MISSISSIPPI
RURAL HEALTH TRANSFORMATION

MISSISSIPPI

Rural Health Transformation Program

PROGRAM MANUAL

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FEDERAL FUNDING ACKNOWLEDGEMENT

This project 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 $205,990,180.16, with 99.96% funded by CMS/HHS ($205,907,220.16) and 0.04% funded by non-government sources ($82,960). 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.

SECTION I: PROGRAM BACKGROUND

1. Introduction

This document provides an overview of the Mississippi Rural Health Transformation Program (RHTP), offering a concise summary of the program for informational purposes. It is intended to serve as a simplified user guide to facilitate a clearer understanding of the RHTP lifecycle for agencies, participants, and the general public.

The information presented herein outlines key components of the project, including its background, transformation plan, stakeholder structure and governance, goals and objectives, program initiatives, funding management, and communication activities throughout the duration of the project lifecycle.

The RHTP represents a significant and historic initiative supported by the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS). This effort is funded through a $50 billion federal investment to address healthcare concerns in rural communities across the nation for future generations.

The State of Mississippi was awarded $205,907,220 by CMS and HHS, with an additional 0.04% funded by non-government sources of $82,960, totaling $205,990,180 in first year of funding with a strategic focus on addressing key challenges such as emergency medical services coordination, outdated technology infrastructure, and healthcare workforce shortages. The Mississippi RHTP is built on a coordinated, systems-based approach to rural healthcare transformation, leveraging investments in infrastructure, technology, care coordination, telehealth, and workforce development.

This Program Manual is intended as general program guidance. In the event of any inconsistency, applicable federal law and regulations, the Notice of Award, award specific terms and conditions, the CMS approved Mississippi Rural Health Transformation Plan and subsequently issued CMS guidance shall control.

2. National Rural Health Context

Rural Healthcare Challenges & Federal Response

Providers, community leaders, patients, and state agencies have consistently identified common challenges across rural communities, including limited access to primary and specialty care, persistent workforce shortages, and barriers related to behavioral health, technology, and

transportation. These issues are further compounded by the prevalence of chronic disease, ongoing maternal and child health concerns, and sustained financial pressures on rural providers.

In response, the development of the RHTP was informed by extensive national-level stakeholder engagement, which reinforced the need for coordinated, system-wide solutions to address these persistent gaps in care.

Under the direction of CMS, the program is guided by several core strategic goals: improving the overall health of rural populations, enhancing sustainable access to healthcare services, strengthening and retaining a highly skilled workforce, fostering innovative models of care, and advancing the adoption of emerging technologies across rural communities.

3. Rural Health Transformation Program Overview

3.1 Program Purpose

The RHTP was established to empower states to strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem. Through innovative system-wide change, the RHTP invests in the rural healthcare delivery ecosystem for future generations.

3.2 Legislative Authority & Funding Structure

Authorized under the One Big Beautiful Bill Act (Section 71401 of Public Law 119-21), the allocation of $50 billion will be provided to states over a five-year period, beginning in Fiscal Year 2026 and concluding in Fiscal Year 2030. Of this total funding, 50 percent will be distributed evenly among all approved states, while the remaining 50 percent will be allocated by CMS based on factors such as rural population, the proportion of rural healthcare facilities, and the condition of certain hospitals, as well as other criteria outlined in the applicable Notice of Funding Opportunity (NOFO), dated September 15, 2025.

3.3 CMS Strategic Goals

CMS has established five Strategic Goals for the RHTP to meet:

- **Goal 1: Make Rural America Healthy Again**
  Supporting innovative approaches and expanded access points to improve preventive health and address the root causes of disease and using evidence-based interventions to enhance prevention, chronic disease management, behavioral health, and prenatal care outcomes.

- **Goal 2: Sustainable Access**
  Supporting the long-term sustainability of rural providers by enhancing efficiency and enabling coordinated care delivery across facilities, regional systems, and service areas.

- **Goal 3: Workforce Development**
  Supporting the recruitment and retention of a highly skilled rural healthcare workforce by expanding workforce capacity, enabling providers to practice at the top of their license, and developing a broader range of care roles to better meet community needs.

- **Goal 4: Innovative Care**
  Supporting the advancement of innovative care models and payment structures that

improve health outcomes, enhance care coordination, and reduce costs by shifting services to more efficient, lower-cost settings.

- **Goal 5: Technology Innovation**
  Promoting the adoption of innovative technologies to enhance care delivery, expanding access to digital and remote services, improving data sharing, and strengthening cybersecurity across rural healthcare systems.

Section II: Mississippi Rural Health Transformation Program Plan

4. Mississippi Rural Health Landscape

4.1 Demographic Overview

Rural communities in Mississippi face significant challenges in healthcare access, workforce capacity, and system sustainability. As of 2025, seven counties do not have a hospital, and more than half of Mississippi's 82 counties are maternity care deserts, limiting access to essential maternal and primary care services. Geographic barriers further complicate access, with about 24% of women in Mississippi living more than 30 minutes from a birthing hospital, and many residents traveling 50 to 75 miles for care. Nearly all rural counties in Mississippi are designated as Health Professional Shortage Areas by the Health Resources and Services Administration, with some exceeding 2,000 residents per primary care physician, reflecting severe provider shortages across medical, nursing, and behavioral health fields.

Behavioral health and maternal care gaps remain critical, with high rates of untreated mental illness, substance use disorder, and one of the nation's highest maternal mortality rates. At the same time, rural hospitals face ongoing financial strain due to low patient volumes and high uncompensated care, increasing the risk of service reductions or closures.

Social and economic challenges, including high levels of poverty and food insecurity, further contribute to poor health outcomes and chronic disease prevalence. Overall, Mississippi faces more than $1 billion in unmet rural healthcare needs. Despite these challenges, the state's strong community networks and rural landscape create an opportunity to implement targeted, scalable solutions that expand access, strengthen the workforce, and improve health outcomes.

4.2 Healthcare Infrastructure

Mississippi's rural healthcare system relies on a network of acute care hospitals, Critical Access Hospitals, Federally Qualified Health Centers (FQHCs), Rural Health Clinics, Emergency Medical Services (EMS) providers, and behavioral health service providers; however, this infrastructure remains unevenly distributed and financially fragile. While these providers form the backbone of rural care, significant gaps persist in access and long-term sustainability.

