission and provide the following for each item:

- ✓ Item description and intended purpose;
- ✓ Manufacturer and model number (or equivalent specification);
- ✓ Unit cost and quantity requested;
- ✓ Written justification explaining why the equipment is necessary to carry out the funded project;
- ✓ Confirmation that the item is not already available within the organization or accessible through a shared-use arrangement;
- ✓ Anticipated useful life of the equipment; and
- ✓ Proposed location and the organization responsible for maintaining the equipment.

Compliance Note: Equipment purchases not approved by **CMS** are not reimbursable. Retroactive approval requests will not be considered. List all potential equipment meeting the definition in 2 CFR §200.1 in your application, using the provided budget template.

Ineligible Use of Funds

The following activities are **ineligible** for this round of funding:

- Activities already funded by another source. All funds awarded by FHC to an applicant must supplement, not replace (supplant) funds. All applicants who receive awards under a GO-NORTH program, including FHC, must ensure that federal funds do not supplant

funds that have been budgeted for the same purpose through non-federal sources. Applicants or award recipients may be required to demonstrate and document that a reduction in non-federal resources occurred for reasons other than the receipt of expected receipt of federal funds

- Capital expenditures for new or expanded facilities (such applicants will be referred to the Community Development Finance Authority)
- Clinical services that duplicate billable services and/or attempt to change payment amounts of existing fee schedules
- Research projects (e.g. clinical trials, secondary data analysis, mixed methods research)
- Lobbying activities
- Workforce recruitment or retention activities that afford a direct cash benefit to an employee
- Organizations that participated in the design of this RFA (per 2 CFR §200.318(c), any entity that advised on or contributed to the development of this RFA's scoring criteria, eligibility requirements, or scope is prohibited from applying)

Applicant Supports

FHC is committed to ensuring all eligible organizations have access to the guidance, resources, and expertise needed to submit a competitive application- regardless of prior grant-writing experience. The following supports are available to all prospective applicants at no cost.

Technical Assistance

FHC program staff are available throughout the application to answer questions about program objectives, eligible activities, the application process, and how to align your proposed project with RHT priorities. Technical assistance is available by email, by appointment, and through group information sessions.

To request one-on-one technical assistance or ask a program question, contact: GO-NORTH-FHC@healthynh.org

Information Sessions

FHC will host one online information session for organizations interested in applying. This session will include an overview of eligible applicants, program objectives, the application process, funding components, and key dates. Attendance is strongly encouraged but not required. The information session will be recorded and posted on FHC website, along with this RFA.

Rural Primary Care RFA Information Session: September 2nd 9:00am – 10:30am Register HERE

Review Process

All completed applications will be reviewed and scored by a committee made up of Subject Matter Experts (SMEs), FHC staff and/or GO-NORTH representatives. Applications with the

highest scores will be selected to advance to GO-NORTH for approval. Following GO-NORTH approval, FHC will finalize the selections and notify all applicants of the funding decisions.

All applications will be assessed based on the following 5 objectives, consistent with GO NORTH's priorities and CMS strategic goals for RHT funding.

1. Transformational Impact (15 total points): Proposal drives structural transformation through the adoptions of new care models, moving to value-based payments, technology investments that produce a return on investment (e.g. more efficient operations, clinical productivity, etc.)

- Proposal clearly aligns with the goals of this RFA and is likely to lead to transformational change. (*15 pts*)

2. Strength of the Project Plan (20 total points): Strong workplan and milestones includes clear and creative approaches to maximizing the immediate impact of GO-NORTH RHT funds.

- Work plan is realistic, well sequenced, and achievable within the award period; timelines and staffing are clearly described; project demonstrates readiness to launch within the next six months. (*10 pts*)
- Proposal demonstrates capacity to execute project including relevant experience, adequate staffing, leadership, governance, financial management, and existing relationships within rural communities. (*10 pts*)

3. Achieve Meaningful Outcomes (10 total points): Outcomes to be achieved are ambitious, achievable, and well-supported. Outcomes directly related to the improvements and transformational changes included in the proposal – e.g. increased access, reduced costs or long-term operating expenses, etc.

- Proposal includes clear metrics such as the examples metric outlined in each focus area; applicant demonstrates capacity to collect, track, and report required data. (*10pts*)

4. Long-Term Impact (35 total points): Significant impact on rural communities' access or population health is meaningful. Proposal includes clear and strong explanations on how the proposal will directly impact rural residents, and how the scale of such rural impact is transformative.