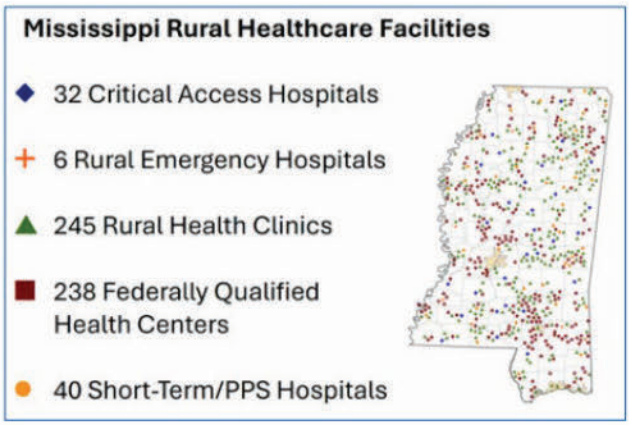
Rural hospitals, including 32 Critical Access Hospitals and 6 Rural Emergency Hospitals, are essential to care delivery but are not consistently accessible. FQHCs and Rural Health Clinics help fill these gaps by providing primary and preventive care, often serving as the first point of contact for rural populations, though they face ongoing workforce and funding constraints.

EMS systems play a vital role, particularly where hospital access is limited. Through the Coordinated Regional Integrated Systems (CRIS) Initiative, Mississippi is strengthening EMS by creating regional networks that facilitate coordination, create streamlined and consistent protocols, and enhance data sharing. Programs like the EMS Treat In Place model further expand access by allowing providers to deliver care on-site, reducing unnecessary hospital use and improving patient outcomes.

Despite these efforts, financial instability remains a major concern. Many rural hospitals operate under significant strain, with high rates of uncompensated care and reliance on Disproportionate Share Hospital (DSH) funding and other supplemental payment programs placing more than half at risk of closure. Low patient volumes and high reliance on emergency departments for non-urgent care further challenge sustainability.

Behavioral health services remain limited across rural communities, with significant gaps in access to mental health and substance use disorder treatment. Expanding integration with primary care and leveraging telehealth are critical to closing these gaps.

In response, the MS RHTP Initiative provides a coordinated, data-driven approach to improving care delivery by aligning providers, enhancing system efficiency, and strengthening long-term sustainability across Mississippi's rural healthcare system.



4.3 Identified Needs

Rural communities in Mississippi face ongoing barriers to timely, high-quality care due to workforce shortages, geographic isolation, limited infrastructure, and fragmented care coordination. Provider shortages across clinical and behavioral health fields strain access, while recruitment and retention remain challenging in rural areas.

Residents often travel long distances, sometimes up to 75 miles, for care, contributing to delays and increased reliance on emergency services. Technology gaps, including outdated systems and limited interoperability, further hinder care delivery and coordination.

5. Development of Mississippi's RHTP Plan

5.1 Planning Process

Mississippi's Rural Health Transformation Program Plan was developed through a collaborative effort led by the Governor's Office in partnership with the State Department of Health, Mississippi Division of Medicaid, and the Mississippi Department of Mental Health. The State prioritized stakeholder engagement to ensure the plan reflects the needs of rural communities.

Input was gathered through a statewide public survey launched in July 2025, which received 145 responses from stakeholders across nearly half of Mississippi's counties, including providers, public

health professionals, community members, and policymakers. These insights were further refined during a statewide stakeholder forum in August 2025, where representatives from healthcare systems, government agencies, and community organizations provided additional input.

Program governance will be led by the Governor's Office, with support and initiative administration provided by subject matter experts from the from the State Department of Health, Department of Mental Health, Department of Education, Accelerate Mississippi, Mississippi Emergency Management Agency, and the Division of Medicaid. The Governor's Office has engaged a third-party entity to provide program implementation, monitoring and compliance services for the RHTP to enhance program integrity. The third-party entity will provide monitoring and compliance services while maintaining an independent role by serving as an objective reviewer and programmatic administrative resource rather than a decision-maker or program beneficiary. In this capacity, the third-party entity will assess documentation, review financial and programmatic reports, conduct risk-based monitoring, and identify potential compliance concerns using established federal, state, and program-specific requirements and will report findings directly to the Governor's Office for review and action. This coordinated approach promotes accountability, responsiveness, and sustained engagement. The State will maintain appropriate separation between personnel providing implementation or applicant assistance and personnel conducting monitoring, compliance reviews, or evaluations of the same activities. The third-party administrator will not make final funding decisions or review work for which it has a direct financial or organizational conflict of interest.

Together, these efforts ensure that Mississippi's rural health transformation remains aligned with local needs and focused on improving access, system performance, and health outcomes.

5.2 Needs Assessment

Mississippi's RHTP efforts are guided by a data-driven approach that combines analysis of health, workforce, and infrastructure data with extensive stakeholder input. The State has identified key disparities in access, workforce distribution, and service availability.

Stakeholder feedback from providers, community leaders, and state agencies consistently highlighted common challenges, including limited access to care, workforce shortages, chronic disease, maternal health concerns, and financial strain on rural providers. These findings aligned closely with data analysis, reinforcing priority needs.

These insights have shaped the State's priorities, which focus on expanding access to essential services, strengthening the workforce, improving care coordination, and modernizing infrastructure to support long-term sustainability.

Section III: Stakeholders and Governance

6. Program Stakeholders

6.1 State Agencies

The Mississippi Rural Health Transformation Program Office, within the Office of the Governor, will oversee the RHTP and will execute grant awards for implementation and administration of the Program's initiatives to the State Department of Health, Department of Mental Health, Department of Education, Accelerate Mississippi, Mississippi Emergency Management Agency, and the Division

of Medicaid. These agencies will be the primary subrecipients of RHTP funds. The agencies will then distribute funds to eligible subgrantees based on the merit of their grant applications.

The Governor's Office will work alongside these state agencies to facilitate the compliant management of various grant programs under the Mississippi RHTP. These agencies will be responsible for vetting and awarding funds to eligible applicants in compliance with program guidelines and applicable state and federal regulations.

6.2 Healthcare Delivery Partners

Mississippi-based eligible providers include the following: Mississippi-based hospitals, physician practices (including solo practitioners), rural health clinics, federally qualified health centers, local health departments, Native American Sovereign Tribe healthcare facilities, certified community behavioral health clinics, substance use disorder facilities, dental care services, and licensed long-term care facilities located in rural areas or servicing rural populations.

Mississippi classifies "rural" as counties with fewer than 50,000 residents, fewer than 500 people per square mile, or municipalities with populations under 15,000. Consistent with Centers for Medicare and Medicaid Services (CMS) guidance, organizations do not need to be physically located in a rural area to be eligible for participation in this initiative. Applicants must demonstrate how proposed activities will provide meaningful, long-lasting benefits to rural communities and rural residents in Mississippi.

6.3 Community Partners

The Mississippi RHTP will collaborate with a broad network of community partners to strengthen local capacity and improve health outcomes across rural communities. Key partners will include community-based organizations, faith-based organizations, educational institutions, and workforce development entities, all of which play an important role in expanding outreach, building trust, supporting workforce pipelines, and connecting residents to needed services.

Through these partnerships, the program will promote strategies that address local needs, enhance access to care, and support sustainable health system transformation throughout Mississippi's rural areas.

6.4 Federal Partnership

The Mississippi RHTP operates under a cooperative agreement with the Centers for Medicare & Medicaid Services (CMS). This partnership provides Mississippi with the flexibility to design and implement solutions tailored to the unique needs of its rural communities while maintaining alignment with federal program requirements, approved objectives, and performance expectations. CMS is heavily involved in Mississippi's execution of the RHTP initiatives. The state is strictly bound by CMS oversight and governance standards, which requires CMS approval of public-facing materials.

As a cooperative agreement, program implementation is guided by ongoing coordination between the State and CMS. Mississippi is responsible for program administration, stakeholder engagement, funding decisions, and day-to-day operations, while CMS provides oversight, technical assistance, and approval of key programmatic and financial actions as required. This collaborative approach promotes accountability, transparency, and continuous improvement while ensuring that program investments advance the goals outlined in the State's approved Rural Health Transformation Plan.

This partnership with CMS requires following the federal grant regulatory requirements, HHS-specific policies, and program-specific guidance. The key applicable requirements include:

- 2 CFR 200 (Uniform Guidance) – States are responsible for carrying out their rural health plans in alignment with program-specific and federal guidance.
- 2 CFR 300 – Supplement to 2 CFR 200 HHS-specific requirement.
- 2 CFR 170 – This covers the *Federal Funding Accountability and Transparency Act* (FFATA).
- 2 CFR 180 – This relates to suspension and debarment.
- HHS Grants Policy Statement – This provides guidance on how the HHS applies federal grant requirements in practice.
- CMS RHTP Program Guidance and Award-Specific Terms – This establishes program-specific requirements.
- CMS RHTP Frequently Asked Questions, and applicable state statutes and regulations.

7. Program Governance Structure

The Mississippi RHTP will operate under a formal governance structure designed to ensure strong state oversight, stakeholder engagement, regional coordination, accountability, and effective decision-making. This structure will support the State's ability to administer the program in alignment with CMS expectations, advance rural health priorities, and promote consistent implementation across participating communities and provider partners.

State Oversight: The State, through the Rural Health Transformation Program Office within the Office of the Governor, will maintain primary responsibility for overall program oversight, administration, fiscal management, compliance, and strategic alignment with federal and state objectives.

Subaward Administration and Program Implementation: To support efficient program delivery and leverage existing state expertise, the State will issue subawards to participating state agencies through Memoranda of Understanding (MOUs). State agency partners will be responsible for administering assigned program components, including managing grant application processes, conducting competitive procurements, selecting awardees in accordance with applicable federal and state requirements, and overseeing implementation activities. The State's third-party administrator will provide administrative, operational, and technical support to state agencies in the development and execution of these processes to promote consistency, compliance, and effective program implementation. All activities will be conducted in alignment with the approved RHTP, CMS requirements, and applicable federal and state regulations.

Training and Technical Assistance: The State's third-party administrator, in coordination with participating state agencies, will provide training, technical assistance, and ongoing support to applicants, subrecipients, contractors, and other participating organizations. Training and support activities will address program requirements, application and procurement processes, allowable uses of funds, performance expectations, reporting obligations, compliance responsibilities, and other topics necessary to support successful implementation and stewardship of public funds.

Ongoing technical assistance will be available throughout the program lifecycle to help subrecipients meet program objectives and reporting requirements.

Reporting Structure: A clearly defined reporting structure will promote transparency and accountability by establishing regular channels for monitoring performance, financial activity, operational progress, and outcomes.

As required as the pass-through entity under the RHTP, the State will monitor each subrecipient's performance to support compliance with federal requirements and award terms, including, but not limited to, thorough review of financial and programmatic reports and performance measures. These subrecipient monitoring requirements will be conducted in accordance with 2 CFR 200, Subpart D.

Subrecipients shall provide all applicable reports in the format specified in an accurate, complete, and timely manner and shall maintain appropriate supporting documentation. Failure to meet submission deadlines for required reports or other requested information may result in the State, in its sole discretion, placing the subrecipient on financial hold without first requiring a corrective action plan, in addition to pursuing any other corrective or remedial actions.

The State is required to submit detailed reports to CMS regarding activities and expenditures under the RHTP, including cumulative expenditures to date and remaining balances for the budget period. The State will require each subrecipient to submit quarterly progress reports and a final evaluation report to permit the State to fulfill its RHTP requirements. Subrecipients may be required to respond to questions from or submit additional reporting to the State's RHTP team as deemed necessary by the State.

Quarterly Progress Reports

- Expenditures to date, reported by approved budget category and performance period, with explanations for any material variances
- Progress against approved workplan milestones, including identification of delays, risks, or implementation challenges
- Preliminary performance or outcome metrics, as applicable, aligned with approved project objectives
- Quarterly reports must be submitted following the schedule below for first 4 quarters of Program Year 2 with similar cadence expected in future periods.

Quarter	Reporting Period	Due Date
Quarter 1	Initial Awarding – September 30, 2026	10/15/2026
Quarter 2	October 1 – December 31, 2026	1/15/2027
Quarter 3	January 1 – March 30, 2027	4/15/2027
Quarter 4	April 1 – June 30, 2027	7/15/2027

Annual Evaluation and Final Reporting

To support the State's required annual CMS progress report due August 30th of each year, subrecipients will be required to submit:

- A cumulative evaluation report summarizing activities, expenditures, and progress toward intended outcomes for the reporting year
- Updated outcome and performance data, including both quantitative measures and qualitative findings
- An assessment of implementation challenges, lessons learned, and implications for sustainability

Decision-Making Framework: Program decisions will be guided by a transparent framework grounded in data, stakeholder input, compliance requirements, and the overarching goals of improving access, quality, and sustainability in rural healthcare delivery. The initiatives, priorities, and approved uses of funds included in the Mississippi RHTP have been established through extensive stakeholder engagement and approved by CMS as part of the State's implementation plan. While these core program elements will remain consistent, decisions regarding the allocation, timing, and deployment of funds may evolve over the life of the program in response to emerging needs, program performance, available data, and implementation experience.