- Proposal demonstrates strong benefits to rural populations and health systems, including improvements in health outcomes, access to care, population health, workforce capacity, and the financial sustainability of rural health systems. (*15 pts*)
- Proposal demonstrates either (i) strong, appropriate partnerships (e.g., hospitals, EMS, schools, community-based organizations, Community College System of New Hampshire/University System of New Hampshire, dental, behavioral health) or identifies necessary partners with a plan to convene and govern implementation; **or** (ii) partnership is unnecessary and applicant demonstrates that

the transformation is achievable within its own organization and that no partner with relevant capability is reasonably available in its service area. (*20 pts*)

5. Sustainability (20 total points): A detailed sustainability plan to sustain the investments and change beyond the term of the award.

- Sustainability plan path is well articulated and describes how the proposed transformation will be sustained beyond GO-NORTH grant funding. (*10 pts*)
- Budget is reasonable, cost effective, and aligned with allowable costs; expenses are clear and justified; budget includes plan for sustainability and corresponds with proposed activities. Organizations must demonstrate that proposed services cannot be reasonably funded through existing organizational resources, including internal revenue streams. The budget aligns with the number of partnerships and transformational change proposed. (*10 pts*)

FHC's goal is to ensure that funding is distributed across a diverse portfolio of primary care providers - independent and system-affiliated, large and small, across all regions of New Hampshire. FHC reserves the right to consider portfolio balance in final award decisions, including geographic distribution, organizational diversity, and project variety, in addition to application scores.

Awardee Expectations

If your organization is selected to receive funding, FHC staff will coordinate to finalize your budget, work plan, and award agreement.

The following items will be required for the contract:

- **Financial Disclosure:** If awarded this grant, I acknowledge that our organization will be required to submit financial disclosures, including an audit, an IRS Form 990, or an Income Statement and Balance Sheet from the organization's most recently completed fiscal year.
- **Executed Certificate of Vote/Authority:** If awarded this grant, I acknowledge that our organization will be required to submit a signed Executed Certificate of Vote/Authority. I understand that the certificate must (a) be signed and dated within 30 days of signing the grant agreement, and (b) be signed by an authorized individual other than the person signing the grant agreement.
- **Certificate of Insurance:** If awarded this grant, I acknowledge that our organization will be required to submit a current ACORD Certificate of Insurance with the Certificate Holder. Certificate Holder listed as:
  Foundation for Healthy Communities
  125 Airport Road
  Concord, NH 03301
- **Unique Entity Identifier (UEI) Number:** As issued by SAM.gov and used for federal contracts and grants.
- **Award Requirements:** If awarded for this grant, I acknowledge that FHC may include additional requirements in the grant contract relative to participation in regional

plannings and collaborations to support the success of the GO-NORTH initiatives. These may include, but not limited to:
    - Collaborating with healthcare, public health, behavioral health, and community partners.
    - Engaging with workforce development efforts involving Community College System of New Hampshire and University System of New Hampshire.
    - Participating in communities of practice related to development of sustainable models of care, including, but not limited to engagement with health systems, payers and other funders related to reimbursement models.
- **Evaluation Requirements:** I acknowledge that we must work with the GO-NORTH's evaluator the National Opinion Research Center (NORC), including but not limited to, refining its evaluation plan, making mid-course corrections/quality improvement, and ensuring reporting of data, lessons learned, and success stories.

Applicant certifies that that:
- (1) they are eligible to apply based on the eligibility criteria stated in the Program Guidelines
- (2) statements contained in this Application are true and complete to the best of their knowledge, and
- (3) they accept the terms of the Grant as documented in the Program Guidelines.

Reporting Requirements

Quarterly Reporting:
Awardees will remain in communication with FHC throughout the award period to provide updates on:
- Budget spending
- Progress on work plan
- Success and challenges

Applicants should be committed to transparency in operations and budgeting, ensuring accountability and efficient use of resources.

Annual Reporting:
At the end of each award year, awardees will submit detailed financial expenditures and outcomes.

Evaluation Reporting:
Awardees may be required to:
- Establish baseline data
- Set measurable targets
- Report on progress throughout the award period

Applicants will be expected to track and report on key metrics related to access to care, health outcomes, and program related activities both quantitatively and qualitatively.