All funding decisions will be made through standardized, transparent processes designed to ensure fairness, accountability, and compliance with applicable requirements. Competitive grant awards will be evaluated using published scoring criteria and rubrics specific to each funding opportunity. Procurement activities administered through participating state agencies will be conducted in accordance with established state procurement procedures and all applicable federal and state laws, regulations, and grant requirements. Funding recommendations and award decisions will be informed by objective data, documented evaluation processes, and alignment with the goals and approved framework of the RHTP. To the maximum extent practicable, the scoring criteria will be objective in nature and will rely on statistical and/or mathematical triggers for point accumulation. Any scoring criteria that would be more subjective in nature will be determined by subject matter experts that are objectively well suited for determining scoring determinations in accordance with the data presented by the applicants.

Section IV: Mississippi RHTP Goals and Objectives

8. Program Vision

The Mississippi RHTP vision is strengthening Mississippi's rural healthcare ecosystem through coordinated, technology-enabled, workforce-supported, and sustainable healthcare delivery systems.

9. Program Goals & Objectives

By 2031, every rural Mississippian will have reliable access to high-quality healthcare services, supporting increased access points and healthier communities across the State. The strategy prioritizes access, measurable improvements in health outcomes, workforce development, financial sustainability, scalable care delivery models, and the strategic application of health technology.

Goal 1: Expand Access to Care

- Increase service availability
- Improve care coordination
- Reduce geographic barriers

Goal 2: Strengthen Rural Workforce

- Recruit healthcare professionals
- Improve retention
- Expand training opportunities

Goal 3: Modernize Infrastructure

- Improve facilities
- Upgrade technology
- Strengthen cybersecurity

Goal 4: Advance Telehealth

- Expand virtual care access
- Improve provider connectivity
- Increase patient engagement

Goal 5: Improve Population Health

- Address chronic disease
- Improve behavioral health outcomes
- Enhance preventive care

Goal 6: Promote Sustainable Care Models

- Integrate regional health systems
- Support value-based care
- Implement long-term system sustainability measures

Program key performance objectives: The State will use a structured evaluation framework with specific and measurable metrics aligned with program goals that meet the statutory requirements of Public Law 119-21, §71401(h)(2)(A) and align with CMS reporting expectations.

By the end of the funding period in FY 2031, the State expects the RHTP to have established a more integrated, data-informed, and sustainable rural health system, improving access, quality, workforce capacity, care coordination, technology adoption, virtual care, behavioral health services, and infrastructure across the State.

The following section specifies the metrics used for evaluation within and across the program's initiatives. These objectives reflect the State's intended outcomes and may evolve as programs are designed and implemented.

Statewide Rural Health Assessment: By planned project completion in the fourth quarter 2026, 100% of planned assessment activities, including data collection, stakeholder engagement, analysis, and reporting, will be executed. The assessment will engage ≥150 stakeholders across hospitals, FQHCs, EMS, behavioral health, and community representatives. It will identify ≥5 major

service, workforce, or infrastructure gaps statewide and deliver a data-driven roadmap with recommendations aligned with assessment findings, prioritized by urgency, impact, and feasibility.

The **Coordinated Regional Integrated Systems (CRIS) Initiative** will strengthen regional care networks and patient care continuity. By the end of Year 5, CRIS is designed to reduce low-acuity ER visits by ≥10% through nurse navigation and treat-in-place interventions, engage ≥50% of rural hospitals and clinics in coordinated care networks, and ensure ≥35% of high-risk patients have completed care plans within 7 days of discharge, resulting in a ≤20% 30-day readmission rate for high-risk patients.

The **Workforce Expansion Initiative (WEI)** will expand and sustain the rural healthcare workforce. By FY 2031, the State intends to recruit and retain ≥150 clinicians, allied health professionals, and support staff in rural areas for at least 5 years, with ≥20% of program participants remaining in rural practice 5 years post-completion. WEI is designed to create and fill ≥35 new residency or training positions and engage ≥50 preceptors or mentors to provide high-quality supervision.

The **Health Technology Advancement and Modernization (HTAM) Initiative** will modernize rural provider systems and support digital health. By Year 5, ≥90% of funded providers will have upgraded, interoperable EHR systems, ≥75% of eligible providers will actively share data through the statewide HIE, ≥50% of applicable provider staff will complete cybersecurity or IT training, and ≥40% of patients will actively engage with digital tools, including patient portals, telehealth, and remote monitoring.

The **Telehealth Adoption and Provider Support (TAPS) Initiative** will increase virtual care access and capacity. By Year 5, TAPS is structured to increase telehealth visits by ≥40% among funded providers, enroll and sustain ≥50% of eligible providers in telehealth service delivery for at least two consecutive years, achieve full operational readiness for ≥85% of funded sites, and ensure that ≥50% of applicable provider staff will complete telehealth competency training within the first year.

The **Building Rural Infrastructure for Delivery, Growth, and Efficiency (BRIDGE) Initiative** will improve rural behavioral health access and infrastructure. BRIDGE is poised by Year 5 to have ≥3 Psychiatric Emergency Services (PES) units established, and ≥100 Community Health Workers and clinical staff trained and deployed. Also, by Year 5, ≥25 rural capital projects will be completed, contributing to ≥15% increases in service capacity, a ≥15% reduction in patient travel distances, and a ≥15% reduction in preventable ER visits in pilot program areas. ≥50% of pilot programs will show measurable improvements, and BRIDGE will reach ≥100,000 rural residents statewide.

Collectively, these initiatives create a resilient, well-connected rural health system by FY 2031, guided by evidence, measurable outcomes, and coordinated stakeholder engagement. Each objective has defined numeric targets and baseline measurements where available, ensuring progress can be monitored and evaluated consistently.

Section V: Mississippi Program Initiatives

10. Statewide Rural Health Assessment Initiative

Findings from the Statewide Rural Health Assessment will inform ongoing program prioritization, funding decisions, and continuous improvement across all RHTP initiatives. This will be a “living

program" that utilizes relevant data to adjust as the program moves forward. This will allow toggling of procedures and solutions to maximize outcomes and minimize waste.

To ensure effective and sustainable use of funds, the State will engage a third-party to conduct a comprehensive statewide assessment of rural health needs. This assessment will validate and enhance the existing plan, confirming that proposed investments address critical gaps and deliver measurable, long-term impact.

By developing a data-driven roadmap that confirms the best use of RHTP funds this initiative will help support long-term transformation of rural health in Mississippi.

Outcomes include confirming that proposed initiatives are aligned with the most urgent and impactful rural health needs across Mississippi and identifying critical gaps in service delivery, workforce capacity, infrastructure, and technology. Through engagement with providers, community leaders, and patients, the program will generate actionable guidance to ensure that investments are equitable, responsive, and reflective of on-the-ground needs.

Additionally, the State will develop a data-driven funding strategy that outlines how resources should be allocated to maximize sustainability and long-term impact. These efforts will be supported by strengthened partnerships and improved communication across stakeholders, alongside the establishment of clear benchmarks and performance metrics to monitor progress, ensure accountability, and evaluate the success of RHTP-funded initiatives over time.

11. Coordinated Regional Integrated Systems (CRIS)

The Coordinated Regional Integrated Systems (CRIS) Initiative is a core component of Mississippi's RHTP, designed to modernize and strengthen rural healthcare delivery through a regional, integrated model. At the center of this approach is the Regional Healthcare District Model, which brings together emergency medical services (EMS), hospitals, public health entities, and social service providers into coordinated networks.

By aligning these components, CRIS creates a more connected system of care that supports timely emergency response, seamless care transitions, and expanded access to essential services, including behavioral health. This integrated structure ensures that patients can move efficiently across levels of care while remaining connected to both clinical and community-based support.

Through this model, the State expects to achieve meaningful improvements in system performance and patient outcomes. These include faster and more effective emergency response through coordinated EMS and dispatch systems, improved continuity of care as patients transition between providers and settings, and expanded access to behavioral health and other critical services in rural communities. Collectively, these efforts support a more responsive, efficient, and sustainable rural healthcare system that is better equipped to meet the needs of Mississippi residents.

Partners from EMS and Emergency response, Hospitals and Clinics, Public Health agencies, and community and social service organizations will work together within Regional Healthcare Districts, using shared data, aligned protocols, and coordinated care pathways.

12. Workforce Expansion Initiative (WEI)

The Workforce Expansion Initiative (WEI) is Mississippi's initiative to grow, support, and sustain the rural healthcare workforce, so communities have the providers and support staff they need, when they need them. This includes not just physicians and nurses, but the full care team: EMS, behavioral health, dental, pharmacists, technicians, community health workers, and critical support roles like IT and billing.

Designed to build and sustain a strong rural healthcare workforce through a comprehensive, pipeline-focused strategy, WEI addresses the full continuum of workforce development by supporting targeted recruitment and retention programs, expanding training opportunities, and strengthening partnerships with educational institutions. Through coordinated efforts with high schools, community colleges, and clinical partners, the initiative creates clear career pathways into healthcare professions while offering incentives and professional development opportunities to encourage long-term service in rural communities.

Key components of WEI include the expansion of residency programs to increase the number of providers trained in rural settings, development of preceptors to enhance clinical training capacity, and implementation of "Earn While You Learn" programs that allow individuals to gain hands-on experience while receiving financial support. Together, these efforts strengthen the healthcare workforce pipeline, improve recruitment and retention outcomes, and ensure a sustainable supply of qualified professionals to meet the evolving needs of rural Mississippi.

13. Health Technology Advancement and Modernization (HTAM)

The Health Technology Advancement & Modernization Initiative (HTAM) is Mississippi's effort to modernize the technology that supports rural healthcare, so providers can deliver safer, faster, and more coordinated care.

Focused on strengthening the digital infrastructure that supports coordinated, efficient, and secure healthcare delivery across rural communities through targeted investments in health IT modernization, HTAM enables providers to upgrade electronic health record (EHR) systems, enhance interoperability, and participate in statewide data exchange efforts such as the Health Information Exchange (HIE). These efforts ensure that providers have access to timely, accurate patient information, supporting better clinical decision-making, improved care coordination, and more effective population health management.

In addition, HTAM prioritizes cybersecurity and the adoption of consumer-facing technologies to improve both system resilience and patient engagement. By strengthening network security, protecting sensitive health data, and supporting tools such as telehealth and remote monitoring, the initiative reduces operational risks while expanding access to care. Collectively, these investments modernize rural healthcare systems, improve data sharing across providers, and create a foundation for innovation, efficiency, and long-term sustainability in care delivery.

14. Telehealth Adoption and Provider Support (TAPS)

The Telehealth Adoption and Provider Support (TAPS) Initiative is designed to expand access to care across rural Mississippi by strengthening telehealth infrastructure, supporting provider adoption,

and enabling the delivery of high-quality virtual care. Through targeted investments in connectivity, equipment, and platform integration, the initiative enhances the ability of providers to deliver real-time care remotely, reducing geographic barriers and improving access to essential services. TAPS also provides technical assistance and training to ensure providers can effectively integrate telehealth into clinical workflows, while addressing broadband limitations and infrastructure gaps that may impact access in rural communities.

In addition, TAPS promotes the expansion of virtual care through provider support programs, community outreach, and innovative payment models that enable sustainable telehealth adoption. By increasing provider participation, improving patient awareness and utilization, and incorporating telehealth into settings such as schools, the initiative supports more consistent access to preventive, primary, and behavioral health services. Performance metrics and data-driven evaluation will be used to monitor utilization, outcomes, and system effectiveness, ensuring continuous improvement and long-term sustainability of telehealth services across the State.

15. Building Rural Infrastructure for Delivery, Growth, and Efficiency (BRIDGE)

The Building Rural Infrastructure for Delivery, Growth, and Efficiency (BRIDGE) Initiative is designed to strengthen rural healthcare systems by expanding infrastructure, improving access to specialized services, and addressing critical care gaps across Mississippi. Through targeted capital investments and programmatic enhancements, BRIDGE supports facility upgrades, equipment acquisition, and operational improvements that increase service capacity and efficiency in underserved areas. The initiative also advances the development of Psychiatric Emergency Services (PES) to expand crisis response capabilities, reduce strain on emergency departments, and ensure timely access to behavioral health care.

BRIDGE supports community health programs, care gap reduction efforts, and innovation pilots that test new models of care delivery, including value-based care demonstrations. These efforts promote coordination across providers, improve outcomes for high-need populations, and enable the State to evaluate scalable solutions to persistent rural health challenges. By combining infrastructure development with innovative programming, BRIDGE helps create a more resilient, efficient, and sustainable rural health care system aligned with long-term transformation goals.

Section VI: Funding and Financial Management

16. Funding Overview

The Rural Health Transformation Program (RHTP) was authorized by the One Big Beautiful Bill Act (Section 71401 of Public Law 119-21) signed July 4, 2025. RHTP funding includes $50 billion to be allocated to approved states over five fiscal years, with $10 billion of funding available each fiscal year, beginning in fiscal year 2026 and ending in fiscal year 2030.

The program is administered by Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS). Of this total funding, 50 percent will be distributed evenly among all approved states, while the remaining 50 percent will be allocated by the CMS based on factors such as rural population, the proportion of rural health care facilities, and the condition of certain hospitals, as well as other criteria outlined in the applicable Notice of Funding Opportunity

(NOFO). Before the November 2025 deadline, states submitted applications to CMS that included Rural Health Transformation Plan outlining initiatives, funding use, and expected outcomes. By December 31, 2025, award decisions were completed and all 50 states were awarded year one funding.