Technical Assistance and Capacity Building

Additional support will be provided throughout the award period, including, but not limited to:

- Check-ins between awardee organization lead/program staff and the FHC award management team
- Information sharing with other awardee organizations receiving funding from FHC

Additional Evaluation Activities

In addition to routine reporting, awardees may be asked to participate in broader evaluation activities (e.g., surveys, interviews, learning sessions) to support shared learning and system improvements across the state.

Contact Information

Questions regarding the RFP and your application: GO-NORTH-FHC@healthynh.org

All questions must be submitted no later than 10 calendar days before the application submission deadline. FHC cannot guarantee a response to questions received after this deadline.

Website: healthynh.org

Resources

The Foundation for Healthy Communities (FHC)

FHC builds statewide connections among hospitals, healthcare organizations, and community partners to advance equitable health for all New Hampshire residents. FHC will manage this award program including distributing and overseeing awards, providing technical assistance, coordinating required reporting, and evaluating the program to ensure impact and accountability.

Appendix A:
Example Projects by Readiness Stage

Example Projects by Readiness Stage

The following examples illustrate what a competitive proposal might look like at different stages of organizational readiness. These are illustrative only - applicants are not limited to these approaches and should propose projects that reflect their own community needs, capacity, and stage of development.

Example 1: Project Development Stage- *A rural, stand-alone primary care office exploring team-based care* transformation

Organization: A rural, stand-alone primary care office serving approximately 8,000 patients in a rural county with limited access to behavioral health and specialty services. The organization currently operates a traditional physician-centric model with minimal care coordination infrastructure.

Proposed project: The office requests funding to design and pilot an integrated team-based care model. During the first funding cycle (through September 30, 2027), the organization would:

- Conduct a comprehensive needs assessment of the patient panel, identifying gaps in preventive care, chronic disease management, and behavioral health access.
- Convene local partners - including the regional community mental health center (CMHC), a community paramedicine program, and the local visiting nurse association - to design referral pathways and care coordination workflows.
- Pilot a team-based care model with one care team, embedding a behavioral health provider and a community health worker.
- Evaluate an EHR module upgrade to support population health tracking and health-related social needs screening, with a plan for full implementation in Cycle 2 if the pilot demonstrates value.
- Develop a sustainability plan that identifies how the team-based care model will be funded after the award period, including leveraging the NH Medicaid Primary Care and Prevention Model of Care.

How this proposal addresses the four focus areas:

Focus Area	How This Proposal Addresses It
1. Adoption of Innovative Care Models	Pilots a team-based care model with embedded behavioral health and CHW - a structural shift from the current physician-centric model. Includes early exploration of occupational health integration through the Work-Health Hub. Planning activities (needs assessment, partner convening, workflow design) lay the groundwork for full-scale adoption in Cycle 2.
2. Technology with Return on Investment	Conducts an EHR needs assessment to evaluate population health and HRSN screening modules. Technology investment is deferred until the pilot validates the care model, but the assessment identifies specific modules, expected costs, and projected return on investment (improved preventive care capture, reduced gaps in chronic disease management).

3. Transition to Value-Based Care	The sustainability plan identifies leveraging the NH Medicaid Primary Care and Prevention Model of Care as the pathway to VBC. The needs assessment establishes baseline quality and utilization data needed to pursue VBP arrangements. VBC readiness is in its earliest stage - this proposal builds the foundation, not the transition itself.
4. Financial Stability & Operational Efficiency	The pilot evaluates whether team-based care reduces ED utilization and readmissions (cost drivers). The sustainability plan maps how embedded behavioral health and CHW roles will be funded post-award. The needs assessment identifies current operational inefficiencies and revenue gaps. Planning-stage financial analysis is appropriate- full financial modeling is expected in Cycle 2.

Why this fits Project Development: The organization is not yet ready for full-scale implementation. It needs to assess its current state, build partnerships, pilot the model on a small scale, and develop a credible roadmap before committing to a larger transformation. The budget is modest - consultant support, part-time CHW salary, EHR needs assessment, and convening costs.

Example 2: Preparatory Investments Stage- *A rural primary care practice investing in technology and revenue cycle infrastructure*

Organization: A multi-provider rural primary care practice affiliated with a Critical Access Hospital, serving approximately 12,000 patients. The practice has an existing EHR but struggles with administrative inefficiency, high denial rates, and limited interoperability with the hospital and behavioral health partners.

Proposed project: The practice requests funding for a bounded technology and workflow investment designed to remove specific operational barriers. During the first funding cycle, the organization would:

- Upgrade its EHR to add population health, care coordination, and claims management modules.
- Implement real-time claims tracking and denial management software, with staff training.
- Establish bidirectional EHR interoperability with the affiliated CAH, including Admission, Discharge, and Transfer (ADT) notifications and shared care plans.
- Integrate Care Connections including the Unite Us CLRS for closed-loop social needs referrals.
- Build a shared patient registry for diabetes and hypertension to support proactive outreach
- Capture currently unbilled revenue for preventive services and care coordination visits

How this proposal addresses the four focus areas: investment - reduced denial rates, increased captured revenue for preventive services, reduced staff hours on administrative tasks

Focus Area	How This Proposal Addresses It

1. Adoption of Innovative Care Models	E-consult capabilities represent a new care delivery model - secure specialist messaging replaces in-person referrals, reducing wait times and expanding access. Shared care plans and ADT notifications enable a coordinated care model across the practice and CAH that doesn't currently exist. CLRS integration creates a closed-loop referral model connecting patients to social services.
2. Technology with Return on Investment	This is the core of the proposal. EHR upgrade with claims management modules, real-time denial tracking, and revenue cycle improvements produce a direct, measurable return on Current denial rate is 12%; target is 6%, recovering approximately $X in previously denied claims.
3. Transition to Value-Based Care	Shared patient registries for diabetes and hypertension, population health tracking, and quality measure dashboards build the data infrastructure needed for VBP participation. The interoperability improvements with the CAH support the care coordination metrics that VBP arrangements require. This proposal doesn't transition to VBP directly but builds the operational readiness to do so in Cycle 2.
4. Financial Stability & Operational Efficiency	Direct financial impact: capturing currently unbilled preventive services and care coordination revenue, reducing denial rates, and streamlining prior authorization and referral workflows. Shared infrastructure with the CAH reduces duplicated administrative costs. The technology investment is self-sustaining - once deployed, the ongoing maintenance costs are offset by increased revenue capture and reduced administrative labor.

Why this fits Preparatory Investments: The organization has a clear, specific barrier - outdated technology and administrative inefficiency - and a defined investment to address it. The project is bounded, one-time, and tied to a demonstrable return on investment (reduced denial rates, increased captured revenue, reduced administrative hours per encounter). The practice has the staffing and operational capacity to deploy the technology but needs the capital investment to do so. Sustainability is built in: the technology reduces ongoing operating costs and increases revenue capture, making the investment self-sustaining after the award period.

Example 3: Program Ready Stage- *A regional primary care network implementing a full transformation to value-based care*

Organization: A network of three rural primary care practices and one CAH serving approximately 25,000 patients across a two-county region. The practices already operate a basic team-based care model with embedded behavioral health and have participated in a shared savings program for two years. They are ready to scale but lack the infrastructure to fully transition to VBP.

Proposed project: The network requests funding to complete its transformation to a fully integrated, VBC delivery system. Across both funding timeframes, the organization would:

- **Budget Period 1 (through September 30, 2027):**

    - Expand the team-based care model across all three practices, adding clinical pharmacists, community health workers, and peer support specialists to each care team.
    - Implement a shared analytics platform for population health management, predictive risk modeling, and quality measure tracking across the network.
    - Establish e-consult capabilities with cardiology, endocrinology, and behavioral health specialists via telehealth.
    - Launch a community paramedicine program for post-discharge follow-up and chronic disease monitoring in partnership with a CAH's EMS unit.
    - Embed a Work Health Spoke Team in partnership with the State Rural Work-Health Hub.
- **Budget Period 2–5 (October 1, 2027 – September 30, 2031):**
    - Transition to full capitation or shared downside risk with at least one payer.
    - Scale the analytics platform to support ACO readiness and alternative payment model participation.
    - Achieve measurable reductions in total cost of care, ED utilization, and readmissions across the network.
    - Sustain team-based care staffing through VBP revenue and shared savings rather than award funding

How this proposal addresses the four focus areas:

Focus Area	How This Proposal Addresses It
1. Adoption of Innovative Care Models	Full-scale team-based care with embedded clinical pharmacists, CHWs, peer support specialists, and a Work Health Spoke Team - operational across all three practices. Community paramedicine for post-discharge follow-up. E-consults for specialty access. This is a mature, operational care model transformation, not a pilot - the organization has already proven the model on a smaller scale and is now scaling it.
2. Technology with Return on Investment	Shared analytics platform for population health, predictive risk modeling, and quality tracking across the network - directly enabling VBP participation and shared savings capture. Centralized revenue cycle management on a shared platform reduces duplicated administrative costs across three practices. The return on investment is concrete: reduced total cost of care, increased shared savings, and reduced per-encounter administrative cost.
3. Transition to Value-Based Care	This is the heart of the proposal. The organization moves from shared savings (upside-only) to full capitation or shared downside risk with at least one payer. The analytics platform, quality measure tracking, and population health infrastructure are all built specifically to support this transition. By the end of Cycle 2,

	the network expects a measurable percentage of revenue tied to alternative payment models.
4. Financial Stability & Operational Efficiency	Centralized revenue cycle management eliminates duplicated billing infrastructure across three practices. VBP revenue and shared savings replace award funding as the financial engine for team-based care staffing. Reduced ED utilization and readmissions lower the total cost of care. The sustainability plan is concrete — by Cycle 3, the network operates on VBP revenue, not award funding. The applicant should project specific financial metrics: target shared savings, reduced cost per encounter, and percentage of revenue from alternative payment models.

Why this fits Program Ready: The organization has completed its planning, has committed partnerships (signed agreements with the CAH, CMHC, and EMS), and already has operational experience with team-based care and shared savings. The proposal describes a specific, mature transformation ready to execute - not a planning exercise. The metrics are tied directly to GO-NORTH KPIs, the budget reflects full operational costs, and the sustainability plan is concrete (VBP revenue, shared savings, and reduced total cost of care).

Appendix B:
Understanding Budget Periods

Understanding Budget Periods

GO-NORTH funding is appropriated by the federal government from Federal Fiscal Year (FFY) 2026 through FFY 2030, organized into five sequential Budget Periods. Understanding how Budget Periods relate to Federal Fiscal Years will help you plan your project timeline and spending schedule.

How it Works

Each Budget Period begins when funding is distributed and extends through the end of the following Federal Fiscal Year - giving recipients a period of time to spend awarded funds before the close of each period depending on award.

Budget Period	Funding Distributed Targets	Spending Deadline
Budget Period 1 (BP1)	March 16, 2026	September 30, 2027
Budget Period 2 (BP2)	October 1, 2027	September 30, 2028
Budget Period 3 (BP3)	October 1, 2028	September 30, 2029
Budget Period 4 (BP4)	October 1, 2029	September 30, 2030
Budget Period 5 (BP5)	October 1, 2030	September 30, 2031

What this Means for your Project

Awards made under BP1 will be funded with a spending deadline of **September 30, 2027**. All project activities, expenditures, and deliverables must be completed and documented by that date. As the GO-NORTH program ramps up, our goal is to award the funding earlier to allow more time awardees to use the funds.

FHC will monitor spending against Budget Period timelines and may work with awardees to adjust project scope or redistribute funds if expenditure targets are not being met. GO-NORTH retains the right to recoup unexpended funds at the close of each Budget Period. Funds that are not spent by the end of a budget period are not available to be redistributed in future budget periods.

Planning Guidance

When developing your project budget and work plan, we strongly encourage you to:

- → Map all planned expenditures to the BP1 spending window (through September 30, 2027)
- → Avoid back-loading your budget - plan for meaningful spend in the first six months of your award
- → Build in time for procurement, onboarding, and contracting activities before your project spending ramps up
- → Identify any expenditures that may require pre-approval (e.g., equipment ≥ $10,000) and factor in the required approval lead time

If your project spans beyond Budget Period 1, we want to see the multi-year estimates where appropriate. Multi-period projects will require updated work plans and budgets at the start of each subsequent Budget Period, pending additional funding authorization.

Retroactive Reimbursement of Pre-Award Costs

Subrecipient award agreements executed by FHC may include a provision allowing retroactive reimbursement of eligible costs incurred on or after March 16, 2026, but prior to the date the subaward agreement is fully executed. This means that if FHC executes an award agreement with a subrecipient on, for example, August 15, 2026, the agreement may include a provision to reimburse the subrecipient for permissible costs incurred between March 16, 2026 and August 15, 2026 - provided all conditions below are met.

Conditions for Retroactive Reimbursement

To be eligible for retroactive reimbursement, all four of the following conditions must be satisfied:

Timing: The cost was incurred on or after March 16, 2026. Costs incurred before this date are not eligible under any circumstances.

Scope: The cost is directly related to a project within the scope of FHC's contract with GO-NORTH and the funding component under which the applicant is applying. Costs unrelated to the proposed initiative are not eligible.