States will have yearly budget reconciliation with CMS to update program plans based on allocated funds. CMS will re-calculate each approved state's technical score and corresponding workload funding amount for each subsequent budget period based on the information and data the state provides in the required annual reporting each year. For each budget period, states will have until the end of the following fiscal year to spend awarded funding.

Determination of the four following award amounts will be made by these dates:

- For funding appropriated for fiscal year 2027: October 31, 2026
- For funding appropriated for fiscal year 2028: October 31, 2027
- For funding appropriated for fiscal year 2029: October 31, 2028
- For funding appropriated for fiscal year 2030: October 31, 2029

For year one, the State of Mississippi was awarded $205,907,220 by CMS/HHS (and has an additional 0.04% funded by non-government sources ($82,960)) totaling $205,990,180 to be set towards Rural Health Transformation Program initiatives in the State of Mississippi.

Implementation Plan and Timeline

The RHTP will be implemented using a phased, multi-year approach (Stage 0–Stage 5) across all initiatives, ensuring structured rollout, early validation, and scalable expansion. Each initiative follows a consistent lifecycle that includes establishing governance and baseline assessments, deploying initial programs, scaling successful models, conducting midpoint and final evaluations, and transitioning effective initiatives into sustainable operations. This approach ensures that all program activities are data-driven, continuously monitored, and adapted based on performance and stakeholder input, supporting long-term improvements in rural healthcare access, quality, and system sustainability.

Stage 0 – Planning and Design (January-June 2026)

Stage 1 – Program Setup and Initial Launch (April-June 2026)

Stage 2 – Pilot Implementation (July 2026-2027)

Stage 3 – Expansion and optimization (2028-2029)

Stage 4 – Evaluation and Sustainability Planning (2030)

Stage 5 – Full Implementation and Sustainability (2030-2031)

Budget Categories

Throughout the RHTP, the expectation is that the State and any of their subrecipients or contractors provide an equal and thorough level of detail so CMS can confirm all costs are allowable (i.e., necessary, reasonable, and allocable, and consistent with the terms of the NOFO).

CMS requires applicants and subrecipients to develop budgets using the standard SF-424A format and corresponding object class cost categories, with a detailed budget narrative that aligns with and supports those categories.

Budget Categories include: Personnel Salaries and Wages, Fringe Benefits, Travel, Equipment, Supplies, Consultant/Subrecipient/Contractual, Other and Indirect Costs (Mississippi indirect cost limited to 5%).

17. Program Funds

Allowable Uses of Funds

Per the permissible uses described in Section 71401 of Public Law 119-21, states must use funds for three or more of the approved uses of funds.

- ***Prevention and chronic disease:*** Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.
- ***Provider payments:*** Providing payments to health care providers for the provision of health care items or services, subject to restrictions described in the funding policies and limitations. Restrictions include provisions that provider payments cannot be for current services and must be for new or expanded services.
- ***Consumer tech solutions:*** Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.
- ***Training and technical assistance:*** Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.
- ***Workforce:*** Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.
- ***IT advances:*** Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.
- ***Appropriate care availability:*** Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
- ***Behavioral health:*** Supporting access to substance abuse treatment services and mental health services.
- ***Innovative care:*** Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.

Additional uses as designed to promote sustainable access to high quality rural health care services, as determined by the Administrator.

Ineligible Uses of Funds

Per the non-permissible uses described in Section 71401 of Public Law 119-21, states cannot use funds for:

- ***Construction Restrictions:*** Funds cannot build new health care facilities, expand buildings, or materially increase the useful life of a facility.
- ***Duplicate Insurance:*** Funds may not replace payments for clinical services that are already reimbursable by insurance, Medicare, Medicaid, or CHIP.
- ***Non-Compete Clauses:*** Funds cannot support the salaries or wages of clinicians working at facilities that have non-compete clauses in their employment contracts.
- ***Lobbying:*** Federal money may not be used for lobbying efforts.
- ***Other Federal Programs:*** RHTP funds cannot be used to meet the matching requirements for other federal programs.
- ***Medicaid Matching:*** Funds cannot be used to finance the non-federal share (the state match) for Medicaid.

Caps on Funding

Per Section 71401 of Public Law 119-21, states must allocate funding across specific categories, observing the following strict caps:

- ***Administrative costs:*** Capped at ≤ 10% of the total award (including both direct and indirect costs).
- ***Provider payments:*** Capped at ≤ 15% of the total award per budget period.
- ***Infrastructure and capital investments:*** Capped at ≤ 20% of the total award for minor alterations with prior CMS approval.
- ***Electronic medical record (EMR) replacement:*** Capped at ≤ 5% of the total award per budget period.
- ***Technology catalyst funding:*** Capped at ≤ 10% of the total award or ≤ $20 million (whichever is less).

18. Financial Accountability

Subrecipients

RHTP funds made available through competitive grant programs will be awarded to eligible subrecipients by participating Mississippi state agencies. Other funds may be administered through interagency awards, contracts, procurements, or direct State program expenditures, as authorized by the approved plan and applicable requirements. Any funding through grant programs will be publicly announced and accessible to all eligible organizations.. Please note that grant programs are being designed to be accessible to all eligible applicants. Clear instructions, guidance, and application materials will be provided in addition to technical assistance available throughout the application process.

States receiving RHTP funding that issue subawards are considered pass-through entities and are responsible for ensuring that subrecipients comply with all applicable federal statutes, regulations, and award terms. Subrecipient monitoring is a required component of federal grant management and is governed by 2 CFR Part 200, Subpart D (Post Federal Award Requirements).

The State will identify and properly classify each entity as a subrecipient or contractor based on the nature of the relationship and the role the entity plays in carrying out program objectives.

Once subrecipients are established, the State will evaluate the risk of noncompliance for each subrecipient, and tailor monitoring activities based on risk.

Ongoing monitoring is required throughout the life of the award to ensure that funds are used for authorized purposes and that program objectives are achieved. This includes reviewing financial and programmatic reports, maintaining regular communication, and conducting additional oversight activities such as desk reviews or site visits when appropriate.

The State will also verify that subrecipients meet audit requirements, maintain adequate internal controls, and adhere to all applicable grant conditions.

Subrecipients are expected to implement the project as proposed and use funds for approved purposes. They are expected to share data needed to measure impact and support continuous improvement and to report on project progress, outcomes, and expenditures.