No Supplanting: The reimbursement supplements, and does not replace (supplant), non-federal funds or other federal funding. Per the State of New Hampshire's Notice of Award: "Federal award funds must supplement, not replace (supplant) non-federal funds. All recipients who receive awards under programs must ensure that federal funds do not supplant funds that have been budgeted for the same purpose through non-federal sources. Applicants or award recipients may be required to demonstrate and document that a reduction in non-federal resources occurred for reasons other than the receipt or expected receipt of federal funds."

Allowability: The cost meets all applicable requirements under 2 CFR Part 200, including but not limited to cost principles (§200.400–§200.476), allowability (§200.403), and equipment pre-approval requirements. Costs that would have required FHC's prior written approval before being incurred- such as equipment purchases of $10,000 or more- must still meet all pre-approval requirements and will be evaluated for allowability at the time of award.

Certification Requirement

As a condition of retroactive reimbursement, the subrecipient must provide FHC with a written certification that all four conditions above are met, along with supporting documentation (e.g., invoices, purchase orders, bank records, payroll records) evidencing each cost for which retroactive reimbursement is requested. FHC reserves the right to request additional documentation as needed to verify allowability and compliance. This will be completed if the applicant is selected.

Important Notes

- No guarantee of funding: Incurring costs prior to execution of a subaward agreement is done at the applicant's sole risk. FHC's willingness to consider retroactive reimbursement does not constitute a guarantee that any application will be funded or that any specific cost will be determined to be allowable. Applicants who incur pre-award costs should be prepared to absorb those costs if they are not selected for funding or if the costs are determined to be unallowable.
- Equipment purchases: Equipment purchased prior to execution of a subaward agreement will be evaluated for allowability at the time of award. FHC will apply the same equipment pre-approval standards retroactively. If the equipment meets all allowability requirements, federal property tracking will commence from the actual acquisition date - not the agreement execution date.
- Retroactive period limit: Retroactive reimbursement is limited to costs incurred between March 16, 2026 and the date the subaward agreement is fully executed. No costs incurred outside this window are eligible for retroactive coverage.

Appendix C:

Funding Direct Health Care Services (Provider Payments)

Funding Direct Health Care Services (Provider Payments)

Funds may support the provision of health care items or services that are not paid for by insurers or other programs. If your proposed project includes funding for direct health care services, your application must address all the following:

1. Non-Reimbursable Justification. Explain why the proposed services are not currently reimbursable through Medicare, Medicaid, private insurance, or other existing payment programs. Identify the specific payer gap - whether the service is not covered under existing fee schedules, is provided to uninsured or underinsured populations, or represents a new service model for which no reimbursement pathway currently exists.

2. Care Gap or Coverage Deficit. Describe how funding will fill a gap in care coverage. This may include serving populations without access to the service, providing services in geographic areas where the service is not available, addressing uncompensated care, or delivering services not covered by insurance.

3. Care Delivery Transformation. Explain how the funded services transform the current care delivery model rather than duplicating or expanding existing reimbursable services. Funding that would duplicate billable services under existing fee schedules, or that would supplant existing funding sources, is not allowable.

Additional Requirements for Direct Clinical Services:

1. **GO-NORTH Pre-Approval.** Clinical services funded for provider payments are evaluated by GO-NORTH on a case-by-case basis. There is no pre-approved list of eligible clinical service lines. Applicants should identify all proposed clinical services and associated personnel costs in the application for review. FHC will submit clinical service components to GO-NORTH as part of the award recommendation process.
2. **Mixed Billable/Non-Billable Personnel Costs.** If personnel will deliver a mix of reimbursable and non-reimbursable services, the applicant must describe a tracking mechanism that identifies the percentage of personnel time that is reimbursable through insurance or other payers, the percentage that is non-reimbursable and therefore eligible for funding, and the percentage attributable to administrative/implementation activities. Only the non-reimbursable portion of personnel costs are eligible for funding. Reimbursable portions must be offset against the award or reconciled post-award.
3. **Equipment vs. Clinical Service Costs.** Equipment that enables reimbursable services (e.g., cardiac monitors, transport ventilators) is evaluated under the equipment provisions of this RFA, not as a clinical service under provider payments. However, replacement of existing equipment for an already reimbursable service may be subject to supplanting restrictions. New equipment that enables a new or expanded non-reimbursable service line (e.g., MIH remote monitoring devices) is allowable as a technology or equipment investment.