Fiscal Controls

The State will maintain effective fiscal controls and internal control systems to ensure that RHTP funds are used solely for authorized purposes and in compliance with all applicable federal, state, and program-specific requirements. This includes the ability to accurately track expenditures, maintain supporting documentation, and implement safeguards to prevent fraud, waste, and abuse. Fiscal controls are established in accordance with 2 CFR 200.302 (Financial Management) and 2 CFR 200.303 (Internal Controls). Internal and external reporting mechanisms will be in place to accurately inform interested parties.

Audit Requirements

Recipients and subrecipients must comply with audit requirements outlined in 2 CFR 200, Subpart F (Audit Requirements). Reports on these audits must be submitted to the Federal Audit Clearinghouse (FAC) either within 30 days after receipt or nine months after the end of the fiscal year, whichever is earlier. The audit reports and a completed data collection form (SF-SAC) must be submitted electronically to FAC. FAC operates on behalf of the Office of Management and Budget (OMB). The State is responsible for ensuring audit readiness, addressing findings, and implementing corrective actions as necessary to maintain compliance and program integrity.

Unexpended or Unobligated Funds

In accordance with federal requirements under 42 U.S.C. 1397ee(h)(1)(B), RHTP funding is subject to redistribution if funds remain unexpended or unobligated. Unexpended funds are defined as those that are not fully spent by the State within the applicable timeframe for each budget period, including funds that have been set aside but not yet disbursed for approved activities, subawards, or contractual obligations. Unobligated funds refer to funding that has not been awarded by CMS within a given budget period.

When such funds become available, CMS will redistribute them in the next feasible fiscal year using the same allocation methodology established for the program. Any funds that remain unexpended or unobligated as of October 1, 2032, will be returned to the U.S. Department of the Treasury.

19. Performance Measurement Framework

The State will implement a comprehensive Performance Measurement Framework to monitor program effectiveness, ensure accountability, and demonstrate measurable progress toward RHTP goals. This framework establishes a structured, data-driven approach to tracking performance at the program and initiative levels, with clearly defined metrics, numeric targets, and reporting timelines. It aligns financial investments with measurable results and supports compliance with CMS reporting and evaluation requirements. Each metric will include defined data sources, reporting geography, and updated frequency to ensure consistency, transparency, and auditability.

Program Metrics

Program metrics provide a high-level view of statewide performance and are aligned with RHTP strategic priorities, including access to care, workforce development, technology adoption, and system sustainability. These metrics are designed to assess overall progress across all initiatives and are supported by standardized reporting processes to ensure consistency, comparability, and transparency.

Initiative-Level Metrics

Initiative-level metrics track implementation progress and outputs within each program area, including defined numeric targets, timelines, and performance thresholds. These metrics are tailored to each initiative and may include measures such as service utilization, provider participation, workforce placements, technology adoption, and infrastructure expansion. Data is collected and reported at the appropriate geographic level (e.g., county or statewide) and updated on a defined frequency (e.g., quarterly or annually) to support active monitoring and course correction.

Outcome Measures

Outcome measures evaluate the longer-term impact of the program on rural healthcare systems and populations, focusing on improvements in access, quality, care coordination, workforce stability, and patient outcomes. These measures are tied to specific performance targets and are used to demonstrate program effectiveness, inform continuous improvement, and support CMS evaluation and annual rescoring processes.

20. Reporting Requirements

To remain eligible to continue to receive funding in subsequent budget periods, awardees must adhere to key program requirements, including the submission of annual and quarterly reports as required by CMS Rural Health Transformation Program (RHTP) Reporting.

Annual reports are due 60 days before the end of the budget period. The first annual report is due August 30, 2026, covering a 7-month period ending July 31st; all subsequent annual reports will cover a 12-month reporting period.

Quarterly reports are reflective of progress made during the relevant quarter. Reports are due 30 days after reporting period ends.

Quarterly Reporting periods are August 1-October 30, October 31-January 30, and January 31-April 30. Please note that to reduce the reporting burden, there is no quarterly report for May 1 – July 31. The first quarterly report is due November 29, 2026.

All reports will be submitted via the GrantSolutions system. The initial annual report will be completed on the CMS provided standardized excel formatted template which will be submitted to GrantSolutions. After the initial report, there will be a shift to a web-based tool.

Additional CMS reporting requirements:

- Progress reports.
- Federal Financial Report (FFR).
- Federal Funding Accountability and Transparency Act (FFATA).
- SAM.gov Responsibility/Qualification records.
- Payment Management System (PMS).
- Audit reporting (Federal Audit Clearinghouse).
- Workplan updates.
- Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification.

The State is required to comply with established reporting requirements, including timely submission of accurate financial and programmatic reports that demonstrate progress toward performance goals and proper use of funds. These reports must be supported by reliable data and sufficient documentation to meet federal transparency and accountability standards.

The Final Report for all RHTP projects is due by February 27, 2031, which will include a comprehensive overview of all activities completed during the entire RHTP (FY26-31).

The State will require subrecipients to comply with all reporting requirements and submit monthly reports.

RHTP funding is subject to federal transparency requirements under the Federal Funding Accountability and Transparency Act (FFATA) and implementing regulations at 2 CFR Part 170, which require public disclosure of federal spending.

21. Continuous Quality Improvement

The State will implement a continuous quality improvement (CQI) and evaluation approach to ensure that RHTP activities are effectively monitored, refined, and aligned with program goals. This approach integrates performance data, stakeholder feedback, and structured evaluation processes to support ongoing program improvement and sustained outcomes.

The State will facilitate learning collaboratives and knowledge-sharing forums across participating providers, stakeholders, and implementing partners. These collaboratives will support the dissemination of best practices, promote peer-to-peer learning, and enable rapid identification and replication of successful models. Regular engagement with stakeholders and program participants will ensure that lessons learned are incorporated into program refinement and future planning.

The State will establish a formal corrective action process to address performance gaps, compliance issues, or implementation challenges identified through monitoring and evaluation activities. When deficiencies are identified, the State will work with subrecipients to develop and implement corrective action plans with defined timelines, measurable milestones, and ongoing oversight. Progress will be tracked to ensure resolution and sustained compliance with program requirements.

Section VII: Communications and Stakeholder Engagement

22. Stakeholder Engagement Strategy

The Mississippi Rural Health Transformation Program plan reflects a deliberate stakeholder engagement process that meets statutory requirements under Public Law 119-21, §71401, while fostering durable partnerships across rural communities. The State's approach emphasizes representation, alignment with federal guidance, and ongoing stakeholder consultation.

The Mississippi Governor's Office launched its stakeholder engagement survey on July 31, 2025, and thus was one of the first states in the nation to begin a formal stakeholder engagement. This public input process yielded 145 responses from stakeholders representing nearly half of the State's counties, including responses from state health officials, public health practitioners, healthcare providers and administrators, health plan representatives, members of the public, legislators, and prospective vendor partners. This stakeholder input directly informed the development of the State's plan.

The Governor's Office, in coordination with state agency partners, determined that the timeline between July and the November 2025 submission deadline did not allow for the level of stakeholder engagement, data analysis, and validation necessary to develop a comprehensive long-term strategy for rural health transformation. To address this constraint, Mississippi incorporated a Statewide Rural Health Assessment into its overall strategy to build upon prior work, validate and refine identified priorities, and identify opportunities to maximize the impact and effectiveness of RHTP investments.

Additionally, the Governor's Office collaborated with the Mississippi State Department of Health, the Division of Medicaid, and the Department of Mental Health to develop the program plan and supporting application.

23. Change Management

The State of Mississippi, in coordination with stakeholders and program administrators, will maintain ongoing monitoring of legislative updates and program guidance issued at the federal level. A designated administrative team will be responsible for communicating all programmatic updates to participants, subrecipients, and advisory bodies in a timely and transparent manner. This team

will also lead all necessary training and technical assistance efforts through regularly scheduled meetings, webinars, and formal communications, ensuring that stakeholders are fully informed of any changes and their implications for program implementation, materials, and compliance requirements.

The administrative team will also be responsible for regularly communicating submission deadlines and maintaining comprehensive records of all communications for future reference. In addition, this team will oversee program closeout activities by developing and implementing processes that align with federal and state requirements related to documentation, record retention, reporting, and financial reconciliation.

24. Sustainability Framework

The Mississippi Rural Health Transformation Program (RHTP) employs a long-term sustainability framework designed to align funding with system-wide transformation and ensure lasting impact beyond the initial federal investment. Mississippi's goal is to ensure the impact created by these funds is sustainable and creates a long-term transformation impact across the state. Through a structured, multi-year funding model with defined budget periods, the program emphasizes accountability, performance measurement, and responsible resource allocation. Strategic investments in coordinated systems of care, workforce development, and technology modernization are intended to improve efficiency, reduce fragmentation, and support sustainable care delivery models.

The State's approach to workforce sustainability focuses on strengthening recruitment and retention, expanding training pathways, and enabling providers to practice at the top of their license, thereby building a resilient workforce capable of meeting evolving community needs. Similarly, the technology sustainability strategy prioritizes the development of an integrated digital health infrastructure, including expanded telehealth, enhanced data sharing, and strengthened cybersecurity, to support long-term access and care coordination. Focus will be given to revenue generation to support provider transition to value-based payment models for long-term sustainability.

In addition, the program advances regional system sustainability through the development of coordinated and integrated networks of care, such as the Coordinated Regional Integrated Systems (CRIS) model, which promotes collaboration among providers and supports efficient, scalable service delivery. Collectively, these efforts establish a comprehensive, sustainable framework for improving healthcare access, quality, and outcomes across rural Mississippi.

25. Future State of Rural Healthcare in Mississippi

The RHTP is structured across five budget periods, spanning Fiscal Year 2026 through Fiscal Year 2030. By providing rural communities with a five-year funding allocation, the program is intended to position them for long-term financial stability and future success.

The overarching objective of the program is to ensure that, by 2031, all rural Mississippians have consistent and reliable access to high-quality healthcare services, resulting in improved health outcomes, enhanced system sustainability, and stronger, more resilient rural healthcare systems statewide. This transformation is intended to establish a lasting program legacy, creating a

sustainable, integrated rural healthcare framework that continues to deliver value and improved outcomes for generations to come.

Appendix A – Glossary of Terms and Acronyms

Building Rural Infrastructure for Delivery, Growth, & Efficiency (BRIDGE) Initiative

A core initiative within the Mississippi Rural Health Transformation Program focused on strengthening rural healthcare infrastructure to support efficient care delivery, system growth, and long-term sustainability.

Centers for Medicare & Medicaid Services (CMS)

A federal agency within the U.S. Department of Health and Human Services (HHS) that administers and oversees major national healthcare programs and distributes federal funding to states to improve healthcare access, quality, and outcomes.

Coordinated Regional Integrated Systems (CRIS) Initiative

A core initiative within the Mississippi Rural Health Transformation Program that establishes regionally coordinated, data-driven networks integrating emergency medical services (EMS), hospitals, public health, and social service providers to improve care delivery and patient outcomes.

Disproportionate Share Hospital (DSH) Program

A hospital that serves a significantly higher proportion of low-income patients—such as Medicaid beneficiaries and uninsured individuals—and receives additional government funding to help cover the cost of uncompensated care.

Emergency Medical Services (EMS)

A system that provides urgent medical care, stabilization, and transportation for individuals experiencing serious illness or injury, typically before they reach a hospital.

Federally Qualified Health Centers (FQHCs)

Community-based healthcare providers that receive federal support to deliver comprehensive primary care services to medically underserved populations, regardless of a patient's ability to pay.

Health Technology Advancement & Modernization (HTAM) Initiative

A core initiative within the Mississippi Rural Health Transformation Program that strengthens and modernizes rural healthcare technology infrastructure to support coordinated, data-driven, and secure care delivery.

Memorandum of Understanding (MOU)

A formal written agreement between two or more parties that outlines their mutual intentions, roles, and responsibilities in a collaborative effort, typically without creating legally binding obligations.

Mississippi Rural Health Transformation Program (RHTP)

A federally funded, state-administered initiative designed to transform the rural healthcare system in Mississippi by improving access, quality, coordination, and long-term sustainability of care delivery.

Notice of Funding Opportunity (NOFO)

A formal announcement issued by a federal agency to notify the public that funding is available for a specific program and to provide instructions and requirements for applying for that funding.

One Big Beautiful Bill Act (OBBBA)

A comprehensive federal budget reconciliation law (Public Law 119-21), signed on July 4, 2025, that implements broad changes to federal taxation, spending, and public programs across multiple policy areas.

Telehealth Adoption & Provider Support (TAPS) Initiative

A core initiative within the Mississippi Rural Health Transformation Program that expands access to healthcare by supporting the adoption, implementation, and sustainability of telehealth services across rural providers.

U.S. Department of Health & Human Services (HHS)

A cabinet-level federal agency responsible for protecting the health of all Americans and providing essential human services, while overseeing and funding national health programs and public health initiatives.

Uniform Guidance (2 CFR Part 200)

A set of federal regulations issued by the U.S. Office of Management and Budget (OMB) that establishes uniform administrative requirements, cost principles, and audit standards for organizations receiving federal financial assistance.

Workforce Expansion Initiative (WEI)

A core component of the Mississippi Rural Health Transformation Program designed to strengthen and expand the rural healthcare workforce through recruitment, retention, training, and capacity-building efforts.